



Department of Speech, Language,
and Hearing Sciences

Clinical Educator Handbook

Revised Spring 2024

**Department of Speech, Language, and Hearing Sciences
Clinical Educator Handbook
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A: ASHA Code of Ethics (2023)

B: ASHA Supervision of Student Clinicians (2023)

C: ASHA Knowledge, Skills and Training Consideration for Individuals Serving as Supervisors (2023)

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E: ASHA Technical Report: Clinical Supervision in Speech-Language Pathology (2008)

F: ASHA Scope of Practice in Speech-Language Pathology (2016)

G: ASHA Practice Portal: Professional Issues – Clinical Education and Supervision (2017)

H: ASHA Self-Assessment of Competencies in Supervision (2016)

I: Map of SFSU

J: Sample Clinic Calendar K: Sample SLHS 880 Syllabus

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N: Reference Articles

American Speech-Language-Hearing Association (1985). *Clinical Supervision in Speech-Language Pathology and Audiology* [Position Statement]/ Available from www.asha.org/policy.

Duthie, J.K, & Robbins, D. (2013). The clinician –directed hierarchy: Effective clinic instruction across university settings. *Perspectives on Administration and Supervision*, 23, 4-16.

Kamhi, A.G. (1995). Defining, developing and teaching clinical expertise. *Language, Speech, and Hearing Services in Schools*, 26, 353-356.

Taylor, K., White, E. Kaplan R. & O'Rourke, C.M. (2012). The supervisory process in speech-language pathology: Graduate students' perspectives. *Perspectives on Administration and Supervision*, 22, 47-54.

Introduction

Nicholas Certo Speech-Language-Hearing Sciences Clinic

The Nicholas Certo Speech-Language-Hearing Sciences Clinic at San Francisco State University was established more than 50 years ago. In Spring 2017, the SLHS Clinic was re-named the Nicholas Certo Speech-Language-Hearing Sciences Clinic in honor of Nicholas Certo, Ph.D., SPED/CD Chair from 2000 – 2012. The SLHS Clinic is an educational and training facility for master's level clinicians preparing to enter the profession of speech-language pathology. Graduate students provide screenings, diagnostic assessments, and therapy services to infants, toddlers, children, adolescents, and adults with various difficulties in speech, language, and hearing. All diagnostic and therapy services are offered by appointment and are performed under the direct supervision of state-licensed and American Speech-Language-Hearing Association (ASHA) certified faculty.

Because the SLHS Clinic is a training facility, we are able to offer screenings, diagnostic evaluations, and speech and language therapy services at a reduced fee, with a sliding scale offered to all clients. Services are provided during the fall, spring, and summer semesters.

The speech and language clinic offers one-on-one and small group therapy sessions for the areas of speech, language, and hearing including:

- Speech sound production difficulty
- Developmental language difficulty
- Stuttering and fluency difficulty
- Oral motor difficulty
- Voice difficulty
- Speech and language difficulties associated with hearing impairment
- Speech or language difficulties resulting from brain injury, stroke, or neuromuscular disability (i.e., aphasia, dysarthria, apraxia)
- Speech production difficulties resulting from craniofacial anomalies
- Augmentative and alternative communication (AAC)
- Autism
- Central Auditory Processing Disorders
- Language enrichment for preschoolers

Individual and small group therapy sessions are typically scheduled for 55 minutes, one to two times per week. Family involvement and participation is highly encouraged to promote understanding and generalization of good communication practices into the individual's environment.

The SLHS Clinic facilities feature closed circuit television for supervision, training, and observation purposes. The clinicians' materials room houses a variety of tests, protocols, and therapy materials appropriate for assessment and intervention.

Located on the ground floor of Burk Hall, the SLHS Clinic was designed and constructed to be accessible to disabled individuals. Adaptive features include elevators, amplified telephones, and wheelchair-friendly water fountains and rest rooms.

Mission

Speech, Language, and Hearing Clinic

Graduate College of Education

The GCOE develops transformative and visionary educators, clinicians, and leaders for social justice to effect change for good across the Bay Area and beyond, and to create an engaged, and productive democracy. Together we do the work necessary to understand and welcome all; prepare equity-focused, caring and highly skilled professionals; to identify and dismantle racist, ableist, and oppressive systems; and to build an equitable and accessible present and future. (<https://gcoe.sfsu.edu/content/about-college>)

Department of Speech, Language, and Hearing Sciences

Mission

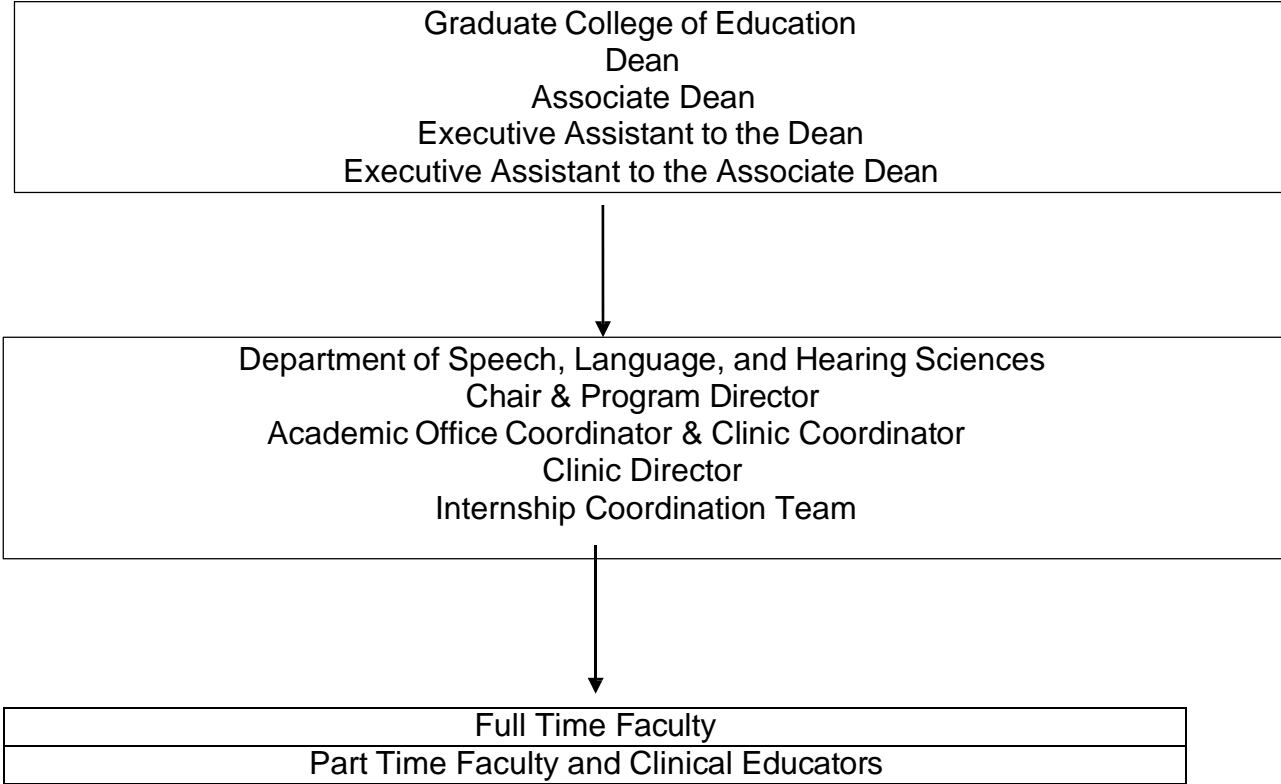
The mission of the Department of Speech, Language and Hearing Sciences (SLHS) at San Francisco State University is based on our commitment to antiracism and other forms of anti-discrimination as fundamental to our professions, and essential to our preparation of professionals to:

- Identify, challenge and dismantle institutional, environmental, sociocultural, informational, attitudinal and linguistic barriers to accessible, equitable and transformative communication for individuals with communication disabilities and those whose right of expression are diminished or silenced;
- Develop, model, disseminate and adopt best practices in the provision of equitable, competent, compassionate and culturally/linguistically responsive services to individuals with communication disabilities across the lifespan; and
- To promotes linguistic diversity and recognize the use of different languages and Englishes among our students and professionals as an asset to our academic and professional community.

Vision

The vision of the SLHS department at SF State is to be a leader in the field of Speech, Language and Hearing Sciences for advancing critical thinking, equity and scientific rigor. We aspire to meet the challenges of creating pathways for recruiting, supporting, retaining and nurturing high qualified students and professionals that represent diverse histories, identities, life experiences, and perspectives. The SLHS administration, faculty, student body and professional partners represent a community of practice that respects and supports individuals with communication disabilities; that integrates research with clinical practice; that embodies equity; and that fosters an inclusive student/professional community in service of accessible communication for all.

**Organizational Chart
Communicative Disorders Program**



Department of Speech, Language and Hearing Sciences Contact Information

Laura Epstein, Ph.D. CCC-SLP
Professor
Department Chair
Internship Coordination Team member
Burk Hall 115
(415) 405-2170
lepstein@sfsu.edu

Nancy Robinson, Ph.D., CCC-SLP
Professor Emerita
AAC Specialization Coordinator
nancyr@sfsu.edu

Gloria Soto, Ph.D.
Professor
AAC Specialization Coordinator
Burk Hall 271
(415) 338-1757
gsoto@sfsu.edu

Marcia Raggio, Ph.D., CCC-A
Professor
Audiology Coordinator
Burk Hall 104
(415) 338-7653
mraggio@sfsu.edu

[Michael Clarke, Ph.D.](#)
[Assistant Professor](#)
Project Allies Co-Director
Burk Hall 103
(415) 338-7655
michaelclarke@sfsu.edu

Betty Yu, Ph.D. CCC-SLP
Professor
Project Allies Director
Clinic Director
Internship Coordination Team member
Burk Hall 105
(415) 338-3429

Teresa Gray, Ph.D., CCC-SLP
Associate Professor
Nonschool Internship Coordinator
Burk Hall 102
(415) 338-1058
teresag@sfsu.edu

Anusha Sundarrajan, Ph.D., CCC-SLP
Assistant Professor
Nonschool Internship Coordinator
Burk Hall 101
(415) 338-7652
anusha@sfsu.edu

Department of Speech, Language and Hearing
Sciences
Academic Office Coordinator
Clinic Coordinator
Mallorie Desimone
Burk Hall 113
(415) 338-1001
mallorie@sfsu.edu

Department of Speech, Language and Hearing
Sciences & Clinic Office Phone: (415) 338-1001
Fax: (415) 338-0916
Email: SLHSinfo@sfsu.edu
Website: <http://slhs.sfsu.edu/>

Mailing Address:
Department of Speech, Language
and Hearing Sciences
San Francisco State University
1600 Holloway, Burk Hall 113
San Francisco, CA 94132

Clinic Courses, Prerequisites and Course Descriptions **Department of Speech, Language, and Hearing Sciences**

Undergraduate Clinic

SLHS 711 or 713: Practicum in Communication Therapy (Volunteer Clinic Aide)

Prerequisites:

- Undergraduate SLHS major with completion of minimum of 18 units of SLHS coursework
- By Advisement

Description:

- 1 unit letter grade during fall/spring; no grade during summer
- Observation of supervised clinical experience in basic testing and treatment of children and adults with communication difficulties.

Graduate Clinics

First Year Graduate Clinics (1 child language required and 1 adult clinic required)

SLHS 880 + SLHS 713 Communicative Disorders in Children

Prerequisites:

- Graduate standing

Description:

- 2 units SLHS 880 letter grade
- 1 unit SLHS 713 letter grade
- Supervised clinical methods and practice in advanced communication rehabilitation.

SLHS 880 + SLHS 713 Communicative Disorders in Adults

Prerequisites:

- Graduate standing

Description:

- 2 units SLHS 880 letter grade
- 1 unit SLHS 713 letter grade
- Supervised clinical methods and practice in advanced communication rehabilitation.

*Please note SLHS 711 and SLHS 713 are not offered during summer semester

Second Year Graduate Clinics

Prerequisites:

- SLHS 701 Language Differences and Disorders in Children
- SLHS 702 Social Communication Development
- SLHS 703 Research Methods, Evidence-Based Practices, and Professional Issues
- SLHS 707 Advanced Seminar in Language Disorders
- SLHS 709 Speech Sound Production
- SLHS 708 Seminar in Adult Neurogenetics of Language
- SLHS 710 Seminar in Dysphagia
- SLHS 754 Voice and Resonance
- SLHS 755 Stuttering
- SLHS 756 Right Hemisphere Stroke, TBI and Dementia
- SLHS 757 Aural Rehabilitation
- SPED 734: Augmentative and Alternative Communication

- SLHS 880 At least one clinic with children
- Description:
- 5 or 8 units SLHS 715 letter grade

- 1 unit SLHS 725 letter grade (student teaching seminar)
- Clinical/rehabilitative experience with language, speech, and/or hearing special needs children in school settings.

SLHS 882 + SLHS 712 Adult Internship II and Medical Internship Seminar

Prerequisites:

- SLHS 701 Language Difference and Disorders in Children
- SLHS 705 Aural Rehabilitation
- SLHS 706 Counseling in CD
- SLHS 707 Advanced Seminar in Language Disorders
- SLHS 708 Seminar in Adult Neurogenetics of Language
- SLHS 709 Seminar in Motor Speech Disorders
- SLHS 710 Seminar in Dysphagia
- SLHS 756 Advanced Diagnosis of Communicative Disabilities
- SLHS 768 Advanced Clinical Skills
- SLHS 880 At least one clinic with adults

Description:

- 3 or 6 units SLHS 882 letter grade
- 1 unit SLHS 712 letter grade (medical internship seminar; no summer seminar)
- Practicum in medical or agency settings

SLHS 884 Advanced Diagnosis in SLHS

Prerequisites:

- SLHS 880 completion of minimum of 2 clinics
- Often concurrent with SLHS 882 Adult Internship II

Description:

- 3 units letter grade
- Supervised clinical diagnosis of communication difficulties

Getting Started

Speech, Language, and Hearing Sciences Clinic

Parking/Building Location

- Park in lot 20 with daily parking permits purchased from a pay station.
- Park in lot 19 or the roof of lot 20 with a semester long parking permit or daily parking permits purchased from Parking and Transportation; you will need to show your SFSU faculty ID card.
- The SLHS Clinic is located on the ground floor of Burk Hall, Room 114.
- See Appendix I for a map of directions to SFSU and the campus.

Keys

- Obtain a key to open the SLHS office, materials room, clinic rooms, and part-time instructor's office from the SLHS Academic Office Coordinator.

Mailbox

- A "mail-slot" with your name is located in the SLHS office, Burk Hall 113.
- You will receive department information in this location and can leave information for other faculty and staff at this location.

Phone/Desk – Part-Time Clinical Educators

- Your desk and a phone are located in the part-time instructor's office; your office will vary across semesters.
- The phone is available for out-going calls.
- Receive phone calls via the clinic coordinator at (415) 338-1001.

Client Files

- On line in password-protected Box folder accessible only by clinical educator.

Clinic Rooms

- One group of clinic rooms is located in Burk Hall 106 (voice lab), 107, 108, 109 and 110.
- A second group of clinic rooms is located in Burk Hall 123, 124, 125 and 126.
- AAC Lab is located in Burk Hall 137.
- SLHS conference room is located in Burk Hall 138.
- Autism play room is located in Burk Hall 140.

Observation

- Located in Burk Hall 136 or use dedicated and password-protected Zoom link.

Assessment and Therapy Materials Room

- Located in Burk Hall 127.

Restroom

- Located in Burk Hall T141.

Photocopy Machine

- Located in Burk Hall 113.
- Ask the AOC to make copies.

Student Workroom

- Located in Burk Hall 116.

Client Waiting Room

- Located in Burk Hall 114.

Clinical Educator Responsibilities Speech, Language, and Hearing Sciences Clinic

Clinical educators will complete the 2-hour supervision CEU and keep their CA licensure and CCC up to date.

- These will be verified by the SLHS clinic coordinator each semester.

Clinical educators will abide by the ASHA Code of Ethics (2023).

- See Appendix A

Clinical educators will adhere to the ASHA Board of Ethics guidance document Supervision of Student Clinicians (2023).

- See Appendix B

Clinical educators will adhere to the ASHA Scope of Practice in Speech-Language Pathology (2007).

- See Appendix F

Clinical educators will be available to meet with students weekly during staff meetings and as arranged by the clinical educator.

Clinical educators will adhere to ASHA requirements for observation of student clinicians:

- Minimum 25% observation of therapy and evaluations

Clinical educators will provide student clinicians with oral and/or written feedback that contains both positive comments and constructive criticism during observed therapy sessions.

Clinical educators will provide student clinicians with written feedback that contains both positive comments and constructive criticism regarding SOAP notes, intended therapy plans, proposed semester's objectives, home programs, and final therapy reports.

Clinical educators will return proposed semester's objectives, home programs, and final therapy reports in a timely manner, per deadlines in the SLHS program calendar.

Clinical educators will be responsible for the following by the final day of the semester:

- File record releases, initialed SOAP notes and signed de-identified final therapy reports in uploaded to online client box folders
- Evaluation protocols to secured clinic folder in Clinic Coordinator office
- Complete and sign final evaluation KASA forms; students to upload to box folders
- Sign student clinician's ASHA clinic clock hours form; students to upload to box folders

Clinic Policies and Procedures

Speech, Language, and Hearing Sciences Clinic

Syllabus

A course syllabus is written and reviewed with student clinicians and clinic aides during the initial planning meeting.

- Place the syllabus on Canvas for student access.
- See Appendix K for a sample CD 880 syllabus.

Clinical Educator Meeting

- The clinical educator and the clinic director meet briefly either the week before or the initial week of the semester to review updated clinic information.

Client Assignments

- The clinic coordinator provides the clinical educator with a list of student clinicians and clinic aides prior to the beginning of the semester.
- The clinic coordinator provides the clinical educator with a list of clients during the initial week of the semester.
- Students are assigned one client/group per 3-unit or 2-unit course
- The clinical educator reviews the client files and assigns clients to student clinicians during the initial week of the semester. If this is the student clinician's second child client, it is important to assign a variety of types of clients to the clinician (e.g. first child client was an articulation delay; second child client should not be an articulation delay, etc.).

Frequency/Duration/Location of Therapy

Individual therapy:

- Clients are generally seen one or twice weekly for 55 minute sessions beginning on the hour or as arranged with client.

Group therapy:

- Clients are seen once or twice weekly as determined by the clinical educator.
- Sessions are generally 55 minutes in duration beginning on the hour.

Student Attire

- Students are expected to dress in a professional manner.

Materials Room

- Assessment and therapy materials are located in Burk Hall 127.
- Student clinicians must reserve and sign out assessment and therapy materials through the AOC.
- Please refer to sign-out policies and procedures as listed in the materials room.

Client Forms

The following client forms must be signed and in the client file during the initial client visit:

- Client agreement form

- Statement of Understanding form
- Release of information form (as needed)

Cancellation Policy

Student Clinician Cancellations:

- Student cancellations are allowed only due to illness or emergency situations.
- Students must contact the client, AOC, and clinical educator as soon as possible.
- Students are required to make-up any cancelled sessions unless instructed otherwise by the clinical educator.

Client Emergencies/Cancellations:

- Student clinicians must provide clients with a phone number to contact them in the event of an emergency/cancellation.
- Clients should also contact the clinic coordinator at 338-1001 to cancel appointments.
- Student clinicians must notify the clinical educator in the event of a cancellation.
- Make-up sessions are not required unless instructed otherwise by the clinical educator.
- If more than 3 sessions are missed, supervisor will reach out to family

Confidentiality Policy

Client confidentiality must be strictly adhered to throughout the semester.

- Student clinicians/clinical educators may not photocopy contents of client folders
- Client discussions may only take place:
 - In the client room
 - In the observation room
 - In the clinical educator's office
 - In the student workroom
- Client discussions MAY NOT take place in the hallways or client waiting areas.
- Email accounts shared with clients must only be SFSU email accounts.
- Student clinicians and clinical educators must not share social media accounts with clients.

Semester Schedule of Activities Speech, Language, and Hearing Sciences Clinic

See Appendix J: Sample Clinic Calendar for an example of a semester schedule

See Appendix L: SLHS Instructors' Canvas Forum for the semester long clinical schedule and forms to use throughout the semester. Refer to this site throughout the semester as a guide and location for up-to-date forms.

Student Clinician/Clinic Aide Staff Meetings

Staff meetings with student clinicians and clinic aides take place for 30 minutes after each therapy session for twice weekly sessions, or for one hour after each therapy session for once weekly sessions.

- Staff meetings include student reflections of strengths/areas for improvement regarding therapy sessions.
- Staff meetings can consist of lecture, brain storming, presentations, individual meetings, etc.

Orientation Meetings

Orientation meetings with student clinicians and clinic aides take place during the initial two weeks of the semester during fall and spring, and the initial week of the semester during summer.

Week One of the Semester: Course and document overview

- Review the syllabus
- Review clinic procedures
- Review forms
- Review grading procedures and criteria
- Assign clients
- Review procedures for contacting clients

Week Two of the Semester: Client preparation

- Client file review form due
- Discuss Intended Therapy Plans and SOAP notes
- Prepare for initial therapy sessions

Paperwork Requirements

Student paperwork to be completed throughout the course of a semester includes:

- Intended Therapy Plans
- SOAP Notes
- Proposed Semester's Objectives
- Background portion of Final Therapy Report
- Client Home Program
- Final Therapy Report

Diagnostic Sessions

The initial 2 to 4 sessions with the client are evaluation/re-evaluation sessions.

Client Conferences

Students complete two client conferences during the course of a semester.

- The initial client conference takes place following completion of the Proposed Semester's Objectives and the initial portion of the Final Therapy Report. Students review evaluation/re-evaluation results, current client status and the objectives for the semester with the client.
- The final client conference takes place during the final day of therapy. The final draft of the complete Final Therapy Report and the Home Carryover Program should be completed. Student clinician reviews progress during the semester, current client status, recommendations for next semester and the home carryover program with the client.

Video-Taping

It is suggested that student clinicians video-tape a therapy session prior to the mid-term evaluation conference. The video-tape can be reviewed with the clinical educator during the mid-term evaluation conference. See pages 35-36 of this handbook for video-taping instructions.

Mid-term and Final Evaluation Conferences

Clinical educators meet with student clinicians twice during the semester for mid-term and final evaluation conferences in lieu of staff meetings. Completed KASA forms are reviewed during the conferences. Evaluation weeks are listed on the CD Program calendar.

Class Rosters/Grading

- Class rosters can be accessed via iLearn.
- Course grades are completed electronically via My SFSU. Instructions for submitting grades are provided approximately one month before the end of the semester.
- Student clinicians receive a letter grade for CD 880.
- Grades for SLHS 711 and SLHS 713 for student clinicians and clinic aides are determined by the clinical educator but submitted by a variety of full time faculty. The clinic director will provide a form to complete at the end of the semester. There are no sections of SLHS 711 or SLHS 713 offered during the summer session.

Using Canvas for Course Communications

SLHS 880 and SLHS 884 course communications are placed on the SFSU Canvas website on a weekly or as needed basis. Communications that might be placed on Canvas include:

- Paperwork deadlines
- Schedules for group sessions
- Staff meeting topics
- Forms
- Handouts
- Sample reports
- Supplemental materials
- Sign-up for mid-term and final evaluations

Access to Canvas

1. Google SFSU Canvas
2. Click to log in
3. Enter SF State ID or email; enter SF State password
4. Log in
5. Click on course number
6. Turn editing on
7. Click on scribe icon
8. Enter content and save changes
9. Add activity or resource
10. Turn editing off
11. Exit Canvas

Sample SLHS 880 iLearn site

**Welcome to SLHS 880.02
Advanced Communication Therapy
Spring 2017
Wednesdays 9:00 - Noon
SFSU Children's Campus**

Clinic Instructor: Patti Solomon-Rice, Ph.D. CCC-SLP

Office Hours: Mondays/Tuesdays 1:00 - 3:00

Phone: (415) 338-7652(415) 338-7652

E-mail: psolomon@sfsu.edu

The purpose of SLHS 880.02 is to introduce you to clinical practicum with toddlers by providing supervised on-campus intervention with toddlers demonstrating a variety of communication difficulties. You will provide push-in services in your toddler's classroom from 9:00 - 9:45, provide pull-out individual therapy with your toddler from 9:50 - 10:15, provide small group therapy from 10:20 - 10:35 and participate in large group pre-literacy intervention from 10:40 - 10:55.

Following intervention, we will meet with the toddler head teachers from approximately 11:00 - 11:15.







Staff meetings will take place from approximately 11:15 - 11:55 to discuss a variety of issues. Topics to be reviewed include: a) clinic procedures, b) clinic documents, c) reviewing client files, d) grading procedures and criteria, e) intended therapy plans, f) SOAP notes, g) initial session preparation, h) reflecting on therapy sessions, i) initial client impressions, j) speech and language analysis, k) writing behavioral objectives, l) determining proposed semester objectives, m) teaching target behaviors, n) teaching strategies, o) data collection, p) writing final therapy reports, q) conducting parent/caregiver conferences, r) creating home programs, s) end-of-semester forms, and t) reflecting on the clinical practicum.

Week 1: January 25th
Syllabus Review
Clinic Procedures
Clinic Documents
Grading Procedures and Criteria
Clinic Aide Guidelines
Client File Review

During week 1 **we will meet from 9:00 to noon in BH 138** to review the syllabus and discuss clinic procedures, clinic documents, grading procedures and criteria, clinic aide guidelines and review of client files. As possible, you will receive your client assignments and begin reviewing your client's files.

In preparation for the first week of clinic, please review the following:

- 1) SLHS 880.02 syllabus (below)
- 2) Clinician's Handbook (below)
- 3) KASA form (below)
- 4) Client file review form (below)
- 5) Client file review form sample (below)
- 6) Clinic aide guidelines (below)

-  [SLHS 880.02 Syllabus Spring 2017 File](#)
-  [Clinician's Handbook August 2016 Version File](#)
-  [KASA Form File](#)
-  [Client File Review Form](#)
-  [Client File Review Form Sample](#)
-  [Clinic Aide Guidelines File](#)

Week 2: MONDAY January 30th
4:00 - 6:00

Meet in BH 138
Deadlines
Client File Review Due January 30th at Noon

Staff Meeting
TB Test Results and COC to Staff Meeting
Video of SLP and Toddlers
ITPs SOAP Notes
Parent Interview Guidelines
Child History Form
Preschool Observation
Assessment Planning
Supervisor Feedback
Schedule of Activities
Visit CC




During our staff meeting we will prepare for your initial week of clinic. We'll set the stage by viewing and discussing language facilitation between a skilled SLP and a toddler. Then we will review ITPs and SOAP notes, review parent interview guidelines and the child history form, review the preschool observation form, discuss how to plan your assessment, discuss receiving clinic instructor feedback and review the schedule of activities. We'll also take a field trip to CC to get the lay of the land regarding classrooms and pull-out therapy rooms.











Preparation for Staffing

- 1) F-24 S/L Therapy Report (below)
- 2) ITP Assessment Template (below)
- 3) ITP Sample Assessment (below)
- 4) F-02 SOAP Template (below)
- 5) SOAP Sample (below)
- 6) F-40 Child Client History (below)
- 7) Guidelines for Parent Interviews (below)
- 8) Preschool Observation Form (below)
- 9) Assessment Planning (below)
- 10) Supervisor Feedback (below)
- 11) Groups and Schedule of Activities (below)

Supplemental Material

ASHA (2008) Roles and Responsibilities of SLP in EI (below)
Macrae (2016) Comprehensive Assessment of Speech Sound Production in Preschool Children

-  [F-24 S/L Therapy Report File](#)
-  [ITP Assessment Template File](#)
-  [ITP Sample Assessment File](#)

-  [F-02 SOAP Template File](#)
-  [SOAP Sample File](#)
-  [F-40 Child Client History File](#)
-  [Guidelines for Parent Interviews File](#)
-  [Preschool Observation Form File](#)
-  [Assessment Planning File](#)
-  [Supervisor Feedback File](#)
-  [Groups and Schedule of Activities File](#)
-  [ASHA \(2008\) Roles and Responsibilities of SLP in EI File](#)
-  [Macrae 2016 File](#)

Week 3: February 8th

Deadlines

ITP Due Monday Noon

Clinic Opens Wednesday - Meet at Children's Campus

Parent Phone Interviews Completed by Feb 14th - Results in 2/15 SOAP Notes

SOAP Notes Due Friday Noon - No Email to Teachers/Parents/CC Director/Patti

Clinic Schedule

9:00 - 10:00: Classroom Observation

10:00 - 10:55: Formal Assessment (PLS-5)

Staffing Topics

- 1) Reflections (below)
- 2) Initial client impressions
- 3) Language facilitation techniques for toddlers (below)
- 4) Language and speech analysis (below)
- 5) Schedule and room assignments (below)

Children's Campus (CC) Contact Information

Phone: (415) 405-4011

Robin Room (Taylor, Julie-Anne, Gina):

Head Teacher Isis Maniago-Torres itorres@sfsu.edu









Sparrow Room (Magda, Julie-Anne, Dolores):

Head Teacher Kristina Langer [langer@sfsu.edu](mailto: langer@sfsu.edu)

CC Director Anna Tobin-Wallis [aatobin@sfsu.edu](mailto: aatobin@sfsu.edu)

Supplemental Material

- 1) Lanza & Flahive (2008) (below)
- 2) Brown's 14 grammatical morphemes (below)
- 3) Brown's Stages 1 and 2 (below)

-  [Reflections Guidelines File](#)
-  [Language Facilitation Techniques File](#)
-  [Language and Speech Analysis File](#)
-  [Schedule and Room Assignments File](#)
-  [Lanza & Flahive 2008 File](#)
-  [Brown's 14 Grammatical Morphemes File](#)
-  [Brown's Stages Part 1 File](#)
-  [Brown's Stages Part 2 File](#)

Week 4: February 15th

Deadlines

ITP Due Monday Noon

Protocols Scored (PLS-5, GFTA-3; results in SOAP notes)

SOAP Notes Due Friday Noon

Note to Parents/Teachers Due Friday Noon; copy Patti









Clinic Schedule

9:00 - 9:45: speech and language sample (pull-out room or classroom)

9:45 - 11:00: complete formal assessment (pull-out room or classroom)

Staff Meetings Topics

- 1) Reflections
- 2) Goals and objectives guidelines (below)
- 3) ITP template and sample (below)
- 4) Story reading guidelines (below)
- 5) Large group pre-literacy and phonological awareness (3 handouts below)
- 6) Large group circle songs (below)

-  [Goals and Objectives Guidelines File](#)
-  [ITP Template File](#)
-  [ITP Sample File](#)
-  [Story Reading Guidelines File](#)
-  [Simpson & Andreassen 2008 File](#)
-  [Andreassen & Simpson 2008 File](#)
-  [Andreassen & Smith 2008 File](#)
-  [Large Group Circle Songs](#)

Sample CD 884 iLearn site

**Welcome to SLHS 884.03
Advanced Diagnosis in Communicative Disorders II
Spring 2012
Thursdays 1:00 - 4:00 PM
BH 138**

Instructor: Patti Solomon-Rice, Ph.D., CCC-SLP
Office Hours: Mondays 1:00 PM - 5:00 PM and by appointment
Phone: (415) 338-7652
E-mail: psolomon@sfsu.edu

The purpose of SLHS 884 is to obtain experience in the assessment and diagnosis of individuals across a broad spectrum of communicative disorders. The goal of the supervised clinical experience is to prepare you to become an independent, competent speech-language pathologist in the assessment and diagnosis of communicative disorders across the life span and from culturally and linguistically diverse backgrounds.

The course will consist of: a) staffing pre and post evaluations, b) conducting client interviews, c) administering formal and informal evaluation tools, d) scoring and analyzing formal and informal evaluation tools, e) writing evaluation reports as directed by, reviewed, and co-signed by the clinical supervisor, and f) completing diagnostic presentations.

**Week 1: January 26th
Syllabus Review
Roles and Responsibilities
Clinic Procedures and Forms
Diagnostic Assignments
General Testing Guidelines**

During our first class we will meet for three hours to review the course syllabus, roles and responsibilities during evaluations, clinic diagnostic procedures and forms, diagnostic assignments for the semester, and general testing guidelines.

Please review the following in preparation for week 1. Many of the forms will be used throughout the semester and all are found below:

Forms

- 1) F-40 Child Case History
- 2) F-39 Adult Case History
- 3) Hearing Screening
- 4) F-22 Speech/Language Evaluation Report
- 5) F-25 Recommendations for Client
- 6) SC-10 Clinical Clock Hours
- 7) KASA Form

Guidelines and Schedules

- 1) CD 884.03 Syllabus
- 2) Diagnostic Clinic Roles and Responsibilities
- 3) Diagnostic Assignments
- 4) Assessment Planning Guidelines for Children
- 5) Guidelines for Interviewing Clients and Caregivers
- 6) Language Sample Analysis Guidelines
- 7) Narrative Analysis Guidelines
- 8) Report Writing Guidelines

Week 2: February 2nd
Comprehensive Speech and Language Testing
Informal Assessment of Speech and Language
Formal Test Analysis
Recommendations
Report Writing
Pre-Staffing for February 9th Client

This week we will continue with preparation for the diagnostic clinic. Mini-lectures will be provided on the topics of comprehensive speech and language testing, informal assessment of speech and language, formal test analysis, recommendations, and report writing. We will also pre-staff for our first client next week.

Handouts

I have added the following forms to facilitate narrative analysis:

- 1) Table 10.2. Story Grammar Components (Owens, 2008)
- 2) Table 10.3 Structural Properties of Narratives (Owens, 2008)

Agenda

- 1) Mini-Lectures
- 2) Pre-staffing for February 9th

Tester:

Interviewer:

Tester-Observer:

Week 3: February 9th
Client Evaluation
Post-Staffing
Pre-Staffing for February 16th Client

February 9th

Tester:

Interviewer:

Tester-Observer:

February 16th

Tester:
Interviewer:
Tester-Observer:

Sample Report
Early Elementary Evaluation (below)

Supplemental Materials
Sample list of classroom modifications and accommodations (below)

**Week 4: February 16th
Client Evaluation
Post-Staffing
Pre-Staffing for March 1st**

February 16th
Tester:
Interviewer:
Tester-Observer:

February 23rd
Tester:
Interviewer:
Tester-Observer:

Sample Report
Preschool Evaluation (below)

Infection Control Universal Precautions

Purpose of Universal Precautions

Used by health care facilities across the country to prevent transmission of blood borne pathogens.

Assumes all body fluids, especially blood or fluids containing blood, are infectious and should be treated as such.

Precautions must be applied to all interactions that involve potential for mucous membrane or skin contact with blood, body fluids or tissues containing blood or potential spills or splashes from them.

On-Campus Clinic Universal Precautions

- **Hand Washing**

- Wash hands immediately and thoroughly if they are potentially contaminated with blood and/or body fluids.

- Wash hands between clients.

- Wash hands after removing disposable gloves.

- Wash hands before and after evaluations.

- Wash hands before and after physical contact with a client.

- Wash hands before and after performing any personal body function.

- Wash hands when obviously soiled.

- Wash hands before leaving the clinic setting.

- **Hand Washing Technique**

- Vigorous mechanical action.

- Use antiseptic or soap under running water.

- 30 second duration if not grossly contaminated.

- 60-second duration if grossly contaminated.

- Dry hands thoroughly.

- **Disposable Gloves**

- Use when touching blood, fluids, mucous membranes, non-intact skin.

- Use when performing invasive procedures such as an OME, using laryngeal mirrors, tympanometry, managing tracheostomy tubes, etc.

- Use if client has non-intact skin, open cuts, sores, scratches.

- Use if changing diapers.

- Change gloves if torn; replace promptly.

- Change gloves after each contact with the client.

- Discard gloves in rest room.

- Wash hands after removing gloves.

- **Laundering Clothes**

- Immediately launder contaminated clothing.

- **Disinfecting Equipment and Materials**
Disinfect equipment and materials that have been contaminated with blood and body fluids.
Clean with bleach solution located in janitorial areas.
Use disposable toweling to dry.
Clean all contaminated areas including therapy materials, work surfaces, seating surfaces, floor surfaces.

Diseases of Concern

- **HIV**
HIV is the virus that causes AIDs, a fatal disease for which there is neither a cure nor vaccine. ASHA has resolved that HIV patients are entitled to civil rights protection and refusal to treat, without just cause, is a violation of the code of ethics and violates state licensing laws.
- **Hepatitis B**
Hep B is a condition of the liver that can be fatal.
There is a vaccine for Hep B that you may choose to get.
The vaccine may be obtained at student health services for a fee or your own insurance may cover it.
- **Tuberculosis**
There is currently an epidemic of TB in this country.
You may obtain a TB test at the student health services if you would like to determine whether you are TB positive.

Student Clinician Responsibilities

Written work will be completed in the format described in the online Student Manual and as instructed by the Clinical Educator.

Written work will be completed on time as indicated in the SLHS Program Calendar, the SLHS 880 syllabus or SLHS 884 syllabus, and as instructed by the Clinical Educator.

The Student Clinician will thoroughly prepare for the initial client diagnostic sessions and all subsequent therapy sessions.

The Student Clinician will maintain client confidentiality at all times.

The Student Clinician will follow infection control procedures during all diagnostic and treatment sessions with a client.

The Student Clinician will ask for assistance from the Clinical Educator when needed.

The Student clinician will express concerns to the Clinical Educator in a timely manner.

The Student Clinician will abide by policies and procedures stated in the Student Manual and instructed by the Clinical Educator.

Intended Therapy Plan (ITP)

Overview

An ITP will be written for each session or week of therapy per client based upon the desire of the clinic instructor.

The format to be used for the ITP includes four sections:

- Objectives
- Rationale
- Materials and Procedures
- Data Analysis

Background Information

Background information is listed at the top of the Lesson Plan and consists of:

- Student clinician name
- Clinical Educator name
- Client file number (for electronic privacy issues, there must be no mention of the client's name or the client's initials on the ITP)
 - Date

Objectives

Each client objective is listed on the ITP based on the list of proposed semester objectives.

- The student clinician should write objectives in the form of behavioral objectives.
- The student clinician should address three to four objectives per therapy session.

Rationale

A rationale is provided for each therapy objective.

- Rationales must be evidence-based referencing clinical literature, course texts, assessment and therapy manuals, and/or lecture notes.
- Rationales must also be applied to the results of the assessment from the initial 1-2 weeks of clinic.

Materials and Procedures

Procedures include the activities and materials to be used to meet each of the objectives stated in the ITP.

- Prompts for meeting the objectives during each activity should also be addressed.

Clinical Educator Review

The clinical educator reviews and provides feedback during the session that the plan has been handed in.

**Intended Therapy Plan
Therapy Session**

**Student Clinician:
Clinical Educator:**

**Client File Number:
Date:**

Measurable Objectives	Rationale	Materials & Procedures	Data Collection
		Materials: Procedure & Prompts:	
		Materials: Procedure & Prompts:	

Intended Therapy Plan

Student Clinician: Jane Doe
Clinical Educator: John Smith, M.A., CCC-SLP

Client File Number: XX-XXX-L-XX-XX
Date: 4/1/17

Measurable Objectives	Rationale	Materials & Procedure	Data Collection
<p>1. Client will provide 3 relevant story elements that relates to a single narrative topic about family life or recent events and experiences.</p> <p>This goal focuses on listing & connecting concepts and ideas to a main topic.</p>	<p>Stadler & Ward (1999) support using narratives as an effective format for the facilitation of oral language skills because stories require more complex language than that needed for daily conversations. According to Applebee (1978) children develop narratives in the following stages: labeling, labeling-listing, listing-connecting, connecting-sequencing, sequencing-narrating.</p> <p>Since the client is currently labeling & listing, the next higher skill of listing & connecting will be targeted.</p>	<p>Materials: Audio recorder, family photos provided by parent, visual story grammar map, stamps with color inkpads.</p> <p>Procedure & Prompts:</p> <ul style="list-style-type: none"> • Student clinician will show the client one photo at a time. Prompt for identifying the topic by asking, "What is this picture about?" If the client does not provide a topic, give choice of topics, e.g., "Is this picture about ____ or ____?" • Write client's response in <i>topic</i> line of visual story map. • Prompt for story elements connected to topic by asking, "Tell me something about [topic]". If the client does not respond, ask a focus questions. (Example of question about event actions "What is/are ____ doing in this picture?" About event setting "Where is/are _____ in this picture?") • Client will stamp the corresponding square in the story map for the story element she provides. 	<p>The stamps on the story map will serve as quantitative data.</p> <p>Student clinician will also take notes on the child's responses as qualitative data.</p>

<p>2. Client will segment 3+ syllable words (elicited by a picture stimulus card) into their syllable counterparts for 8 out of 10 words.</p> <p>Student clinician will choose cards based upon its relevance to client's environment.</p>	<p>Storkel & Marrisett (2002) state that children of preschool age and older show strong relationships between phonological awareness and phonological development.</p> <p>During the assessment, the client demonstrated difficulties producing multi-syllable words. Targeting syllable awareness can decrease syllable deletion tendencies.</p>	<p>Materials: Vocabulary picture stimulus cards for words with 3 or more syllables</p> <p>Procedure & Prompts:</p> <ul style="list-style-type: none"> • Student clinician will present picture stimulus card and ask client to label the picture. If the client cannot name the picture, the student clinician will teach the client the word. • If the client can name or repeat the word, then prompt for syllable count by asking, "How many beats can we find in this word? Let's tap it out." If the client does not respond correctly, model tapping once for each syllable on table and also give visual supports using one block for each syllable. Ask the client to repeat. 	<p>The target words will be printed on a word list. If the client segments a word independently, the word will be marked with a check.</p> <p>If the client does not segment a word independently, student clinician will document the prompts needed for the child to accomplish the task.</p>
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Eye-TV Observation Procedures Faculty Offices

- **Set Up in Burk Hall 136**
Turn on the power switch on the main console of Burk Hall 136.
Turn on the switch for each room to be observed on the main console.

- **Set-Up in Faculty Office**
Obtain a passcode from Academic Office Coordinator
Click on Eye-TV icon on laptop
Enter passcode
Choose room to view
At end of session, exit Eye-TV session on laptop

- **Turn off the power switch on the main console in Burk Hall 136**

San Francisco State University
Graduate College of Education
Department of Speech, Language, and Hearing Sciences
Eye-TV Access and Privacy Procedures

The Eye-TV System was installed in August 2012 and is used for the purpose of clinical education in the Department of Speech, Language, and Hearing Sciences. The system is installed on dedicated computers for supervisory faculty to view students who are engaged in clinical practicum experiences on the SFSU Campus in the Clinic Complex in Burk Hall. The main control unit for the system is housed in Burk Hall 136 and Eye-TV software is then installed on specific computers so that faculty may log into the system and observe students in clinic practice over a closed digital camera system, installed in specific clinical training rooms. Privacy and access to the system are controlled in the following manner:

- The Eye-TV system is only available on dedicated computers for specific supervisory faculty members in the Department of Speech, Language, and Hearing Sciences.
- Eye-TV software is loaded onto specific, dedicated computers that are located in designated faculty offices or SLHS Clinic lab space.
- Each computer is equipped with a specific icon for the faculty member where the computer is located (in the designated faculty office or lab where the computer is located).
- The Eye-TV system is password protected. Faculty members may only log in from the designated computer installed in their own office or secure lab, with a specific icon and password. Log on to Eye-TV is not possible at any other location or from any other computer.
- Computers are kept in locked faculty offices and faculty members ***log out and shut down the computer*** when not observing students.
- Family members sign a video release form, the Statement of Understanding that allows recording of children or adults with communication difficulties for the purpose of educational use in designated clinical seminars that are specific to the clients being discussed. The recordings may be accessed by students and faculty in specific clinical sections that pertain to the clients recorded.
- Recording of observed sessions is possible through DVD technology on designated computers that faculty members use to access the Eye-TV system. Recordings may only be accessed by designated clinical faculty through password sign-in.

- Recordings may be burned to DVDs by clinical educator faculty members. Recorded DVDs are logged with time, date, and initials of client and supervisor. These are submitted to the AOC, and kept in a locked cabinet in a secure room of the SLHS Clinic Office. When recordings are burned to DVDs, they will be erased from the computers where they were originally recorded.
- Recorded DVDs may be also stored in client files, and secured in a locked file cabinet in the SLHS Clinic Office.
- Students and faculty members may check out DVDs of only the clients that are specific to their clinic section. These may be viewed on campus in a secure location in designated SLHS Clinic Offices and lab space. Those observing the recordings may only be students, clinical educators and parents of the client who is being observed for the purpose of reviewing and learning from therapeutic interventions.
- Viewing of recordings is restricted to sessions with the supervising clinical educator faculty member, so that guided observations occur with the students and parent involved. Parents will not observe recordings of children other than those of their own child.
- Viewing and/or recording on laptop computers will not be allowed.

Therapy Observation Feedback

Overview

ASHA requirements for supervision of student clinicians consist of:

- Minimum of 25% observation of therapy and evaluation sessions

From Certification Standard V-E (<https://www.asha.org/certification/2020-slp-certification-standards/>):

Supervision of students must be provided by a clinical educator who holds ASHA certification in the appropriate profession and who, after earning the CCC-A or CCC-SLP, has completed (1) a minimum of 9 months of full-time clinical experience (or its part-time equivalent), and (2) a minimum of 2 hours of professional development in clinical instruction/supervision.

The amount of direct supervision must be commensurate with the student's knowledge, skills, and experience; must not be less than 25% of the student's total contact with each client/patient; and must take place periodically throughout the practicum. Supervision must be sufficient to ensure the welfare of the individual receiving services.

Procedure

- Student clinicians are observed from a faculty office.
- Verbal and/or written feedback is to be provided following each observed therapy session.
- Clinical educator should provide both positive praise and constructive criticism through use of specific examples.

Student Reflections

Staff Meetings

Time should be set aside for student clinician reflections during each staff meeting. Student clinicians should reflect upon:

- What I did well during the session
- What I did not do well during the session
- Changes for the next session

Mid-Term and Final Conferences

Mid-term and final conferences should include student clinician reflections as well. Student clinicians should reflect upon:

- Overall areas of strength
- Overall areas for improvement
- Goals for the duration of the semester or for future clinical practicum

SOAP Notes

Overview

The student clinician will write a daily progress note is upon completion of each client session.

- The daily progress note is due before the beginning of the next therapy session.
- The “SOAP” format is used for daily progress notes, which is a commonly used format for adult clients seen across disciplines including SLP’s, physicians, nurses, PT’s and OT’s.

Procedure

- Background information is listed at the top of the note and consists of the client file number, the student clinician, and the clinical educator. For issues of electronic privacy, the client’s name or initials should not appear on the note; rather state “XX”.
- The date is listed on the left side of the note.
- “S” refers to subjective information – information that does not require data collection.
- “O” refers to objective information – the objectives stated in the ITP and the results of the activities/procedures completed to meet the objectives.
 - *The student clinician will write the results of the objectives using behavioral statements.
 - *The results of data collection are stated in this section.
- “A” refers to assessment information – the current status and progress demonstrated towards achieving the objectives addressed during the session.
 - *The student will write one to two sentences describing the overall client status and progress of the client regarding the objectives addressed during the session.
- “P” refers to plan – the plan of treatment to be completed during the next session.
 - *The student will write one to two sentences describing the objectives to be addressed during the next session.

Clinical Educator Review

- The clinical educator will review the SOAP note and provide feedback prior to the next therapy session.
- The clinical educator must co-sign/initial SOAP notes printed out at the end of the semester for placement in the client file.

**COMMUNICATIVE DISORDERS CLINIC
SAN FRANCISCO STATE UNIVERSITY
F-02: DAILY THERAPY LOG**

Client File Number: Student Clinician:	Clinical Educator:
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SUMMARY OF EVENTS/PROGRESS

DATE:	<p>Subjective: [Provide contextual (qualitative) information for this session. For example, did any unusual events occur that would have affected the client's performance? What was the client's mood or physical state?]</p> <p>Objective: [Provide measurable (quantitative) information for this session. What was the client's actual performance towards therapy objectives? Your data for his/her performance should be documented here.]</p> <p>Analysis: [Looking back on this session, what is your impression of how it went and why? What are the most important points to be highlighted from this day?]</p> <p>Plan: [Given what you learned from this session, how would you plan the next one? What would you do differently or keep the same?]</p>
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Proposed Semester's Objectives (PSO)

Overview

The student clinician will create a list of proposed semester's objectives following completion of an evaluation/re-evaluation at the beginning of the semester.

The PSO should address areas of weakness or delay following analysis of evaluation results.

Procedures: Week 5 and 6 (fall/spring) or Week 3 and 4 (summer)

- Identifying information will include the client file number, student clinician's name, clinic instructor's name, and date of the report.
- The end goal should be reasonable for the amount of time the client receives services.
- One to three goals should be established for the semester, for example 1 goal for a client who enrolls in clinic for correction of a frontal lisp and up to 3 goals for a client with speech and language delays.
- Each goal should include of 3-4 objectives.
- The initial objective should begin with a skill level just above the client's status at the beginning of the semester. The final objective should be the goal listed on the PSO.
- Goals and objectives should be written as behavioral statements.
- A rationale should be submitted with the initial draft of the PSO stating why the goals were selected, based on the results of the evaluation/re-evaluation at the beginning of the semester.

Clinical Educator Review

- The clinical educator will review and approve the PSO.
- Following approval of the PSO, the student clinician will arrange a client conference to review the evaluation/re-evaluation results and the PSO for the duration of the semester.

**SC-06) PROPOSED SEMESTER'S OBJECTIVES (PSO)
(SAMPLE)**

PROPOSED SEMESTER'S OBJECTIVES (PSO)

Note: Rough draft should be double-spaced.

IDENTIFYING INFORMATION

CLIENT FILE NUMBER: XX-XXX-A/L-XX-XX

STUDENT CLINICIAN: *Robert McIntosh*

CLINICAL EDUCATOR: *Dolores McNamara, M.S. CCC-SLP*

DATE OF REPORT: *February 13, 2017*

PROPOSED SEMESTER'S OBJECTIVES – SPRING 2017

Individual

1. *Client will produce the // sound correctly across all positions in words with 80% accuracy.*
2. *Client will produce the /r/ sound in the initial position of words with 50% accuracy.*
3. *Client will monitor sound production with 90% correct response agreement with the student clinician's judgment.*

Group

1. *Client will practice target sound in the context of varied language activities.*
2. *Client will improve social skills during role playing activities.*
3. *Client will follow directions of increasing complexity.*

Client Mid-Term and Final Conferences

Overview

- Student clinicians will complete two client conferences with each client during the semester.
- Mid-term conferences will take approximately 15 minutes while final conferences will take approximately 30 minutes.
- The clinical educator may either be present in the therapy room or observe from the observation room.

Mid-Term Client Conference

- Student clinicians will complete a Mid-Term Client Conference with their client following clinical educator approval of Proposed Semester's Objectives and the initial portion of the Final Therapy Report.
- The student clinician will review:
 - *Relevant client background information
 - *Test results from the evaluation or re-evaluation
 - *Current communication status of the client
 - *Goals for the semester and objectives to meet those goals

Final Client Conference

- Student clinicians will complete a Final Client Conference with their client during the final day of clinic.
- The student clinician will review:
 - *Communication status at the beginning of the semester
 - *Progress towards meeting goals and objectives during the semester
 - *Communication status at the end of the semester
 - *Recommendations for services
 - At the clinic
 - Outside of the clinic
 - *The Home Carryover Program
- The student clinician will inform the client that the Final Therapy Report will be mailed to the client within the next week.
- The student clinician will obtain the following information from the client if clinic is recommended to continue therapy during the following semester:
 - *Is the client interested in returning for additional therapy?
 - *If so, the client must complete a Client Availability Form for the upcoming semester and the student clinician must obtain the completed form before the end of the conference.
- If the client would like to return for additional therapy the following semester, the student clinician will inform the client:
 - *The SLHS Clinic cannot guarantee placement for the next semester.

Home Carryover Program

Overview

An individualized home carryover program will be provided and reviewed with each client during the final client conference on the final day of clinic. The home carryover program consists of instructions, activities and materials to carryover goals and objectives addressed during the course of treatment.

Procedure

1. Handout for the client

Background information is listed at the top of the Home Carryover Program and consists of:

- Title of Clinic
- Date of the final client conference
- Due to electronic privacy issues, the client name and other identifying information cannot be stated in the home program

Introductory Paragraph

The initial paragraph describes the general goals and objectives of therapy during the semester and the progress demonstrated, using lay person terminology.

Therapy Goals and Objectives

The Home Carryover Program addresses approximately three therapy goals and objectives.

- State each goal and objective using lay person terminology.
- State the materials to be used to complete the activity.
- State the activity to be completed for each goal/objective.
- Write simple instructions for completing each activity.

Concluding Paragraph

Write a closure statement thanking the client for attending therapy at the SLHS Clinic.

2. Materials for the Home Carryover Program

Photocopy or create all the necessary materials that the client will need to complete the home program.

3. Packaging the Home Carryover Program

Package the Handout and Materials attractively in a folder, binder or festive bag.

Clinical Educator Review

The clinical educator reviews the Home Carryover Program and returns the program to the student with feedback prior to the final therapy session.

Final Therapy Report

Template

Student clinician's use the F-24: Speech/Language Therapy Report template for completion of the Final Therapy Report.

Procedures: Week 7 and 8 (fall and spring semesters) and Week 5 and 6 (summer semester)

The student clinician will complete the background information and current semester's assessment portions of the Final Therapy Report template during week 7 and 8 of the fall and spring semesters or week 5 and 6 of the summer semester.

1. Identifying Information:

- Client file number
- Student clinician name.
- Clinical Educator's name.
- For electronic privacy issues, there can be no identifying information about the client in the report including the client's name, address, parent/spouse name/s, siblings names or ages, birthdate, school, referral source or names of referral source.

2. Background Information:

- Relevant background information.

3. Current semester's assessment

- Previous testing results.
- Previous therapy results.
- Current test results - modality, severity level, formal test scores and informal test results.
- Client strengths and weaknesses based upon formal and informal test results in each modality.

Procedures: Week 11, 12, and 13

The student clinician will complete the entire Final Therapy Report during week 11, 12, and 13 of the fall/spring semesters and week 8 and 9 of the summer semester.

1. Identifying Information:

- Same as prior approved report.
- Add date of report (final therapy session).

2. Background Information:

- Same as prior approved report.

3. Current semester's assessment

- Same as prior approved report.
4. Intervention Goals and Progress
 - State each goal as listed in the Proposed Semester's Objectives.
 - State "Goal Met", "Goal Partially Met" or "Goal Not Met."
 - Describe current status of goal at the end of the semester.
 - Describe procedures used (activities and materials from lesson plans) to meet the goal.
 - Describe facilitative strategies to meet the goal.
 5. Impressions
 - Describe overall diagnosis and severity levels across modalities.
 - Summarize strengths and weaknesses.
 6. Recommendations
 - State clinic recommendation for the following semester - "Recommended" or "Discharge."
 - If clinic is recommended, list three to five proposed goals for the next semester, written as behavioral objectives.
 - State recommendation for completion of Home Carryover Program.
 - State recommendation/s for services from other departments at SFSU or services off-campus.

Clinical Educator Review

Clinical educator will review the report, provide feedback and will return the report for additional revisions until the final draft of the report is approved during the final week of clinic.

Follow-Up

Upon approval of the final draft of the Final Therapy Report, the following is completed:

- Student clinician and clinical educator sign the de-identified report which is placed in the client file.
- Clinical educator completes an identified report with client's name, address, parent/spouse name/s, siblings names or ages, birthdate, age, gender, school, referral source or names of referral source in the report. Clinical educator prints the identified version and signs the report for mailing to the family. The report is then deleted from the clinical educator's laptop.
- Clinical educator gives the identified FTR, the Recommendation for Client form, and the Client Availability Form (if recommended for therapy) to the AOC.
- The identified version of the FTR is mailed to the client.
- The Recommendation for Client form and Client Availability Form are used to plan the next semester's clinic.

F-24: SPEECH/LANGUAGE THERAPY REPORT

SAN FRANCISCO STATE UNIVERSITY

1600 HOLLOWAY AVENUE, BH 114

SAN FRANCISCO, CA 94132

PHONE: 415.338.1001

FAX: 415.338.0916

CLIENT FILE NUMBER:

BY:

STUDENT CLINICIAN

CLINICAL EDUCATOR

DATE OF REPORT: _____

I. BACKGROUND INFORMATION

[Current/refer to previous report date]

II. CURRENT SEMESTER'S ASSESSMENT

The following assessment procedures were administered:

A. Pretesting

[Describe assessment findings from beginning of semester.]

B. Posttesting

[Describe assessment findings from end of semester.]

III. INTERVENTION GOALS AND PROGRESS

[List long term goals, short term objectives and describe progress towards objectives based on your data]

IV. IMPRESSIONS

[Describe how the child is doing overall.]

V. RECOMMENDATIONS

[What would you recommend for the child for the upcoming semester?]

NOTE:

- **Please type reports in the above format and adhere to standard outline form.**
- **The report should be single-spaced. Number all but the first page.**
- **Provide lines for signatures of supervisor and student clinician.**
- **For sample reports, please see your clinic supervisor for recommendations/examples.**
- **Previous reports may not be in the required format (as shown above).**
- **Do not use the terms "able" or "unable." Either the client did or did not do something.**
- **Grammar: Do not "tense shift."**

F-24: SPEECH/LANGUAGE THERAPY REPORT

SAN FRANCISCO STATE UNIVERSITY
1600 HOLLOWAY AVENUE, BH 114
SAN FRANCISCO, CA 94132
PHONE: 415.338.1001
FAX: 415.338.0916
CLIENT FILE NUMBER:

NAME: *CLIENT NAME*
BIRTHDATE: *CLIENT D.O.B.*
TELEPHONE: *CLIENT PHONE #*
ADDRESS: *CLIENT ADDRESS*
CITY, STATE ZIP
FATHER: *NAME*
MOTHER: *NAME*
SCHOOL/GRADE: *if client is child) or*
WORK: *if client is adult)*
REFERRAL:

BY: _____
STUDENT CLINICIAN

CLINICAL EDUCATOR

DATE OF REPORT: _____

I. BACKGROUND INFORMATION
[Current/refer to previous report date]

II. CURRENT SEMESTER'S ASSESSMENT
The following assessment procedures were administered:
A. Pretesting
[Describe assessment findings from beginning of semester.]
B. Posttesting
[Describe assessment findings from end of semester.]

III. INTERVENTION GOALS AND PROGRESS
[List long term goals, short term objectives and describe progress towards objectives based on your data]

IV. IMPRESSIONS
[Describe how the child is doing overall.]

VI. RECOMMENDATIONS
[What would you recommend for the child for the upcoming semester?]

- NOTE:**
- Please type reports in the above format and adhere to standard outline form.
 - The report should be single-spaced. Number all but the first page.
 - Provide lines for signatures of supervisor and student clinician.
 - For sample reports, please see your clinic supervisor for recommendations/examples.
 - Previous reports may not be in the required format (as shown above).
 - Do not use the terms "able" or "unable." Either the client did or did not do something.
 - Grammar: Do not "tense shift."

SAN FRANCISCO STATE UNIVERSITY
SPEECH, LANGUAGE, and HEARING SCIENCES CLINIC

F-25: RECOMMENDATION FOR CLIENT—SLHS 880 and/or SLHS 884

Client Name: _____	File Number: _____
Difficulty: _____	Clinician: _____
Supervisor: _____	Date of Recommendation: _____

RECOMMENDATION: (Please check appropriate spaces)

- The client is recommended for _____ therapy for _____ 20____.
- The client has successfully completed therapy and no additional therapy is required.
- It is the opinion of the SLHS staff that the client continue. However, the client or parents have decided to terminate for the following reasons:

- The client should be contacted for therapy for _____, 20____.
- The client should be contacted during _____, 20____ for a reevaluation.
- The client did NOT successfully complete therapy but should not return to the clinic for the following reasons:

- Other: _____
- The client's address and telephone number are correct as listed in the folder.
- The client's address and telephone number have changed. The corrected information appears below:
Phone: _____
Address: _____
Client/Parent Signature _____

ADDITIONAL SCHEDULING OR OTHER INFORMATION:

Clinical Educator's Signature

Student Clinician's Signature

**SUMMER 2017
ADULT NEURO CLINIC AVAILABILITY
JUNE 29, 2017 – AUGUST 10, 2017**

Days	Times
Tuesday/Thursday	9:00 – 10:50 AM
Tuesday/Thursday	1:00 – 2:50 PM

Please check all boxes that apply:

- I am available from 9:00 – 10:50 AM.
- I am available from 1:00 – 2:50 PM.
- Please keep me on the waiting list if space is not available.
- I am not available for summer 2017, but keep me on the waiting list for future semesters.
- Please take me off the waiting list for any further semesters.

CLIENT NAME: _____ AGE: _____
ADDRESS: _____
PHONE: () _____
EMAIL: _____

KASA Evaluation Form Instructions

Overview

The KASA evaluation form is the grading form used for clinical practicum courses. The form is completed and reviewed with the student clinician during the mid-term evaluation and the final evaluation at the end of the semester.

Procedures for Completion

Page 1

- Circle the correct course number for the clinical practicum.
- Determine the skill level for the student clinician based upon the number of clients seen. (All student clinicians completing school and adult internships are at an advanced skill level.)
- Circle the types of problems the student clinician is working with and the communication modalities used.
- Grades are based on the average of a 4.0 grading scale; for example, a 3.82 would be graded down to an A- while a 3.83 would be graded up to an A.
- Student clinicians must obtain a B- or better for a final grade to pass the course.

Page 2

Page 2 is an explanation of skill levels. These descriptions will help determine whether the student clinician is performing at the expected skill level.

Pages 3, 4 and 5

- Items on pages 3, 4 and 5 are completed depending on skill level. Beginning items are completed for beginning student clinicians. Beginning and intermediate items are completed for intermediate student clinicians. All items are completed for advanced student clinicians.
- Some items might not be applicable and should be left blank.
- Students performing at an advanced level of proficiency for their skill level should receive a 4.0; students performing at a basic level of proficiency for their skills level should receive a 3.0; students not performing at a basic level of proficiency for their skill level should receive a 2.0; and students performing far below basic proficiency for their skill level should receive a 1.0.
- Space for comments is provided, as desired.
- To determine the final grade, add up the numbers for each item and divide by the total number of items.

Page 5

Following a review of the form during the mid-term and final evaluation meetings, both the clinical educator and student clinician sign and date the form.

CAA of ASHA: Knowledge and Skills Acquisition (KASA) Speech-Language Pathology Services Credential CTC Standards All Clinical Practicum Evaluations

Student Name _____ Semester/Year _____

Clinical Practicum Assignment (Circle one): CD880 CD881 CD882 Other

Skill Level:

- (B) Beginning (1st client)
- (I) Intermediate (2nd/3rd/Additional client)
- (A) Advanced (school/adult internship)

Clinical Practicum Supervisor's Name _____

Name/Location of Clinical Practicum _____

Number of clients _____ Ages of clients _____

Types of problems. Circle all that apply:

A Speech Sound Production

F Fluency

VR Voice and resonance, including respiration and phonation

L Receptive and expressive language (phonology, morphology, syntax, semantics, and pragmatics).

Indicate modality: speaking, listening, reading, writing, manual

H Hearing, including the impact on speech and language

SW Swallowing/feeding (oral, pharyngeal, esophageal, and related functions)

COG Cognitive aspects of communication (attention, memory, sequencing, problem solving, executive functioning)

SOC Social aspects of communication (including challenging behavior, ineffective social skills, lack of communication opportunities)

Grade

Midterm: _____

Final: _____

A 4.0	A- 3.7	B+ 3.3	B 3.0	B- 2.7	C+ 2.3	C 2.0	C- 1.7	D+ 1.3
D 1.0	D- 0.7	F 0.0						

Course Evaluation Based on Skill Level (B- or better to pass)

Midterm:

Pass

Repeat

Final:

Pass

Repeat

Skill Level

Beginning student clinician (1st client)

- High degree of supervisory support
- Can recall some aspects of relevant theory
- Needs support to:
 - Draw conclusions about a client
 - Develop a plan for action
 - Understand the total clinical situation
 - Apply problem solving strategies, principles and theory
- Spends a high degree of time and effort in meeting clinical responsibilities
- Highly focused on own performance rather than the client

Intermediate student clinician (2nd/3rd/Additional client)

- The complexity of the client, the workplace environment and the student's previous experience determines:
 - Degree of supervision (moderate to low)
 - Ability to recognize the meaningful aspects of the situation
- Recognizes several aspects of a problem but not all, and related these to the client's needs and is able to:
 - Draw some accurate conclusions about a client
 - Develop some plans for action
 - Recognize some important aspects of the total clinical situation
- Requires support to:
 - Recognize and prioritize all aspects of a situation
 - Flexibly apply problem solving strategies, principles and theory
- Developing automaticity resulting in:
 - A moderate expenditure of time and effort
 - Greater ability to focus on the situation than on own performance
 - A developing ability to use observations to assist clinical reasoning

Advanced student clinician (school/adult internship)

- Performs the majority of his/her work independently and competently
- Seeks support if the situation is new or a number of features about the client or workplace setting combine to create complexity
- Identifies the meaningful aspects of problems and integrate these to generate a number of logically possible conclusions; conclusions/actions will be modified with new information

- Prioritizes appropriately
- Is sufficiently automatic and maintain a focus on the client or situation
- Carries out his/her work in an efficient and timely manner

(Adapted from: The Speech Pathology Association of Australia Limited (2006). *Competency assessment in speech pathology – Assessment resource manual*. Speech Pathology Australia.)

Clinical Skills Evaluation

	Proficient/ Advanced 4.0	Basic 3.0	Below Basic 2.0	Far Below Basic 1.0	Comments
EVALUATION					
(B) (I) (A) Objectively and accurately observes client behavior.					
(B) (I) (A) Adapts evaluation procedures to meet client needs.					
(I)(A) <i>Selects appropriate, evidence-based evaluation procedures (behavioral observations, non-standardized/standardized tests/instrumental procedures).</i> CTC: PD Standard 1: Program Design, Rationale and Coordination, P, A					
(I) (A) Appropriately administers standardized/non-standardized tests, informal assessments, etc.					
(I)(A) <i>Demonstrates proficiency in the effective use of interpreters/translators in the assessment of English language learners.</i> CTC: SLP Standard 4: Assessment of Speech and Language Disorders, P, A					
(I)(A) Formulates appropriate recommendations based on assessments that <i>evaluate students' needs and strengths, development of academic language making accommodations, modifications, instructional decisions and ongoing program improvements.</i> CTC: PD Standard 3: Educating Diverse Learners CTC: PD Standard 5: Assessment of Students, P, A					
(I)(A) Collects and integrates case history information, <i>including required statewide assessments and local, state and federal accountability systems</i> , with information from clients, family, caregivers, teachers, relevant others, and other professionals. CTC: PD Standard 5: Assessment of Students, P, A					

(I)(A) <i>Consults and/or collaborates with teachers and other relevant personnel, during prevention, assessment and IEP process.</i> CTC: SLP Standard 7: Consultation and Collaboration, A					
(A) Applies clinical judgment during informal screening.					
(A) Interprets, integrates, and synthesizes all information to develop a diagnosis.					
(I)(A) <i>Demonstrates the ability to participate effectively as a team member and/or case manager for the IFSP/IEP/transition planning process, from pre-referral interventions and requisite assessment processes, through planning specially-designed instruction to support access to the core curriculum, developing appropriate IFSP/IEP/transition planning goals based on standards and following all legal requirements of the IFSP/IEP/transition planning process.</i> CTC: PD Standard 8: Participating in IFSP/IEPs and Post-Secondary Transition Planning, A					
(A) Conducts screening and prevention procedures.					
INTERVENTION					
(B) (I) (A) Develops appropriate TX plans with measurable and achievable goals that meet clients' needs.					
(B) (I) (A) Collaborates with clients and relevant others in planning TX, such as <i>trans-disciplinary teams, including but not limited to multi-tiered intervention, Section 504, IEP/IFSP/ITP.</i> CTC: PD Standard 4: Effective Communication and Collaborative Partnerships, A					
(B) (I) (A) Implements TX plans and involves clients and relevant others in the TX process.					
(I)(A) <i>Provides full range of service delivery options, including general education.</i> CTC: PD Standard 1: Program Design, Rationale and Coordination, A					

(I)(A) <i>Collaborates with personnel from other educational and community agencies to plan, implement, and evaluate transitional life experiences for successful transitions by students.</i> CTC: PD Standard 7: Transition and Transitional Planning, A					
(B) (I) (A) Selects or develops and uses appropriate materials and reinforcers which are motivating and stimulating to the client.					
(B) (I) (A) Provides accurate and immediate feedback to client.					
(B) (I) (A) Uses appropriate cueing.					
(B)(I)(A) <i>Demonstrates effective behavioral intervention strategies and effectively monitor the progress of students.</i> CTC: SLP Standard 5: Management of Speech and Language Disorders, A					
(B) (I) (A) Measures and evaluates clients' performance and progress based on data collection and analysis.					
(B) (I) (A) Modifies TX plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients.					
(B) (I) (A) Objectively evaluates each session.					
(B) (I) (A) Completes administrative and reporting functions necessary to support intervention.					
(B)(I)(A) <i>Communicates effectively with the business community, public and non-public agencies, to provide the cohesive delivery of services, and bridge transitional stages across the life span for all learners.</i> CTC: PD Standard 4: Effective Communication and Collaborative Partnerships, A					
(I) (A) Utilizes session data for future therapy sessions.					
(I) (A) Conducts parent and staff conferences.					
(A) <i>Conducts progress monitoring and in decision making regarding eligibility and services.</i> CTC: PD Standard 5: Assessment of Students, A					
PROFESSIONAL, LEGAL AND ETHICAL PRACTICES					

Observes <i>legal requirements for assessment, Individualized Family Service Program, Individualized Education Program (IEP) development and monitoring, services, and instruction of students with disabilities</i> CTC: PD Standard 2: Professional, Legal and Ethical Practices, A					
(B) (I) (A) Observes timelines to submit drafts, revisions.					
(B) (I) (A) Reports information accurately.					
(B) (I) (A) Discussion of procedures and progress written accurately.					
(B) (I) (A) Report summary written comprehensively with synthesis and integration of information.					
(B) (I) (A) Makes appropriate recommendations.					
(B) (I) (A) Demonstrates appropriate writing skills for speech, grammar, and sentence construction.					
(B) (I) (A) Uses professional writing style.					
(I) (A) Test/s, results, and interpretation written accurately and appropriately.					
(I) (A) Includes all pertinent information in client report.					
(I) (A) Report is well organized.					
(I) (A) Report is understandable for client or parent/caregiver.					
PROFESSIONAL AND ETHICAL QUALITIES					
(B) (I) (A) Demonstrates cooperation and teamwork.					
(B) (I) (A) Keeps verbal commitments.					
(B) (I) (A) Never has an unexcused clinical absence.					
(B) (I) (A) Observes legal mandates, most especially client privacy and confidentiality policies.					
(B) (I) (A) Dresses for activities with respect for observers, clients, and the professional setting.					
(B) (I) (A) Is punctual in beginning and ending clinical sessions.					
(B) (I) (A) Demonstrates interest and positive attitude with client.					
(B) (I) (A) Written and/or verbal communication is free from judgmental statements.					

(B) (I) (A) Communicates effectively, recognizing needs, values, preferred mode of communication, cultural/linguistic background of client, family, caregivers.				
(B) (I) (A) Adheres to ASHA Code of Ethics and behaves professionally, <i>given opportunities for demonstration of ethical standards, of teaching, of evidence based educational practices in relation to theories, research and regulations necessary to the provision of services to individuals with disabilities and their families.</i> CTC: PD Standard 2: Professional, Legal and Ethical Practices, A				
(I) (A) Provides counseling regarding communication and swallowing disorders to clients, family, caregivers, and relevant others.				

(I) (A) Encourages client and/or family responsibility in management.				
RESPONSE TO SUPERVISION				
(B) (I) (A) Considers supervisory suggestions and openly discusses differences in ideas.				
(B) (I) (A) Discusses supervisory analysis and evaluation in a positive manner.				
(B) (I) (A) Demonstrates reflective practice and engages in self-supervision to discover areas of strength and those that need improvement.				
(B) (I) (A) Suggests ways to enhance clinical performance.				
(B) (I) (A) Develops increasing confidence about own performance and professional growth.				
(B) (I) (A) Positively deals with own frustrations in treatment and/or supervision.				

Supervisor's Signature _____ Date _____

Clinician's Signature _____ Date _____

Please return this form to the Clinic Coordinator and Site Visitor when applicable

Mid-Term and Final Conferences End-of-Semester Wrap-Up

Mid-term and Final Conferences

- Mid-term evaluation and final evaluation conferences are completed individually with each student clinician according to the clinic calendar.
- Mid-term conferences are typically 15 minutes per student clinician while final conferences are typically 30 minutes per student clinician.
- Student clinicians reflect upon strengths, areas for improvement and clinical goals for the duration of the semester/next semester.
- KASA evaluation form is discussed, reviewed and signed by the student clinician and the clinic instructor.
- During the final conference, additional forms are completed for the end-of-semester wrap-up.

End of Semester Wrap-Up

- The signed final evaluation KASA forms are turned into the clinic director upon completion of the final conference.
- The SC-10 Clinical Clock Hours Form is completed and turned into the clinic director upon completion of the final conference.
- Record release forms, evaluation protocols and signed/initialed SOAP notes are filed in the client file upon completion of the final conference.
- The signed Final Therapy Report, completed F-25 Recommendation for Client form, and completed Client Availability Form are turned into the AOC before the final day of the semester.

SAN FRANCISCO STATE UNIVERSITY
CLINICAL PRACTICUM IN SPEECH, LANGUAGE, AND HEARING SCIENCES
DEPARTMENT
(SC-10) CLINICAL CLOCK HOURS

This is to certify that _____ completed _____ hours of clinical practicum, for which _____ units of academic credit were earned. This practicum was completed during _____ Semester, 20_____.

Please fill out a separate form for each category:

- Audiology (includes speech and language services for those with hearing impairment)
- Speech (check one): articulation, fluency, voice, dysphagia
- Language

DIAGNOSTIC

THERAPY

_____ hours w/preschool

_____ hours w/preschool

_____ hours w/school age

_____ hours w/school age

_____ hours w/adult

_____ hours w/adult

Clinical Educator's Signature _____ Date

(Print Clinical Educator's Name) _____

Clinical Educator's ASHA CCC # _____ *Clinical Educator's CA State License #*

Site / Agency Name _____

Type of Clinical Setting* _____

 Patti Solomon-Rice, Ph.D., CD Clinic Director _____ Date
 ASHA CCC# 00766360; CA License #SP4057

By signing this form, the supervisor/clinical instructor affirms that "At least 25% of the student's total contact time in clinical evaluation and treatment was observed directly."

*Types of clinical settings include separate units/settings within an institution or its affiliates (brain injury units/stroke units/nursing homes/classrooms for severely language-impaired children), community clinics, public schools, rehabilitation centers, hospitals, and private practice settings. For the 3 clinical settings to be classified as different settings, it must be determined that the student has gained unique experiences in each one (i.e., public schools: pull-out services versus a classroom for children who present communication disorders; or hospital: acute-care versus long-term care).

Orientation and Ongoing Training for Clinical Educators Speech, Language, and Hearing Sciences Clinic

New Clinical Educator Orientation

New clinical educators will meet with the Clinic Director for a 3-hour orientation meeting prior to the beginning of the initial semester of clinical supervision. The purpose of the orientation is to:

- Review the policies and procedures of the Communicative Disorders Clinic
- Review the contents of the Clinical Educator Handbook including clinical procedures addressing the welfare of our clients, providing the manner and amount of clinical supervision that reflects the competence of each student, ensuring client safety/confidentiality/security, and applying ethical standards to all clinical activities according to ASHA's Code of Ethics
- Tour the clinic complex, materials room, clinic rooms, and meet the office manager
- Discuss the assigned clinical practicum assignment

Ongoing Training

All adjunct clinical educators meet with the Clinic Director at the beginning of each semester of clinical supervision to:

- Review new clinical policies and procedures
- Review clinical procedures addressing the welfare of our clients, providing the manner and amount of clinical supervision that reflects the competence of each student, ensuring client safety/confidentiality/security, and applying ethical standards to all clinical activities according to ASHA's Code of Ethics

Tenure/tenure track faculty participate in decision-making about clinical policies and procedures during bi-monthly Speech, Language, and Hearing Sciences Department staff meetings. At the beginning of each semester, the Clinic Director:

- Reviews new clinical policies and procedures
- Reviews clinical procedures addressing the welfare of our clients, providing the manner and amount of clinical supervision that reflects the competence of each student, ensuring client safety/confidentiality/security, and applying ethical standards to all clinical activities according to ASHA's Code of Ethics

Procedures to Ensure Adequate Student Supervision Speech, Language, and Hearing Sciences Clinic

Determination of Manner and Amount of Supervision

A minimum of 25% supervision is required for all student clinicians.

- More hands-on supervision and a slightly higher percentage of supervision will be provided to student clinicians working with their first client versus second or third clients.
- More hands-on supervision and a slightly higher percentage of supervision and will be provided to student clinicians who have demonstrated weaker clinical skills in comparison to other student clinicians.
- More hands-on supervision and a slightly higher percentage of supervision and will be provided to student clinicians working with more challenging clients.
- Group and paired activities or other innovative practices add quality to students' experiences.
- Hours earned in shared clinical experiences must be divided across the number of clinicians participating.

Adjustments to Reflect Competence of Each Student and Specific Needs of Clients Served

Adjustments to the manner and amount of supervision will be made throughout the semester to reflect the competence of each student and specific needs of the client served.

- Students will be afforded more decision-making capabilities, less specific supervisory feedback and a slightly lower percentage of supervision as competence increases, if the specific needs of the client continue to be met.
- Higher student clinician expectations are reflected in the grading process on the KASA clinical evaluation form as clinical experience increases.

Preceptor Consultation

Thirty-three percent of clinical practicum course time consists of staff meetings to:

- Reflect on clinical practices during clinical sessions
- Provide specific oral and written feedback to student clinicians
- Review clinical policies and procedures
- Teach relevant clinical skills
- Discuss relevant clinical topics such as ethical considerations and client confidentiality

Clinical educators also consult with student clinicians during advising hours, via the SFSU iLearn website and via de-identified email exchange.

Procedures to Ensure Client Safety, Confidentiality and Security Speech, Language, and Hearing Sciences Clinic

The Speech, Language, and Hearing Sciences Clinic follows the policies and procedures set forth by the San Francisco State University Office of Security to ensure the safety, confidentiality and security of the clients attending the SLHS Clinic.

Client Safety

- ADA requirements and regulations for safety have been met by the Burk Hall physical plant/1st floor Communicative Disorders Clinic complex, e.g. automatic entrance to the building, width of clinic room entrances, restroom facilities, height of water fountains, and hallway/clinic room lighting.
- Wheelchair accessible parking is available in a near-by parking lot.

Client Confidentiality

- Hard copies of client files are kept behind two to three sets of locked doors in Burk Hall 113 and Burk Hall 138.
- Hard copies of client files are de-identified by client file number.
- Electronic transmission of PHI is de-identified per HIPAA requirements.
- Client files cannot leave the clinic complex; student clinicians must provide student ID numbers to the clinic manager to review client files within the clinic complex.
- Clinical discussions can only occur inside clinic rooms and faculty offices with closed doors.
- A HIPAA incident log is maintained with records of any breach of client confidentiality.

Security of Client Records

- Back-up electronic copies of de-identified client records are kept in a cloud-based, secure, encrypted server for 3.5 years.

Procedures to Ensure Ethical Standards are Met Speech, Language, and Hearing Sciences Clinic

Student Clinician Procedures

The Speech, Language, and Hearing Sciences Clinic abides by the ASHA Code of Ethics (2016) across all academic and clinical aspects of the graduate program. The Code of Ethics is discussed and applied within numerous academic and clinical courses, including but not limited to:

- SLHS 703 Research Methods, Evidence-Based Practices, and Professional Issues
- SLHS 880 Advanced Clinical Practicum
- SLHS 712 Internship Seminar

Clinical Educator Procedures

The Code of Ethics is discussed and applied to clinical education with all clinical faculty.



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

CODE OF ETHICS

Reference this material as: American Speech-Language-Hearing Association. (2023). Code of Ethics [Ethics]. Available from www.asha.org/policy/. © Copyright 2023 American Speech-Language-Hearing Association. All rights reserved. Disclaimer: The American Speech-Language-Hearing Association disclaims any liability to any party for the accuracy, completeness, or availability of these documents, or for any damages arising out of the use of the documents and any information they contain.

Reference this material as: American Speech-Language-Hearing Association. (2023). Code of Ethics [Ethics]. Available from www.asha.org/policy/. © Copyright 2023 American Speech-Language-Hearing Association. All rights reserved. Disclaimer: The American Speech-Language-Hearing Association disclaims any liability to any party for the accuracy, completeness, or availability of these documents, or for any damages arising out of the use of the documents and any information they contain.

ASHA Code of Ethics PREAMBLE The American Speech-Language-Hearing Association (ASHA; hereafter, also known as “the Association”) has been committed to a framework of common principles and standards of practice since ASHA’s inception in 1925. This commitment was formalized in 1952 as the Association’s first Code of Ethics. This code has been modified and adapted to reflect the current state of practice and to address evolving issues within the professions. The ASHA Code of Ethics reflects professional values and expectations for scientific and clinical practice. It is based on principles of duty, accountability, fairness, and responsibility and is intended to ensure the welfare of the consumer and to protect the reputation and integrity of the professions. The Code of Ethics is a framework and a guide for professionals in support of day-to-day decision making related to professional conduct. The Code of Ethics is obligatory and disciplinary as well as aspirational and descriptive in that it defines the professional’s role. It is an integral educational resource regarding ethical principles and standards that are expected of audiologists, speech-language pathologists, and speech, language, and hearing scientists. The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by audiologists, speech-language pathologists, and speech, language, and hearing scientists who serve as clinicians, educators, mentors, researchers, supervisors, and administrators. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose and is applicable to the following individuals: • a member of ASHA holding the Certificate of Clinical Competence • a member of ASHA not holding the Certificate of Clinical Competence • a nonmember of ASHA holding the Certificate of Clinical Competence • an applicant for ASHA certification or for ASHA membership and certification ASHA members who provide clinical services must hold the Certificate of Clinical Competence and must abide by the Code of Ethics. By holding ASHA certification and/or membership, or through application for such, all individuals are subject to the jurisdiction of the ASHA Board of Ethics for ethics complaint adjudication. The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics. The four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas: (I) responsibility to persons served professionally and to © Copyright 2023 American Speech-Language-Hearing Association. All rights reserved. 2 ASHA Code of Ethics research participants; (II) responsibility for one’s professional competence; (III) responsibility to the public; and (IV) responsibility for professional relationships. Individuals shall honor and abide by these Principles as affirmative obligations under all conditions of applicable professional activity. Rules of Ethics are specific statements of minimally acceptable as well as unacceptable professional conduct. The Code of Ethics is designed to provide guidance to members, certified individuals, and applicants as they make professional decisions. Because the Code of Ethics is not intended to address specific situations and is not inclusive of all possible ethical dilemmas, professionals are expected to follow its written provisions and to uphold its spirit and purpose. Adherence to the Code of Ethics and its enforcement results in respect for the professions and positive outcomes for those who benefit from the work of audiologists, speech-language pathologists, and speech, language, and hearing scientists. PRINCIPLE OF ETHICS I Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities. RULES OF ETHICS A. Individuals shall provide all clinical services and scientific activities competently. B. Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided. C. Individuals shall not discriminate in the delivery of professional services or in the conduct of research and scholarly activities on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; or veteran status. D. Individuals shall not misrepresent the credentials of aides, assistants, technicians, students, research assistants, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the

name, role, and professional credentials of persons providing services. E. Individuals who hold the Certificate of Clinical Competence may delegate tasks related to the provision of clinical services to aides, assistants, technicians, or any other persons only if those persons are adequately prepared and are appropriately supervised. The © Copyright 2023 American Speech-Language-Hearing Association. All rights reserved. 3 ASHA Code of Ethics responsibility for the welfare of those being served remains with the certified audiologist or speech-language pathologist. F. Individuals who hold the Certificate of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, judgment, or credentials that are within the scope of their profession to aides, assistants, technicians, or any nonprofessionals over whom they have supervisory responsibility. G. Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified audiologist or speechlanguage pathologist. H. Individuals shall obtain informed consent from the persons they serve about the nature and possible risks and effects of services provided, technology employed, and products dispensed. This obligation also includes informing persons served about possible effects of not engaging in treatment or not following clinical recommendations. If diminished decision-making ability of persons served is suspected, individuals should seek appropriate authorization for services, such as authorization from a legally authorized/appointed representative. I. Individuals shall enroll and include persons as participants in research or teaching demonstrations/simulations only if participation is voluntary, without coercion, and with informed consent. J. Individuals shall accurately represent the intended purpose of a service, product, or research endeavor and shall abide by established guidelines for clinical practice and the responsible conduct of research, including humane treatment of animals involved in research. K. Individuals who hold the Certificate of Clinical Competence shall evaluate the effectiveness of services provided, technology employed, and products dispensed, and they shall provide services or dispense products only when benefit can reasonably be expected. L. Individuals who hold the Certificate of Clinical Competence shall use independent and evidence-based clinical judgment, keeping paramount the best interests of those being served. M. Individuals may make a reasonable statement of prognosis, but they shall not guarantee—directly or by implication—the results of any treatment or procedure. © Copyright 2023 American Speech-Language-Hearing Association. All rights reserved. 4 ASHA Code of Ethics N. Individuals who hold the Certificate of Clinical Competence may provide services via telepractice consistent with professional standards and state and federal regulations, but they shall not provide clinical services solely by written communication. O. Individuals shall protect the confidentiality and security of records of professional services provided, research and scholarly activities conducted, and products dispensed. Access to these records shall be allowed only when doing so is legally authorized or required by law. P. Individuals shall protect the confidentiality of information about persons served professionally or participants involved in research and scholarly activities. Disclosure of confidential information shall be allowed only when doing so is legally authorized or required by law. Q. Individuals shall maintain timely records; shall accurately record and bill for services provided and products dispensed; and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted. R. Individuals shall not allow personal hardships, psychosocial distress, substance use/misuse, or physical or mental health conditions to interfere with their duty to provide professional services with reasonable skill and safety. Individuals whose professional practice is adversely affected by any of the above-listed factors should seek professional assistance regarding whether their professional responsibilities should be limited or suspended. S. Individuals who have knowledge that a colleague is unable to provide professional services with reasonable skill and safety shall report this information to the appropriate authority, internally if such a mechanism exists and, when appropriate, externally to the applicable professional licensing authority or board, other professional regulatory body, or professional association. T. Individuals shall give reasonable notice to ensure continuity of care and shall provide information about alternatives for care in the event that they can no longer provide professional services. © Copyright 2023 American Speech-Language-Hearing Association. All rights reserved. 5 ASHA Code of Ethics PRINCIPLE OF ETHICS II Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance. RULES OF ETHICS A. Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience. B. ASHA members who do not hold the

Certificate of Clinical Competence may not engage in the provision of clinical services; however, individuals who are in the certification application process may provide clinical services consistent with current local and state laws and regulations and with ASHA certification requirements. C. Individuals shall enhance and refine their professional competence and expertise through engagement in lifelong learning applicable to their professional activities and skills. D. Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research. E. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience. F. Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct clinical activities that compromise the staff member's independent and objective professional judgment. G. Individuals shall use technology and instrumentation consistent with accepted professional guidelines in their areas of practice. When such technology is warranted but not available, an appropriate referral should be made. H. Individuals shall ensure that all technology and instrumentation used to provide services or to conduct research and scholarly activities are in proper working order and are properly calibrated. © Copyright 2023 American Speech-Language-Hearing Association. All rights reserved. 6

ASHA Code of Ethics PRINCIPLE OF ETHICS III In their professional role, individuals shall act with honesty and integrity when engaging with the public and shall provide accurate information involving any aspect of the professions. RULES OF ETHICS A. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly contributions. B. Individuals shall avoid engaging in conflicts of interest whereby a personal, professional, financial, or other interest or relationship could influence their objectivity, competence, or effectiveness in performing professional responsibilities. If such conflicts of interest cannot be avoided, proper disclosure and management is required. C. Individuals shall not misrepresent diagnostic information, services provided, results of services provided, products dispensed, effects of products dispensed, or research and scholarly activities. D. Individuals shall not defraud, scheme to defraud, or engage in any illegal or negligent conduct related to obtaining payment or reimbursement for services, products, research, or grants. E. Individuals' statements to the public shall provide accurate information regarding the professions, professional services and products, and research and scholarly activities. F. Individuals' statements to the public shall adhere to prevailing professional standards and shall not contain misrepresentations when advertising, announcing, or promoting their professional services, products, or research. G. Individuals shall not knowingly make false financial or nonfinancial statements and shall complete all materials honestly and without omission. PRINCIPLE OF ETHICS IV Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' selfimposed standards. RULES OF ETHICS A. Individuals shall work collaboratively with members of their own profession and/or members of other professions, when appropriate, to deliver the highest quality of care. © Copyright 2023 American Speech-Language-Hearing Association. All rights reserved. 7

ASHA Code of Ethics B. Individuals shall exercise independent professional judgment in recommending and providing professional services when an administrative directive, referral source, or prescription prevents them from keeping the welfare of persons served paramount. C. Individuals' statements to colleagues about professional services, products, or research results shall adhere to prevailing professional standards and shall contain no misrepresentations. D. Individuals shall not engage in any form of conduct that adversely reflects on the professions or on the individual's fitness to serve persons professionally. E. Individuals shall not engage in dishonesty, negligence, deceit, or misrepresentation. F. Individuals who mentor Clinical Fellows, act as a preceptor to audiology externs, or supervise undergraduate or graduate students, assistants, or other staff shall provide appropriate supervision and shall comply—fully and in a timely manner—with all ASHA certification and supervisory requirements. G. Applicants for certification or membership, and individuals making disclosures, shall not make false statements and shall complete all application and disclosure materials honestly and without omission. H. Individuals shall not engage in any form of harassment or power abuse. I. Individuals shall not engage in sexual activities with persons over whom they exercise professional authority or power, including persons receiving services, other than those with whom an ongoing consensual relationship existed prior to the date on which the professional relationship began. J. Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics. K. Individuals shall assign credit only to those who have contributed to a publication, presentation, process, or product. Credit shall be assigned in proportion to the contribution and only

with the contributor's consent. L. Individuals shall reference the source when using other persons' ideas, research, presentations, results, or products in written, oral, or any other media presentation or summary. To do otherwise constitutes plagiarism. M. Individuals shall not discriminate in their relationships with colleagues, members of other professions, or individuals under their supervision on the basis of age; citizenship; disability; ethnicity; gender; gender expression; gender identity; genetic information; national origin, including culture, language, dialect, and accent; race; religion; sex; sexual orientation; socioeconomic status; or veteran status.

N. Individuals with evidence that the Code of Ethics may have been violated have the responsibility to either work collaboratively to resolve the situation where possible or to inform the Board of Ethics through its established procedures. O. Individuals shall report members of other professions who they know have violated standards of care to the appropriate professional licensing authority or board, other professional regulatory body, or professional association when such violation compromises the welfare of persons served and/or research participants.

P. Individuals shall not file or encourage others to file complaints that disregard or ignore facts that would disprove the allegation; the Code of Ethics shall not be used for personal reprisal, as a means of addressing personal animosity, or as a vehicle for retaliation.

Q. Individuals making and responding to complaints shall comply fully with the policies of the Board of Ethics in its consideration, adjudication, and resolution of complaints of alleged violations of the Code of Ethics.

R. Individuals involved in ethics complaints shall not knowingly make false statements of fact or withhold relevant facts necessary to fairly adjudicate the complaints.

S. Individuals shall comply with local, state, and federal laws and regulations applicable to professional practice and to the responsible conduct of research.

T. Individuals who have been convicted of, been found guilty of, or entered a plea of guilty or nolo contendere to (1) any misdemeanor involving dishonesty, physical harm—or the threat of physical harm—to the person or property of another or (2) any felony shall self-report by notifying the ASHA Ethics Office in writing within 60 days of the conviction, plea, or finding of guilt. Individuals shall also provide a copy of the conviction, plea, or nolo contendere record with their self-report notification, and any other court documents as reasonably requested by the ASHA Ethics Office.

U. Individuals who have (1) been publicly disciplined or denied a license or a professional credential by any professional association, professional licensing authority or board, or other professional regulatory body; or (2) voluntarily relinquished or surrendered their license, certification, or registration with any such body while under investigation for alleged unprofessional or improper conduct shall self-report by notifying the ASHA Ethics Office in writing within 60 days of the final action or disposition. Individuals shall also provide a copy of the final action, sanction, or disposition—with their self-report notification—to the ASHA Ethics Office.

ASHA Code of Ethics

TERMINOLOGY The purpose of the following Terminology section is to provide additional clarification for terms not defined within the Principles of Ethics and Rules of Ethics sections.

ASHA Ethics Office

The ASHA Ethics Office assists the Board of Ethics with the confidential administration and processing of self-reports from and ethics complaints against individuals (as defined below). All complaints and self-reports should be sent to this office. The mailing address for the ASHA Ethics Office is American Speech-Language-Hearing Association, attn: Ethics Office, 2200 Research Blvd., #309, Rockville, MD 20850. The email address is ethics@asha.org. advertising Any form of communication with the public regarding services, therapies, research, products, or publications. diminished decision-making ability The inability to comprehend, retain, or apply

information necessary to determine a reasonable course of action.

individuals

Within the Code of Ethics, this term refers to ASHA members and/or certificate holders and applicants for ASHA certification.

informed consent

An agreement by persons served, those with legal authority for persons served, or research participants that constitutes authorization of a proposed course of action after the communication of adequate information regarding expected outcomes and potential risks. Such an agreement may be verbal or written, as required by applicable law or policy.

may vs. shall

May denotes an allowance for discretion; shall denotes something that is required. misrepresentation Any statement by words or other conduct that, under the circumstances, amounts to an assertion that is false, erroneous, or misleading (i.e., not in accordance with the facts).

negligence

Failing to exercise a standard of care toward others that a reasonable or prudent person would use in the circumstances, or taking actions that a reasonable person would not. nolo contendere A plea made by a defendant stating that they will not contest a criminal charge.

plagiarism

Representation of another person's idea, research, presentation, result, or product as one's own through irresponsible citation, attribution, or paraphrasing.

publicly disciplined

A formal disciplinary action of public record. reasonable or reasonable Being supported or justified by fact or circumstance and being in accordance with reason, fairness, duty, or prudence.

self-report

A professional obligation of self-disclosure that requires (a) notifying the ASHA Ethics Office in writing and (b) sending a copy of the required documentation to the ASHA Ethics Office (see definition of "written" below).

shall vs. may

Shall denotes something that is required; may denotes an allowance for discretion.

telepractice

Application of telecommunications technology to the delivery of audiology and speechlanguage pathology professional services at a distance by linking clinician to client/patient/student or by linking clinician to clinician for assessment, intervention, consultation, or supervision. The quality of the service should be equivalent to that of in-person service. For more information, see Telepractice on the ASHA Practice Portal. written Encompasses both electronic and hard-copy writings or communications.

Issues in Ethics: Supervision of Student Clinicians

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About This Document

Published 2017. This Issues in Ethics statement is a revision of *Supervision of Student Clinicians* (originally published in 2003 and revised in 2010). It has been updated to make any references to the Code of Ethics consistent with the *Code of Ethics* (2016). The Board of Ethics reviews Issues in Ethics statements periodically to ensure that they meet the needs of the professions and are consistent with ASHA policies.

Issues in Ethics Statements: Definition

From time to time, the Board of Ethics (hereinafter, the "Board") determines that members and certificate holders can benefit from additional analysis and instruction concerning a specific issue of ethical conduct. Issues in Ethics statements are intended to heighten sensitivity and increase awareness. They are illustrative of the *Code of Ethics* (2016) (hereinafter, the "Code") and are intended to promote thoughtful consideration of ethical issues. They may assist members and certificate holders in engaging in self-guided ethical decision making. These statements do not absolutely prohibit or require specified activity. The facts and circumstances surrounding a matter of concern will determine whether the activity is ethical.

Introduction

This Issues in Ethics statement is presented for the guidance of ASHA members and certificate holders in matters relating to supervision of students engaged in the provision of clinical services during all practicum experiences (on campus and off campus) and externships. ASHA members and certificate holders are employed in a variety of work settings and are required by their employers, by their states, and by governmental agencies—as well as by ASHA—to comply with prescribed personnel standards related to certification and licensure. The term **clinical educator** often is used to describe individuals engaged in supervision of student clinicians (audiology students and speech-language pathology students) in any clinical setting. The term **preceptor** applies to audiologists who supervise audiology students in their final externship.

Although the standards and requirements can and do differ, under the Code, members and certificate holders delivering or supervising clinical services must hold ASHA certification—the Certificate of Clinical Competence in Audiology (CCC-A) or the Certificate of Clinical

Competence in Speech-Language Pathology (CCC-SLP)—in the area of their clinical or supervisory work regardless of the work setting, state, or jurisdiction in which they are employed. As the Issues in Ethics statement [Clinical Practice by Certificate Holders in the Profession in Which They Are Not Certified](#) (ASHA, 2017) states, "When audiologists and speech-language pathologists are engaged in any aspect of professional practice, it is essential that they function within the scope of practice of their respective professions (i.e., audiology or speech-language pathology) and only within the scope of their competence, as determined by their certification status, education, training, and experience."

Further, ASHA-certified individuals who are engaged in supervision of student clinicians are bound to honor their responsibility to hold paramount the welfare of persons they serve professionally and to ensure that services are provided competently by students under their supervision. Whether the term used is **supervisor**, **clinical educator**, or **preceptor**, all of these individuals exercise professional authority or power over students. With that professional authority or power over students also comes an expectation of trust.

Discussion

The Board of Ethics cites and interprets the following sections of the Code that pertain to the supervision of student clinicians:

- *Principle I*: Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.
- *Principle I, Rule A*: Individuals shall provide all clinical services and scientific activities competently.
- *Principle I, Rule D*: Individuals shall not misrepresent the credentials of aides, assistants, technicians, support personnel, students, research interns, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name, role, and professional credentials of persons providing services.
- *Principle I, Rule G*: Individuals who hold the Certificate of Clinical Competence may delegate to students tasks related to the provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope of practice of their profession only if those students are adequately prepared and are appropriately supervised. The responsibility for the welfare of those being served remains with the certified individual.
- *Principle II, Rule A*: Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.
- *Principle IV, Rule H*: Individuals shall not engage in sexual activities with individuals (other than a spouse or other individual with whom a prior consensual relationship exists) over whom they exercise professional authority or power, including persons receiving services, assistants, students, or research participants.
- *Principle IV, Rule I*: Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.

- *Principle IV, Rule L:* Individuals shall not discriminate in their relationships with colleagues, assistants, students, support personnel, and members of other professions and disciplines on the basis of race, ethnicity, sex, gender identity/gender expression, sexual orientation, age, religion, national origin, disability, culture, language, dialect, or socioeconomic status.

ASHA-certified individuals who supervise students cannot delegate the responsibility for clinical decision making and management to the student. The legal and ethical responsibility for persons served remains with the certified individual. However, the student can, as part of the educational process, make client management recommendations and decisions pending review and approval by the supervisor. Further, the supervisor must inform the client or client's family of the qualifications and credentials of the student supervisee involved in the provision of clinical services.

All supervised clinical activities provided by the student must fall within the scope of practice for the specific profession to count toward the student's certification. The supervisor or preceptor must achieve and maintain competency in supervisory practice as well as in the disability areas for which supervision is provided. The amount of supervision provided by the ASHA-certified supervisor must be commensurate with the student's knowledge, experience, and competence to ensure that the welfare of the client is protected. The supervisor must also ensure that the student supervisee maintains confidentiality of client information and documents all client records and billing information, if applicable, in an accurate and timely manner.

Differences may exist in the type and amount of supervision of student supervisees that is required for teacher certification in audiology and speech-language pathology, state licensure in the professions of audiology and speech-language pathology, and ASHA certification in audiology and speech-language pathology. In states where credential requirements or state licensure requirements differ from ASHA certification standards, supervised clinical experiences (including student practica for teacher licensing) will count toward or may be applied toward ASHA certification requirements only if those clinical experience hours have been supervised by ASHA-certified personnel.

Guidance

ASHA-certified individuals who supervise students should possess or seek training in supervisory practice and provide supervision only in practice areas for which they possess the appropriate knowledge and skills. The supervisor must oversee the clinical activities and make or approve all clinical decisions to ensure that the welfare of the client is protected. The supervisor should inform the client or the client's family about the supervisory relationship and the qualifications of the student supervisee.

The supervisor must provide no less than the level of supervision that is outlined in the current certification standards and increase supervision if needed based on the student's knowledge, experience, and competence. The supervisor should document the amount of direct and indirect supervision provided and should design and implement procedures that will protect client confidentiality for services provided by students under supervision.

ASHA members and certificate holders who are engaged in the preparation, placement, and supervision of student clinicians must make reasonable efforts to ensure that direct practicum supervision is provided by professionals holding the CCC-A or CCC-SLP. They must inform students who engage in student practica for teacher licensing or who engage in other clinical experiences under a non-ASHA-certified supervisor that these experiences cannot be applied to ASHA certification. ASHA-certified personnel cannot sign for clinical practicum experiences that were actually supervised by non-ASHA-certified individuals. It is unethical for certificate holders to approve or sign for clinical hours for which they did not provide supervision.



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Ad Hoc Committee on Supervision

December 2013

Final Report

Knowledge, Skills and Training Consideration for Individuals Serving as Supervisors

Sue Hale, CCC-SLP, TN, Ad Hoc Committee Chair, academic clinical educator

Silvia Quevedo, CCC-SLP, ASHA ex officio

Susan Brannen, CCC-A, NY, ASHA Board of Ethics

Melanie Hudson, CCC-SLP, GA, Coordinator, ASHA Special Interest Group (SIG) 11, Administration and Supervision

Pamela Klick, CCC-SLP, Council of Academic Programs in Communication Sciences and Disorders (CAPCSD)

Janet Koehnke, CCC-A, NJ, ASHA Academic Affairs Board (AAB)

Celeste Krueger, CCC-SLP, CA, school speech-language pathology

Colleen Noe, CCC-A, TN, health care (Veterans Administration), audiology

Judith Page, CCC-SLP, KY, ASHA Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC),

Kathy Panther, CCC-SLP, KY, health care, speech-language pathology

Ruth Peaper-Fillyaw, CCC-SLP, NH, Council of Academic Programs in Communication Sciences and Disorders CAPCSD

Heidi Ramrattan, CCC-A, IL, educational audiology

Margaret Rogers, CCC-SLP, ASHA chief staff officer for science and research

Neil Shepard, CCC-A, MN, ASHA vice president for academic affairs in audiology and ASHA BOD liaison

Introduction and Overview

This report was prepared by the Ad Hoc Committee on Supervision, which was appointed by the American Speech-Language-Hearing Association (ASHA) Board of Directors (BOD) in 2012. The committee included audiology and speech-language pathology volunteer members from a variety of work settings who had experience and expertise in clinical education. The committee member composition also included representation from the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) and select ASHA boards and committees. The members and their affiliations/areas of expertise included:

In 2012, a subcommittee of the ASHA BOD was charged with responding to input from members and constituent groups regarding the need for formal training for individuals engaged in clinical supervision. The same year, members of SIG 11 and a CAPCSD working group were addressing this issue. The BOD subcommittee recommended—and gained BOD approval for—the appointment of an Ad Hoc Committee on Supervision (also referred to as the *Blue Ribbon Panel on Supervision*) whose members would include individuals with knowledge of the science of clinical supervision and representatives from stakeholder constituencies.

Charge of the Committee

The Ad Hoc Committee was charged with determining the training essential to the development of skills and knowledge required for effective clinical supervision. Additionally, the committee was asked to consider training for supervisory skills and knowledge in relation to five distinct groups who provide clinical supervision:

1. individuals in academic training programs who supervise graduate students,
2. individuals in clinical or educational settings who provide externship or off-campus supervision to graduate students,
3. practitioners who supervise audiology or speech-language pathology assistants,
4. speech-language pathologists who supervise clinical fellows and audiologists who supervise audiology clinical doctoral students in the final externship,
5. speech-language pathologists and audiologists who supervise credentialed colleagues who are changing their primary clinical focus.

The committee was also asked to make recommendations for comprehensive and systematic supervisory training mechanisms.

The committee reviewed current ASHA resources on supervision, which included ASHA practice policy documents, ASHA professional development products on clinical education, and *Perspectives* articles pertinent to supervision, as well as resources and materials from other allied health organizations and associations.

In reviewing resources, the committee noted that terminology regarding the clinical supervisor's exact role varies, often in relation to the person being supervised. Graduate students learn from *clinical educators*, while clinical fellows are supervised by *mentors*. Audiology externs often are guided by *preceptors*, and assistants usually report to *supervisors*. In order to be consistent in this report, the term *supervisors* will be used to refer to individuals who are clinical educators, preceptors, or mentors in recognition of their guidance of students or others who are developing clinical knowledge and skills in the profession of audiology or speech-language pathology. The term *supervision* will be used to refer to all of the activities used to guide students and others in developing such skills.

While current supervisors can find information on the supervisory process in both old and new textbooks and online training modules from publishers or providers other than ASHA, little guidance exists on the critical aspects necessary for training effective supervision for specific audiences. This report of the Ad Hoc Committee on Supervision provides a philosophical framework regarding training in clinical supervision; guidance for determining what aspects of supervision require training for which audiences in what contexts and who should provide that training; and recommendations for developing comprehensive and systematic training programs in supervisory education.

Framework

A prevailing philosophy suggests that competency in clinical service delivery translates into effective clinical supervision. However, leaders in supervision have long argued that this is a flawed assumption and that effective supervision requires a unique set of knowledge and skills.

The Ad Hoc Committee acknowledges that supervision is a distinct area of practice and, as in other distinct areas, individuals must receive training to gain competence before engaging in the activity. Education in the supervisory process

should begin early, with—as a minimum—an introduction to the subject as part of the graduate curriculum and more extensive training readily available to practicing and aspiring supervisors. Effective education for supervision should focus on unique aspects of knowledge and specialized skills for the supervisory process and should not be limited to regulatory aspects (e.g., observation time, clock hours) of the process. Effective supervision ensures that new professionals are well prepared and that quality services are provided to individuals with communication disorders. It is by this means that effective supervision contributes to the ongoing vitality of the professions. Formal training in the supervisory process is essential to maximize practitioners' clinical and professional skills in the workplace.

General assumptions and operating principles were identified.

- A body of literature exists describing necessary knowledge and skills required for effective supervision.
- In all instances, the supervisor should possess the clinical skills necessary to guide the supervisee in the correct course of evaluation or treatment to achieve positive patient outcomes.
- Those engaged in clinical supervision should possess a dedication to lifelong learning specific to clinical education, which is evidenced by participating in relevant continuing education programs.
- Individuals engaging in supervision should adhere to and model principles of ethical practice in accordance with the ASHA Code of Ethics.

In responding to its charge, the Ad Hoc Committee attempted to adhere to the distinctions of the different target groups as identified by the BOD subcommittee, but concluded that similar training was appropriate for certain skills and knowledge required by multiple groups. To that end, in its initial section, the committee addressed overarching training needs for core skills and knowledge, regardless of the supervisee or venue; there was one exception, which is noted below.

Subsequent sections of the report differ slightly from the original charge with respect to groups listed by the BOD subcommittee. The groups addressed in this report include:

1. students in university training clinics or in externship/off-campus clinical settings,
2. audiology students in the final externship,
3. clinical fellows,

4. professionals transitioning to a new area of practice or re-entering the workforce,
5. support personnel.

Note that, though the last group was identified by the subcommittee, the Ad Hoc Committee determined that supervision of assistants would not include goals related to promoting clinical independence, specifically those mentioned in the overarching category.

During the working period for the committee, two reports/guidelines related to supervision and clinical education were published and approved by the sponsoring organizations. These documents included CAPCSD's White Paper: Preparation of Speech-Language Pathology Clinical Educators (2013) and ASHA's Speech-Language Pathology Assistant Scope of Practice (2013). The CAPCSD working group that developed the white paper recommended requiring formal training and preparation of clinical educators and suggested a standard curriculum for such training (CAPCSD, 2013). The ASHA scope of practice document for assistants stated that qualifications for a supervising speech-language pathologist should include an academic course or at least 10 hours of continuing education in the area of supervision (ASHA, 2013).

Overarching Knowledge and Skills

**Goal: “... guide and support the learner through hands-on clinical training with the goal of developing clinical and professional knowledge and skills.”
(Newman, 2005)**

Areas of training for all persons engaged in supervision will include knowledge and skills development in the following delineated categories.

KNOWLEDGE:

Supervisory Process and Clinical Education—Supervisor will possess:

- Knowledge of collaborative models of supervision
- Knowledge of adult learning styles
- Knowledge of teaching techniques (e.g., reflective practice, questioning techniques)
- Ability to define supervisor/supervisee roles and responsibilities appropriate to the setting

SKILLS:

Relationship Development—Supervisor will:

- Develop supportive and trusting relationship with supervisee
- Create an environment that fosters learning and exploration of personal strengths and needs
- Work within the relationship to transfer decision making and social power to the supervisee, as appropriate
- Educate supervisee about the supervisory process

Communication Skills—Supervisor will define/demonstrate:

- Expectations, goal setting, and requirements of the supervisor/supervisee relationship
- Expectations for interpersonal and modes of communication, including written/oral messages with supervisor, families, clients, referral sources, or colleagues
- Appropriate responses to differences in communication styles and evidence of cultural competence
- Recognition of and access to appropriate accommodations for supervisees with disabilities
- Engagement in difficult conversations, when appropriate, regarding supervisee performance
- Access to and use of technology, when appropriate, for remote supervision

Establishing and Implementing Goals—Supervisor will:

- Develop goals/objectives—collaboratively with the supervisee—that allow for the supervisee’s clinical and professional growth in critical thinking, problem solving, etc.
- Set personal goals to enhance supervisory skills
- Observe sessions, collect and interpret data, and share data with the supervisee
- Give the supervisee objective feedback designed to motivate and improve performance
- Understand the levels and use of questions to facilitate clinical learning
- Adjust supervisory style based on level and needs of the supervisee
- Review relevant paperwork and documentation

Analysis—Supervisor will:

- Examine collected data and observation notes to identify patterns of behavior and target areas for improvement
- Assist the supervisee in conducting self-reflections until independence is achieved

Evaluation—Supervisor will collaborate with the supervisee and continually:

- Assess performance of the supervisee
- Determine if progress is being made toward achieving the supervisee’s goals
- Modify current goals or establish new goals if needed

Clinical Decisions—Supervisor will model and guide supervisee to:

- Respond appropriately to ethical dilemmas
- Apply regulatory guidance in service delivery
- Access payment/reimbursement for services rendered

Performance Decisions—Supervisor will:

- Guide supervisee in using reflective practice techniques to modify his/her own performance
- Assess supervisee performance and provide guidance regarding both effective and ineffective performance
- Determine if progress is being made toward achieving the supervisee’s goals
- Identify issues of concern in regard to supervisee performance
- Create and implement plans for improvement that encourage supervisee engagement
- Assess response to plans for improvement and determine next steps, including possibility of failure, remediation, or dismissal

Research/Evidence-Based Practice—Supervisor will adhere to principles of evidence-based practice and effectively convey applicable research information/analysis to the supervisee and will:

- Refer to research and outcomes data and their application in clinical practice
- Encourage the supervisee to seek applicable research and outcomes data
- Utilize methods for measuring treatment outcomes

Knowledge and Skills Specific to Student Training (in the university clinic setting and in external placements)

Goal: Develop clinical and professional knowledge and skills for entry-level practice.

Specific areas of training for persons engaged in supervision of students in university clinic settings and in external placements will include knowledge and skills development in the following areas.

The supervisor will:

- Connect academic knowledge and clinical procedures
- Sequence the student's knowledge and skills development
- Facilitate the student's ability to respond to various clinical settings and supervisory expectations
- Build professional identity and engagement
- Facilitate the student's utilization of information to support clinical decision making and problem solving
- Understand the relationship defined by the agreement between the university and clinic site and adhere to the requirements (when applicable)

Knowledge and Skills Specific to Supervisors of Students in the Culminating Externship in Audiology

Goal: Facilitate transition from supervised/mentored student to independent practitioner.

Specific areas of training for persons engaged in supervision of audiology students in the culminating externship will include knowledge and skills development in the following areas.

The supervisor will:

- Understand the relationship defined by the agreement between the university and clinic site and adhere to the requirements
- Develop a multi-faceted experience for the extern across the scope of the profession
- Serve as an effective liaison in the relationship between the university, the student, and the facility
- Provide ongoing assessment and objective (data-based) feedback, including the use of any reporting tools provided by the university
- Allow the student to develop increasing independence in the externship
- Collaborate with other supervisors where and when applicable to ensure meaningful and relevant educational experiences for the student
- Guide the student in reflective practice (goal setting, self-monitoring, knowing when to request immediate vs. delayed supervisory intervention, and using data to guide clinical decisions) to encourage flexibility, growth, and independence
- Facilitate the student's use of information to support clinical practice (problem solving, accessing evidence-based tools/information, and professional development)
- Assist in the development of workplace navigation skills, including becoming a part of the team and adhering to the policies and procedures of the facility
- Establish and maintain professional boundaries and appropriate relationships
- Foster a professional identity and engagement
- Guide the student in developing advocacy skills for clients, himself/herself, and the profession

Knowledge and Skills Specific to Mentors of Clinical Fellows in Speech-Language Pathology

Goal: Facilitate transition from supervised student to mentored professional to certified independent practitioner.

Specific areas of training for persons engaged in supervision of clinical fellows (speech-language pathology) will include knowledge and skills development in the following areas.

The supervisor will:

- Accept and adhere to ASHA roles and responsibilities for mentoring clinical fellows (reference the Roles and Responsibilities of CF Mentor document from ASHA)
- Establish goals for the CF experience through a collaborative process of development/assessment
- Provide appropriate balance of direct observation and other monitoring activities consistent with the clinical fellow's skills and goals while maintaining compliance with ASHA CF guidelines
- Provide ongoing assessment and objective (data-based) feedback, including the use of any required reporting tool
- Provide opportunities to achieve independence in the workplace
- Guide the clinical fellow in reflective practice (goal setting, self-monitoring, knowing when to request immediate vs. delayed intervention, and using data to guide clinical decisions) to encourage flexibility, growth, and independence
- Facilitate the clinical fellow's use of information to support clinical practice (problem solving, accessing evidence-based tools/information, and professional development)
- Assist in the development of workplace navigation skills, including becoming a part of the team and adhering to the policies and procedures of the facility
- Establish and maintain professional boundaries and appropriate relationships
- Foster a professional identity and engagement
- Guide the clinical fellow in developing advocacy skills for clients, himself/herself, and the profession

Knowledge and Skills Specific to Supervisors of Support Personnel

Goal: Facilitate the acquisition of skills needed for the provision of efficient and effective services within the scope of practice under the supervision of a credentialed provider.

Specific areas of training for persons engaged in supervision of support personnel will include knowledge and skills development in the following areas.

The supervisor will:

- Model and develop appropriate relationships with the support personnel and within the organizational structure
- Understand, and communicate to others in the setting, respective roles and responsibilities, including appropriate ASHA guidelines (ASHA 2008a, b, c) and state regulations
- Facilitate collaboration with multiple/joint supervisors
- Adapt to changes in the service delivery environment
- Hold appropriate credentialing for the professional and supervisory roles
- Assign responsibilities to support personnel based on skills assessment
- Analyze existing skills of the support person
- Match/develop skills with job assignments
- Delegate responsibilities effectively
- Evaluate support personnel through performance-based measures rather than developmental assessment
- Conduct ongoing and measurable competency assessment
- Identify needs for basic and continuing education and develop a plan
- Know and ensure compliance with state federal, regulatory, and ASHA guidelines for duties and responsibilities, reimbursement, and legal and ethical repercussions in relation to the scope of practice of the supervisor
- Facilitate efficiency, team building, and interprofessional relationships
- Focus on client-centered care
- Empower support personnel to work at top potential and to continue to develop relevant additional skills

Knowledge and Skills Specific to Individuals Who Are Transitioning to a New Area of Practice or Re-entering the Profession

Goal: Facilitate the acquisition of knowledge and skills needed for the professional in transition.

Specific areas of training for persons engaged in supervising/guiding professionals in workplace transition will include knowledge and skills development in the following areas.

The supervisor will:

- Explore existing skills and knowledge, including transferable skills
- Identify the need for continuing education and training and develop a plan for achieving necessary skills/knowledge

- Assist in the development of workplace navigation skills, including becoming part of the team and adhering to the policies and procedures of the facility
- Promote self-reflection to learn new skills and hone existing skills
- Provide ongoing collaborative assessment

Development of Training Programs

Fundamental Considerations

The committee determined that there are fundamental considerations that should inform the process of designing and disseminating curricula or products for supervisory education. As a distinct area of practice, supervision is fundamental to the professions of audiology and speech-language pathology and requires special training (ASHA, 2008b). Knowledgeable individuals and key stakeholder groups, as cited earlier, have urged required supervisory training for all individuals engaged in clinical education; this ad hoc committee agrees. However, the committee recognizes that compulsory training in clinical education and supervision would need to be phased in over a period of time in order to avoid a dramatic impact on graduate education programs as well as on clinical facilities that employ/accept graduate students, clinical fellows, and audiology externs.

This committee also suggests that it would be desirable to build on the consensus of what constitutes best practice in the area of clinical education and supervision to advise the development of programs for supervisory training (ASHA, 2008a, 2008b, 2008c). Such a foundation would help ensure that clinical educators develop the skills and knowledge cited in this document, as well as those abilities identified in other practice and policy documents. Clinical education literature across all allied health fields should be employed for the development of training materials—notably the information related to the scholarship of teaching and learning, adult learning, and successful models for training clinical educators in related disciplines. Thus, a comprehensive, systematic review of the science of clinical education would be a useful undertaking. If supervisory training is determined to be essential and required, the standards community—Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA), Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC), and Board of Ethics (BOE)—as well as other stakeholder groups, such as

the Council of Academic Programs in Communication Sciences and Disorders, will need to engage in discussions and partnerships to determine guiding principles and standards to address such a potential requirement.

The following sections address issues more specific to the development of training, with the understanding that the aforementioned standards and professional bodies will work within their autonomous roles and scopes to address the question of whether the committee recommendation for required training in supervision will be implemented.

In addition, the committee chose to address specific issues in regard to

- development of and options for the delivery of educational products,
- utilization of a cadre of persons skilled in supervisory education as trainers and product developers,
- identification of potential consumers for the training,
- development of outcomes and perhaps incentives for those who engage in supervisory training.

Development and Delivery of Educational Products

Educational content, regardless of mode of delivery, should be accessible, engaging, and appropriate for adult learners. There are model programs in the allied health arena (American Occupational Therapy Association [AOTA] 2013; American Physical Therapy Association [APTA] 2009) that could serve as models for program development and for delivery options. Core assumptions for the design and implementation of supervisory education include:

- materials should be developed to address a variety of learning styles;
- content should be developed in modules or segments that have clear learning outcomes, but certain modules could be taken in sequence to build toward a logical “whole”;
- content must include the core knowledge areas identified earlier in this document—some of that knowledge can be gained through didactic instruction, as well as interactive opportunities to model and modify behaviors;
- whenever possible, collaboration between providing entities, such as universities and clinical settings, is recommended, as it may enhance learners’ access and success in achieving desired outcomes.

Curricular development is critical in that supervision permeates all areas of practice, and all practitioners are products of supervision. Education in the roles and responsibilities of supervisors should include and support ethical practice and decision making.

Product Recommendations

1. Develop comprehensive learning modules that reflect sufficient depth and breadth of the knowledge and skills identified in the overarching section of this report.
2. Develop separate modules to reflect the specialized knowledge and skills needed for each of the identified target audiences.
3. Consider the development of modules related to core theories of supervision, reflective practice, cultural competence, and other fundamental concepts.
4. Develop means for pre-assessment and post-assessment of learning to gauge effectiveness of content presentation and need for modifying module content.

Delivery Recommendations

1. Face-to-face training is recommended as the initial delivery mode to facilitate product development and assessment of efficacy.
2. Multiple delivery models would ensure accessibility and affordability.
3. For face-to-face delivery, additional training curricula would be necessary to “train the trainers.”
4. For hybrid delivery, online modules might be followed by face-to-face practice or face-to-face training might be followed by online assessment.
5. Online-only delivery should have versions that facilitate individual learning, as well as versions that might be more useful for learning in groups.

Venue Recommendations

1. Conferences
 - a. National—Consider pre-conference options at the ASHA Convention and at other ASHA conferences, such as the Schools, Health Care, and Audiology Conferences. Consider creating a new conference dedicated solely to supervision (perhaps in collaboration with CAPCSD and using the Summit construct, Lessons for Success/GRRT, and/or Leadership Development programs as models).
 - b. State—Conduct supervisory training at state association meetings with the same type of rotation as the ASHA leadership schedule for the president’s attendance at state meetings and/or utilizing trained trainers within the state.

- c. Local—Use training materials and trainers for groups that exist at the local level, such as regional/metro associations or groups formed with a special interest in a particular area of practice.
2. University programs—Consider holding training events for supervisors who support student training by participating in supervision.
3. Employment sites—Consider providing training for supervision of clinical fellows and for students who are accepted for placements in the respective settings.
4. Partnerships—Consider creating partnerships between employers and university programs in a region/area.

Qualified Persons to Develop Materials, Provide Initial Training

Individuals who have expertise and a history of training supervisors will be needed to consult and assist in the development of curricular materials. While it is assumed that educational materials for supervision might be developed by a variety of vendors, it would also be expected that ASHA, perhaps in partnership with CAPCSD, would develop curricular materials that would be readily available to members. A group of subject-matter experts in supervision would not only have the knowledge to develop such training materials, but could also assist in the actual training of the initial cadre of trainers for face-to-face delivery of a curriculum. In the initial development of training, valuable information can be derived from other supervisory training programs. For example, APTA has implemented a successful clinical instructor training program (Clinical Instructor Education and Credentialing Program (CIECP)). According to K. Stoneley, APTA's director of academic and clinical education affairs and manager of CIECP and M. Emery, Chair of DPT program at Sacred Heart University and an author of the CIECP curriculum, 35,000 physical therapists have completed the program over the last 19 years. As in any such endeavor, a means for assessing efficacy of training and the development of a plan for logical expansion of the offerings will be needed on an ongoing basis.

Specific recommendations for a core curriculum include:

- Explore potential sources for developing the curriculum and possibly utilize an RFP.
- Collaborate with other allied health organizations, such as APTA, who have a history of clinical instructor training.
- Partner with CAPCSD to identify subject-matter experts to serve as initial trainers.

- Develop an application and review process for potential trainers.
- Conduct and assess the efficacy of training.

In selecting applicants for training, consideration should be given to identification of required credentials for participation, ensuring a commitment to teach others (specified number of classes within a timeframe), possession of considerable supervisory experience in the professions, and evidence of ongoing teaching/training experience in supervision.

Potential Consumers of the Training

While the various groups of supervisors were identified in the initial charge to the committee (and the skills and knowledge specific for training those groups are described in earlier sections of this report), there are considerations for delineating levels of training that may supersede those categories. Additionally, review of data regarding supervision (e.g., percentage of the ASHA membership engaged in supervision) would inform the development of modules to meet the needs of specific groups of supervisors. The consumers of training identified below reflect a realistic framework for the development of training content:

- (1) Students in clinical graduate programs—Those in training for clinical degrees have the potential to participate in supervision at some point in their careers. Some graduate programs currently include such content, and such training is a requirement in the credentialing standards for the Certificate of Clinical Competence in Audiology. Training modules specific to graduate students could benefit university programs wishing to offer supervisory training content to meet their own requirements or possible future standards. Individuals who supervise students in clinical programs is clearly the largest potential audience for the educational programs.
- (2) Early-career supervisors—New professionals who have not yet supervised or are not yet eligible in their workplaces to supervise would benefit from training in preparation for a time when they will serve in a supervisory capacity.
- (3) Experienced supervisors—Those who currently engage in supervision may have had little or no formal training in clinical education and are often motivated to improve their skills/knowledge in supervision. These individuals would benefit from readily accessible training specific to their supervisory needs. Training programs would be of particular benefit to

experienced supervisors whose supervisory skills have been identified as needing improvement.

- (4) Individuals who are reluctant to supervise—Experienced or inexperienced supervisors who are being asked/required to engage in supervision, and are reluctant to do so, might be more willing to provide clinical education if supervisory training is available to them.
- (5) Individuals who train/manage staff—Those who are in positions requiring management of professional personnel would benefit from access to supervisory training materials specific to certain employment settings (hospitals, schools, universities).

Where training is currently required (in some state regulations, for speech-language pathology assistant supervision, for CCC-A requirements), readily accessible training tools will assist in the development of a predictable and desirable set of skills and knowledge in clinical supervision. Where supervisory training remains voluntary, highly engaging training tools would motivate individuals to seek training on their own.

Outcomes/Incentives

A long-term goal is that all supervisors would engage in supervisory training. For those who do participate and complete the program or programs that are developed, a certificate of completion or attendance could be considered. Such a recognition might be referred to with a term such as *clinical educator-basic* or *clinical educator-advanced* and include an opportunity for registration with ASHA, a listing which could be made available to stakeholders upon request. As with the question of requiring supervisory training, such a registry could be phased in over time and in collaboration with standards bodies, as appropriate. A future consideration regarding a supervision credential might also be warranted.

Summary

The Ad Hoc Committee on Supervision operated with the philosophy that clinical supervision is fundamental to the professions of audiology and speech-language pathology and requires special training. This report provides recommendations for the training of clinical supervisors in regard to overarching skills and knowledge as well as specific training necessary for supervision of targeted groups of supervisees, including students in clinical training programs, audiology students in the culminating externship, speech-language pathology graduates in the clinical fellowship, professionals transitioning from one area of practice to

another, and support personnel. The committee also makes recommendations for development and implementation of comprehensive and systematic training in supervision. These recommendations are specific to the development of educational products, the determination of qualified persons to develop materials and provide initial training, expected audiences for the training, and potential incentives and anticipated outcomes for trainees. The committee offers this report of its work with the recommendation that supervisory training be required of those who engage in clinical supervision and also recognizes the need for careful planning, assessment at every phase of implementation, and a thoughtful phase-in of any such requirement.

References

American Occupational Therapy Association. (2013). *Fieldwork Educators Certificate Workshop*. Available from www.aota.org.

American Physical Therapy Association. (2009). *Credentialed Clinical Instructor Program*. Alexandria, VA: Author

American Speech-Language-Hearing Association. (2008a). *Clinical supervision in speech-language pathology* [Technical report]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2008b). *Clinical supervision in speech-language pathology* [Position statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2008c). Knowledge and skills needed by speech-language pathologists providing clinical supervision [Knowledge and skills]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2004). Training, use, and supervision of support personnel in speech-language pathology [Position statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2013). Speech-language pathology assistant scope of practice [Scope of practice]. Available from www.asha.org/policy.

Council of Academic Programs in Communication Sciences and Disorders. (2013). White paper: Preparation of speech-language pathology clinical educators. Available from www.capcsd.org.

Newman, W. (2005, August 16). The basics of supervision. *The ASHA Leader*. Retrieved from www.asha.org/Publications/leader/2005/050816/f050816c.htm.

Additional Sources Reviewed by the Committee

American Speech-Language-Hearing Association. (2011). *Audiology support personnel: preparation, supervision, and ethical considerations* [Guidelines, Position statement]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2010). *Supervision of student clinicians* [Issues in ethics]. Available from www.asha.org/policy.

American Speech-Language-Hearing Association. (2012). *CFCC standards for certification in speech-language pathology comparison*. Retrieved from www.asha.org/uploadedFiles/2005-2014-SIP-Standards-Comparison.pdf.

Dudding, C., & Lucks Mendel, L. (n.d.). *Essential supervisory skills for clinical educators* [eWorkshop]. Available from www.asha.org/eweb/OLSDynamicPage.aspx?title=Essential%20Supervisory%20Skills%20for%20Clinical%20Educators&webcode=olsdetails.



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Knowledge and Skills Needed by Speech- Language Pathologists Providing Clinical Supervision

Ad Hoc Committee on Supervision in Speech-Language Pathology

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About This Document

This knowledge and skills document is an official statement of the American Speech-Language-Hearing Association (ASHA). This knowledge and skills statement was developed by the Ad Hoc Committee on Supervision. Members of the committee were Lisa O'Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Knowledge and Skills

This document accompanies ASHA's policy documents *Clinical Supervision in Speech-Language Pathology: Position Statement* and *Technical Report* (ASHA, 2008a, 2008b). ASHA's position statement affirms that clinical supervision (also called clinical teaching or clinical education) is a distinct area of expertise and practice, and that it is critically important that individuals who engage in supervision obtain education in the supervisory process. The role of supervisor may include administrative responsibilities in some settings, and, should this be the case, the supervisor will have two major responsibilities: clinical teaching and program management tasks. However, the knowledge and skills addressed in this document are focused on the essential elements of being a clinical educator in any service delivery setting with students, clinical fellows, and professionals.

Professionals looking for guidance in supervising support personnel should refer to the ASHA position statement and knowledge and skills documents on that topic (ASHA, 2002, 2004a, 2004b).

ASHA's technical report on clinical supervision in speech-language pathology (2008b) cites Jean Anderson's (1988) definition of supervision:

Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)

The ASHA technical report (2008b) adds the following elements to the above definition:

Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised. (p. 3)

This expanded definition was used as a basis for the following knowledge and skills statements.

Developing Knowledge and Skills

All certified SLPs have received supervision during their student practica and clinical fellowship; however, this by itself does not ensure competence as a supervisor. Furthermore, achieving clinical competence does not imply that one has the special skills required to be an effective supervisor. ASHA does not have specific requirements for coursework or credentials to serve as a supervisor; however, some states or settings may require coursework and/or years of experience to serve as a supervisor. Knowledge and skills may be developed in a variety of ways: participating in courses or workshops on supervision, engaging in self-study, participating in Division 11 (Administration and Supervision), and gaining mentored experiences under the guidance of an experienced clinical educator.

The following 11 items represent core areas of knowledge and skills. The supervisee is an essential partner in the supervisory process; however, these areas are presented from the perspective of knowledge and skills that should be acquired by the supervisor.

A. Preparation for the Supervisory Experience

A. Knowledge Required

1. Be familiar with the literature on supervision and the impact of supervisor behaviors on the growth and development of the supervisee.
2. Recognize that planning and goal setting are critical components of the supervisory process both for the clinical care provided to the client by the supervisee and for the professional growth of the supervisee.
3. Understand the value of different observation formats to benefit supervisee growth and development.
4. Understand the importance of implementing a supervisory style that corresponds to the knowledge and skill level of the supervisee.
5. Understand the basic principles and dynamics of effective collaboration.
6. Be familiar with data collection methods and tools for analysis of clinical behaviors.
7. Understand types and uses of technology and their application in supervision.

B. Skills Required

1. Facilitate an understanding of the supervisory process that includes the objectives of supervision, the roles of the participants, the components of the supervisory process, and a clear description of the assigned tasks and responsibilities.
2. Assist the supervisee in formulating goals for the clinical and supervisory processes, as needed.
3. Assess the supervisee's knowledge, skills, and prior experiences in relationship to the clients served.
4. Adapt or develop observational formats that facilitate objective data collection.
5. Be able to select and apply a supervisory style based on the needs of the clients served, and the knowledge and skill of the supervisee.
6. Model effective collaboration and communication skills in interdisciplinary teams.
7. Be able to analyze the data collected to facilitate the supervisee's clinical skill development and professional growth.

8. Use technology as appropriate to enhance communication effectiveness and efficiency in the supervisory process.

II. Interpersonal Communication and the Supervisor-Supervisee Relationship

A. Knowledge Required

1. Understand the basic principles and dynamics of effective interpersonal communication.
2. Understand different learning styles and how to work most effectively with each style in the supervisory relationship.
3. Understand how differences in age, gender, culture, social roles, and self-concept can present challenges to effective interpersonal communication.
4. Understand the importance of effective listening skills.
5. Understand differences in communication styles, including cultural/linguistic, generational, and gender differences, and how this may have an impact on the working relationship with the supervisee.
6. Be familiar with research on supervision in terms of developing supervisory relationships and in analyzing supervisor and supervisee behaviors.
7. Understand key principles of conflict resolution.

B. Skills Required

1. Demonstrate the use of effective interpersonal skills.
2. Facilitate the supervisee's use of interpersonal communication skills that will maximize communication effectiveness.
3. Recognize and accommodate differences in learning styles as part of the supervisory process.
4. Recognize and be able to address the challenges to successful communication interactions (e.g., generational and/or gender differences and cultural/linguistic factors).
5. Recognize and accommodate differences in communication styles.
6. Demonstrate behaviors that facilitate effective listening (e.g., silent listening, questioning, paraphrasing, empathizing, and supporting).
7. Maintain a professional and supportive relationship that allows for both supervisee and supervisor growth.
8. Apply research on supervision in developing supervisory relationships and in analyzing supervisor and supervisee behaviors.
9. Conduct a supervisor self-assessment to identify strengths as well as areas that need improvement (e.g., interpersonal communication).
10. Use appropriate conflict resolution strategies.

III. Development of the Supervisee's Critical Thinking and Problem-Solving Skills

A. Knowledge Required

1. Understand methods of collecting data to analyze the clinical and supervisory processes.
2. Understand how data can be used to facilitate change in client, clinician, and/or supervisory behaviors.
3. Understand how communication style influences the supervisee's development of critical thinking and problem-solving skills.

4. Understand the use of self-evaluation to promote supervisee growth.

B. Skills Required

1. Assist the supervisee in using a variety of data collection procedures.
2. Assist the supervisee in objectively analyzing and interpreting the data obtained and in understanding how to use it for modification of intervention plans.
3. Assist the supervisee in identifying salient patterns in either clinician or client behavior that facilitate or hinder learning.
4. Use language that fosters independent thinking and assists the supervisee in recognizing and defining problems, and in developing solutions.
5. Assist the supervisee in determining whether the objectives for the client and/or the supervisory experience have been met.

IV. Development of the Supervisee's Clinical Competence in Assessment

A. Knowledge Required

1. Understand and demonstrate best practices, including the application of current research in speech-language pathology, for assessing clients with specific communication and swallowing disorders.
2. Understand principles and techniques for establishing an effective client–clinician relationship.
3. Understand assessment tools and techniques specific to the clients served.
4. Understand the principles of counseling when providing assessment results.
5. Understand and demonstrate alternative assessment procedures for linguistically diverse clients, including the use of interpreters and culture brokers.

B. Skills Required

1. Facilitate the supervisee's use of best practices in assessment, including the application of current research to the assessment process.
2. Facilitate the supervisee's use of verbal and nonverbal behaviors to establish an effective client–clinician relationship.
3. Assist the supervisee in selecting and using assessment tools and techniques specific to the clients served.
4. Assist the supervisee in providing rationales for the selected procedures.
5. Demonstrate how to integrate assessment findings and observations to diagnose and develop appropriate recommendations for intervention and/or management.
6. Provide instruction, modeling, and/or feedback in counseling clients and/or caregivers about assessment results and recommendations in a respectful and sensitive manner.
7. Facilitate the supervisee's ability to use alternative assessment procedures for linguistically diverse clients.

V. Development of the Supervisee's Clinical Competence in Intervention

A. Knowledge Required

1. Understand best practices, including the application of current research in speech-language pathology, for developing a treatment plan for and providing intervention to clients with specific communication and swallowing disorders.

2. Be familiar with intervention materials, procedures, and techniques that are evidence based.
3. Be familiar with methods of data collection to analyze client behaviors and performance.
4. Understand the role of counseling in the therapeutic process.
5. Know when and how to identify and use resources for intervention with linguistically diverse clients.

B. Skills Required

1. Assist the supervisee in developing and prioritizing appropriate treatment goals.
2. Facilitate the supervisee's consideration of evidence in selecting materials, procedures, and techniques, and in providing a rationale for their use.
3. Assist the supervisee in selecting and using a variety of clinical materials and techniques appropriate to the clients served, and in providing a rationale for their use.
4. Demonstrate the use of a variety of data collection procedures appropriate to the specific clinical situation.
5. Assist the supervisee in analyzing the data collected in order to reformulate goals, treatment plans, procedures, and techniques.
6. Facilitate supervisee's effective use of counseling to promote and facilitate change in client and/or caregiver behavior.
7. Facilitate the supervisee's use of alternative intervention materials or techniques for linguistically diverse clients.

VI. Supervisory Conferences or Meetings of Clinical Teaching Teams

A. Knowledge Required

1. Understand the importance of scheduling regular supervisory conferences and/or team meetings.
2. Understand the use of supervisory conferences to address salient issues relevant to the professional growth of both the supervisor and the supervisee.
3. Understand the need to involve the supervisee in jointly establishing the conference agenda (e.g., purpose, content, timing, and rationale).
4. Understand how to facilitate a joint discussion of clinical or supervisory issues.
5. Understand the characteristics of constructive feedback and the strategies for providing such feedback.
6. Understand the importance of data collection and analysis for evaluating the effectiveness of conferences and/or team meetings.
7. Demonstrate collaborative behaviors when functioning as part of a service delivery team.

B. Skills Required

1. Regularly schedule supervisory conferences and/or team meetings.
2. Facilitate planning of supervisory conference agendas in collaboration with the supervisee.
3. Select items for the conference based on saliency, accessibility of patterns for treatment, and the use of data that are appropriate for measuring the accomplishment of clinical and supervisory objectives.

4. Use active listening as well as verbal and nonverbal response behaviors that facilitate the supervisee's active participation in the conference.
5. Ability to use the type of questions that stimulate thinking and promote problem solving by the supervisee.
6. Provide feedback that is descriptive and objective rather than evaluative.
7. Use data collection to analyze the extent to which the content and dynamics of the conference are facilitating goal achievement, desired outcomes, and planned changes.
8. Assist the supervisee in collaborating and functioning effectively as a member of a service delivery team.

VII. Evaluating the Growth of the Supervisee Both as a Clinician and as a Professional

A. Knowledge Required

1. Recognize the significance of the supervisory role in clinical accountability to the clients served and to the growth of the supervisee.
2. Understand the evaluation process as a collaborative activity and facilitate the involvement of the supervisee in this process.
3. Understand the purposes and use of evaluation tools to measure the clinical and professional growth of the supervisee.
4. Understand the differences between subjective and objective aspects of evaluation.
5. Understand strategies that foster self-evaluation.

B. Skills Required

1. Use data collection methods that will assist in analyzing the relationship between client/supervisee behaviors and specific clinical outcomes.
2. Identify and/or develop and appropriately use evaluation tools that measure the clinical and professional growth of the supervisee.
3. Analyze data collected prior to formulating conclusions and evaluating the supervisee's clinical skills.
4. Provide verbal and written feedback that is descriptive and objective in a timely manner.
5. Assist the supervisee in describing and measuring his or her own progress and achievement.

VIII. Diversity (Ability, Race, Ethnicity, Gender, Age, Culture, Language, Class, Experience, and Education)

A. Knowledge Required

1. Understand how differences (e.g., race, culture, gender, age) may influence learning and behavioral styles and how to adjust supervisory style to meet the supervisee's needs.
2. Understand the role culture plays in the way individuals interact with those in positions of authority.
3. Consider cross-cultural differences in determining appropriate feedback mechanisms and modes.
4. Understand impact of assimilation and/or acculturation processes on a person's behavioral response style.
5. Understand impact of culture and language differences on clinician interactions with clients and/or family members.

B. Skills Required

1. Create a learning and work environment that uses the strengths and expertise of all participants.
2. Demonstrate empathy and concern for others as evidenced by behaviors such as active listening, asking questions, and facilitating open and honest communication.
3. Apply culturally appropriate methods for providing feedback to supervisees.
4. Know when to consult someone who can serve as a cultural mediator or advisor concerning effective strategies for culturally appropriate interactions with individuals (clients and supervisees) from specific backgrounds.
5. Demonstrate the effective use of interpreters, translators, and/or culture brokers as appropriate for clients from diverse backgrounds.

IX. The Development and Maintenance of Clinical and Supervisory Documentation

A. Knowledge Required

1. Understand the value of accurate and timely documentation.
2. Understand effective record-keeping systems and practices for clinically related interactions.
3. Understand current regulatory requirements for clinical documentation in different settings (e.g., health care, schools).
4. Be familiar with documentation formats used in different settings.

B. Skills Required

1. Facilitate the supervisee's ability to complete clinical documentation accurately and effectively, and in compliance with accrediting and regulatory agencies and third party funding sources.
2. Assist the supervisee in sharing information collaboratively while adhering to requirements for confidentiality (e.g., HIPAA, FERPA).
3. Assist the supervisee in maintaining documentation regarding supervisory interactions (e.g., Clinical Fellowship requirements).

X. Ethical, Regulatory, and Legal Requirements

A. Knowledge Required

1. Understand current standards for student supervision (Council on Academic Accreditation in Audiology and Speech-Language Pathology, 2004)
2. Understand current standards for mentoring clinical fellows (Council for Clinical Certification in Audiology and Speech-Language Pathology, 2005).
3. Understand current ASHA Code of Ethics rules, particularly regarding supervision, competence, delegation, representation of credentials, and interprofessional and intraprofessional relationships.
4. Understand current state licensure board requirements for supervision.
5. Understand state, national, and setting-specific requirements for confidentiality and privacy, billing, and documentation policies.

B. Skills Required

1. Adhere to all ASHA, state, and facility standards, regulations, and requirements for supervision.

2. Assist the supervisee in adhering to standards, regulations, and setting-specific requirements for documentation, billing, and protection of privacy and confidentiality.
3. Demonstrate ethical behaviors in both interprofessional and intraprofessional relationships.
4. Assist the supervisee in conforming with standards and regulations for professional conduct.
5. Assist the supervisee in developing strategies to remain current with standards and regulations throughout their professional careers.

XI. Principles of Mentoring

A. Knowledge Required

1. Understand the similarities and differences between supervision and mentoring.
2. Understand how the skill level of the supervisee influences the mentoring process (e.g., mentoring is more appropriate with individuals who are approaching the self-supervision stage).
3. Understand how to facilitate the professional and personal growth of supervisees.
4. Understand the key aspects of mentoring, including educating, modeling, consulting, coaching, encouraging, supporting, and counseling.

B. Skills Required

1. Model professional and personal behaviors necessary for maintenance and life-long development of professional competency.
2. Foster a mutually trusting relationship with the supervisee.
3. Communicate in a manner that provides support and encouragement.
4. Provide professional growth opportunities to the supervisee.

References

- Anderson, J. L. (1988). *The supervisory process in speech-language pathology and audiology*. Austin, TX: Pro-Ed.
- American Speech-Language-Hearing Association. (2002). *Knowledge and skills for supervisors of speech-language pathology assistants*. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2004a). *Guidelines for the training, use, and supervision of speech-language pathology assistants*. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2004b). *Training, use, and supervision of support personnel in speech-language pathology* [Position Statement]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2008a). *Clinical supervision in speech-language pathology* [Position Statement]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2008b). *Clinical supervision in speech-language pathology* [Technical Report]. Available from www.asha.org/policy.
- Council for Clinical Certification in Audiology and Speech-Language Pathology 2005 *Membership and certification handbook of the American Speech-Language-Hearing Association*. Retrieved December 28, 2007, from www.asha.org/about/membership-certification/handbooks/slp/slp_standards.htm
- Council on Academic Accreditation in Audiology and Speech-Language Pathology. (2004). *Standards for accreditation of graduate education programs in audiology and speech-language pathology programs*. Available from www.asha.org/policy.



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About This Document

This technical report was developed by the Ad Hoc Committee on Supervision in Speech-Language Pathology of the American Speech-Language-Hearing Association (ASHA). Members of the committee were Lisa O'Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Introduction

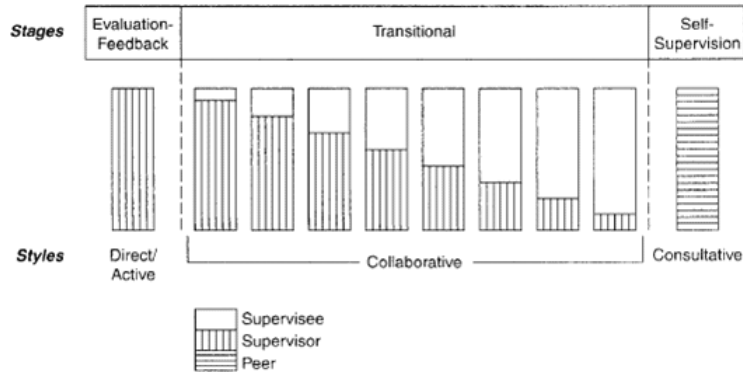
Because of increasing amounts of data from studies on supervision, advances in technology, and a greater understanding of the value of interpersonal factors in the supervisory process, there was a need to update ASHA's 1985 position statement *Clinical Supervision in Speech-Language Pathology and Audiology* (ASHA, 1985b). This 2008 technical report accompanies an updated position statement and knowledge and skills document for the profession of speech-language pathology (ASHA 2008a, 2008b). Although the principles of supervision (also called clinical teaching or clinical education) are common to both professions, the updated documents address only speech-language pathology because of differences in pre-service education and practice between the two professions.

The 1985 position statement identified specified competencies for supervisors, with an emphasis on clinical supervision of students. This 2008 technical report addresses supervision across the spectrum of supervisees, with the exception of speech-language pathology assistants. Professionals looking for guidance in supervising support personnel should refer to the ASHA position statement, guidelines, and knowledge and skills documents on this topic (ASHA, 2002, 2004b, 2004e).

As stated in ASHA's position statement on clinical supervision in speech-language pathology (ASHA, 2008a), "clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and ... is an essential component in the education of students and the continual professional growth of speech-language pathologists" (p. 1). Clinical supervision is also a collaborative process, with shared responsibility for many of the activities throughout the supervisory experience.

At some point in their career, many speech-language pathologists (SLPs) will be involved in a role that involves supervising students, clinical fellows, practicing SLPs, and/or paraprofessionals. Many of these SLPs do not have formal training or preparation in supervision. Recognizing the importance and complexity involved in the supervisory process, it is critical that increased focus be devoted to knowledge of the issues and skills in providing clinical supervision across the spectrum of a professional career in speech-language pathology. The purpose of this technical report is to highlight key principles and issues that reflect the importance and the highly skilled nature of providing exemplary supervision. It is not intended to provide a comprehensive text on how to become a supervisor. The companion document *Knowledge and Skills Needed by Speech-Language*

Figure 1. Continuum of supervision. From *The Supervisory Process in Speech-Language Pathology and Audiology* (p. 25), by E. S. McCrea and J. A. Brasseur, 2003, Boston: Allyn and Bacon. Copyright © 2003 by Pearson Education. Reprinted by permission of the publisher.



Background Information

Pathologists Providing Clinical Supervision (ASHA, 2008b) delineates areas of competence, and the position statement *Clinical Supervision in Speech-Language Pathology* (ASHA, 2008a) affirms the role of supervision within the profession.

In 1978, the ASHA Committee on Supervision indicated that there was little knowledge of the critical factors in supervision methodology (American Speech and Hearing Association, 1978). During the three decades since that report was written, a body of work has been published that has helped to identify some of the critical factors in supervision methodology and their relationship to the effectiveness of supervision.

Jean Anderson's *The Supervisory Process in Speech-Language Pathology and Audiology* (1988) played a significant role in helping professionals understand the critical factors in supervision methodology and their contribution to the effectiveness of supervision. Her continuum of supervision is the most widely recognized supervision model in speech-language pathology (see Figure 1). This model is based on a developmental continuum that spans a professional career.

The continuum mandates a change over time in the amount and type of involvement of both the supervisor and the supervisee in the supervisory process. As the amount of direction by the supervisor decreases, the amount of participation by the supervisee increases across the continuum (J. L. Anderson, 1988). The stages (evaluation-feedback, transitional, self-supervision) should not be viewed as time-bound, as any individual supervisee may be found at any point on the continuum depending on situational variables as well as the knowledge and skill of the supervisee. The model stresses the importance of modifying the supervisor's style in response to the needs, knowledge, and skills of the supervisee at each stage of clinical development. This model also fosters professional growth on the part of both the supervisor and the supervisee.

Research on Supervision

In addition to the publications from acknowledged experts in the profession, ASHA has provided guidance in the area of supervision through standards, the Code of Ethics, and Issues in Ethics statements. These documents are described below in the sections *Standards, Regulations, and Legal Issues and Ethical Considerations in Supervision*.

As the profession of speech-language pathology has advanced, evidence-based knowledge about practice in clinical disorders has developed through experimental and descriptive research. However, there is little empirical evidence in the area of supervision (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001), especially as it relates to client outcomes. Knowledge about supervision in speech-language pathology has primarily come from descriptive studies documented in texts by acknowledged experts, conference proceedings, and personal and shared experience. The results of descriptive studies have led to the identification of some of the behaviors that supervisors need to modify in order to be less directive and to facilitate high levels of critical thinking in supervisees (Dowling, 1995; Strike-Roussos, 1988, 1995, as cited in McCrea and Brasseur, 2003). Another major source of information about supervision comes from the research literature from other professions. McCrea and Brasseur (2003) examined the work of Rogers (1951), Carkhuff (1967, 1969), Leddick and Barnard (1980), and Hart (1982) in psychology; Fiedler (1967) in business management; Kagan (1970) in social work; and Cogan (1973) and Goldhammer (1969; Goldhammer, Anderson, & Kajewski, 1980) in education to show the extent to which other disciplines have contributed to our knowledge of effective supervision, and to emphasize the shared core principles of supervision regardless of the discipline and/or service delivery setting (Dowling, 2001).

Definition of Supervision

In 1988 Jean Anderson offered the following definition of the supervisory process:

Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)

Anderson's definition is still consistent with the goals of the process but needs some expansion. ASHA's position statement (1985b) noted that "effective clinical teaching" involves the development of self-analysis, self-evaluation, and problem-solving skills on the part of the individual being supervised. Self-analysis and self-evaluation are important activities for the supervisor as well. Therefore, Anderson's definition may be expanded to include the following:

Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised.

Supervision Across Settings

Critical thinking is based on building hypotheses, collecting data, and analyzing outcomes. A supervisor can facilitate the critical thinking abilities of supervisees through collecting data and facilitating problem solving. Engaging in this process will also help supervisees assess the quality of their service delivery. The *Data Collection in Supervision* section that follows provides further information on this topic.

The following sections discuss key issues that affect supervision or influence the supervisory process.

Professional, clinical, and operational demands across practice settings vary; however, the supervisory process can be viewed as basically the same wherever speech-language pathology services are delivered. Client populations as well as equipment, tools, and techniques used to provide clinical services can differ across the practice settings. Nevertheless, the dynamics of the supervisory relationship and the components of the supervisory process are similar regardless of work setting.

Often the supervisor is also responsible for day-to-day operations and program management. These supervisors with management responsibilities are accountable to multiple stakeholders (e.g., administrators, regulatory agencies, consumers, employees, and payers). These supervisors also have an obligation to provide clinical teaching to supervisees at all levels of their career. Clinical education may be managed directly by the supervisor, facilitated as a collaborative activity by the supervisor, or delivered in peer training formats (e.g., through literature review and discussion, or continuing education). Methods may vary according to the needs of the clinical population, developmental level of the supervisee, supervisor and supervisee teaching/learning styles and preferences, economics, and practice setting. The basic objective of professional growth and development for both the supervisor and supervisee remains at the core of the supervisory process.

Technology in Supervision

Although technology is not a new concept in supervision, the ways in which technology may be used have changed immensely. It can allow one message to be received by many at one time (through an e-mail list) or it can provide support to just one supervisee through the use of two-way videoconferencing (i.e., “e-supervision”). Through the use of technology, information can be delivered at a distance in real time or be archived for users to retrieve at their convenience. Many forms of technology can be used to support communication and clinical teaching, particularly the Internet, which facilitates the use of e-mail, e-mail lists, instant messaging, Web sites/pages, videoconferencing, video software, Weblogs (or “blogs”), and podcasting. The Appendix provides examples of current uses of technology for supervision. When one uses technology in supervision (e.g., videoconferencing) it is important to be aware of and follow regulatory guidelines involving confidentiality.

The Influence of Power in Supervision

Power has been defined as the ability of one party to change or control the behavior, attitudes, opinions, objectives, needs, and values of another party (Rahim, 1989). Although different models and descriptions of power are described in the literature, some researchers have acknowledged the importance of modifying supervisees' behavior using social and interpersonal influence processes. One form of social

Mentoring in Supervision

influence is power (Wagner & Hess, 1999). According to Robyak, Goodyear, and Prange (1987), supervisors' power influences trainees to change their clinical behaviors. Other disciplines have extensively investigated social power because of the influence that power has on subordinates' compliance, motivation, satisfaction, task commitment, job performance, and interpersonal conflicts (Wagner & Hess, 1999).

Understanding the influence of social power on the supervisory relationship is important. Supervisors hold the power of grading, signing off on clinical hours, conducting performance evaluations, and making promotion decisions. Lack of awareness of the influence of power can result in intimidation and a reluctance on the part of the supervisee to participate actively in the supervisory experience.

Individuals from diverse cultural and/or linguistic backgrounds may respond differently to the power dynamic (e.g., to people they perceive to be in roles of authority). They may behave in ways that may be interpreted as inappropriate by those who are unfamiliar with their culture and/or background (Coleman, 2000). Therefore, it is important for supervisors to know when to consult someone who can serve as a cultural mediator or advisor concerning effective strategies for culturally appropriate interactions with individuals (clients and supervisees) from specific backgrounds.

The terms *mentoring* and *supervision* are not synonymous but are often used interchangeably (Urish, 2004). Mentoring is typically defined as a relationship between two people in which one person (the mentor) is dedicated to the personal and professional growth of the other (the mentee) (Robertson, 1992). While this definition may sound similar to the relationship of the supervisor and the supervisee, the primary focus of supervision is accountability for the supervisee's performance (e.g., providing grades or conducting performance evaluations; documenting professional behavior and clinical performance). In contrast, mentoring focuses on creating effective ways to build skills, influence attitudes, and cultivate aspirations. Mentors advise, tutor, sponsor, and instill a professional identity in mentees. Mentoring is an intense interaction between two people, where the mentor has authority and power based on experience. To highlight the importance of the mentoring role, the 2005 ASHA Standards for Clinical Certification references mentoring. In some sections the terminology has been changed from *supervision* to *mentoring* and from *clinical fellowship supervisor* to *clinical fellowship mentor* (Council for Clinical Certification in Audiology and Speech-Language Pathology [CFCC], 2005).

Some aspect of mentoring should be involved in all supervisory relationships, the degree being dependent on supervisory style, the amount of experience and skill level of the supervisee, and factors associated with the practice setting. Supervisors who maintain a "direct-active" style of supervision as described by J. L. Anderson (1988) are less likely to address the mentoring aspect of supervision. The "direct-active" style focuses mainly on growth in performance rather than on the personal growth of the supervisee. "Collaborative" or "consultative" styles, as described by J. L. Anderson (1988), better facilitate the ability to address the mentoring aspect of supervision. Mentoring is most appropriate when supervisees have moved into the advanced level of the "transitional stage" and/or the self-supervision stage on the Anderson continuum.

Training in Supervision

Many professionals are thrust into the role of supervisor or clinical educator without adequate preparation or training (J. L. Anderson, 1988; Dowling, 2001; McCrea & Brasseur, 2003; Spence et al., 2001). They become “overnight supervisors” and are forced to draw on their own past experiences as supervisees, positive or negative, as a source for their own techniques and methodologies. Supervisors in all practice settings may also have unrealistic expectations concerning the academic and clinical preparation of supervisees, particularly students.

Dowling (2001) and McCrea and Brasseur (2003) discussed research in speech-language pathology by Culatta and Seltzer (1976), Irwin (1975, 1976), McCrea (1980), Roberts and Smith (1982), and Strike-Roussos (1988, 1995) indicating that supervisors who engage in supervisory conferences/meetings without formal supervisory training tend to dominate talk time, problem solving, and strategy development. These supervisors tend to use the same direct style of supervision with all supervisees regardless of their knowledge or skill levels, and without regard for the supervisee's learning style, which can lead to passive supervisee involvement and dependence on the supervisor (J. L. Anderson, 1988). Further, a direct style of supervision diminishes the need for the supervisee to use critical thinking and problem-solving skills. Supervisors should seek training on the supervisory process so that they can learn about differing supervisory styles and develop competence in supervision. This will help ensure the use of strategies and behaviors that promote supervisee learning and development. ASHA's *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) lists competencies for effective supervision. Training in supervision can be obtained through course work, continuing education programs, self-study, peer mentoring, and resources from ASHA (e.g., products and/or continuing education offerings) and from Special Interest Division 11, Administration and Supervision.

Supervisor Accountability

Quite often, the effectiveness of a supervisor is determined by asking the supervisee to evaluate the clinical instructor. While such evaluations do have some importance, few supervisees have sufficient understanding of the supervisory process to know what to expect of a supervisor. Further, unless complete anonymity is ensured, the likelihood of receiving honest feedback may be questioned. Therefore, supervisors should also evaluate their own behaviors relative to the supervisory process. Given the lack of validated guidelines for accomplishing such self-evaluation, supervisors must devise their own methods of data collection (McCrea & Brasseur, 2003) or turn to resources from other fields. Casey (1985) and colleagues (Casey, Smith, & Ulrich, 1988) developed a self-assessment guide to assist supervisors in determining their effectiveness in acquiring the 13 tasks and 81 associated competencies contained in the 1985 position statement (ASHA, 1985b). Analyzing the results allows the supervisor to identify supervisory objectives, decide on certain procedures, and determine whether goals were accomplished.

Studying the supervisory process in relation to one's own behavior is an opportunity for the supervisor to develop a personalized quality assurance mechanism, and a way to ensure accountability. Making a decision to improve as a supervisor also promotes job satisfaction, self-fulfillment, and ethical behavior, and prevents burnout (Dowling, 2001).

Data Collection in Supervision

Objective data about the supervisee's performance adds credibility and facilitates the supervisory process (J. L. Anderson, 1988; Shapiro, 1994). According to J. L. Anderson (1988) and Shapiro (1994), data collection methods can include rating scales, tallying behaviors, verbatim recording, interaction analysis, and individually designed methods. A number of tools have also been developed for analysis of behaviors and self-assessment (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994). Results from the analysis of this data can be applied both to the supervisee's clinical interactions with clients as well as to behaviors of the supervisor and supervisee during supervisory conferences. Analysis of both the supervisee and supervisor's behaviors during supervisory conferences can yield valuable insights to improve the interactions and outcomes of the supervisory experience for both individuals.

To be effective at their job, supervisors must be concerned about their own learning and development. Studying one's own behavior in supervisory process not only facilitates accountability in clinical teaching, but also is an opportunity for supervisors to examine their own behavior in order to improve their effectiveness in supervision.

Communication Skills in Supervision

Although supervisors may collect data and analyze the behaviors of supervisees, success in facilitating a supervisee's development may ultimately rest on the supervisor's skill in communicating effectively about these behaviors. While there are many resources that discuss interpersonal communication, McCrea and Brasseur (2003) briefly reviewed the literature in speech-language pathology on the interpersonal aspects of the supervisory process, citing Pickering (1979, 1984, 1987, 1990), Caracciolo and colleagues (1978), Crago (1987), Hagler, Casey, and DesRochers (1989), McCrea (1980), McCready and colleagues (1987, 1996), and Ghitter (1987). All of these researchers found a relationship between the interpersonal skills of supervisors and the clinical effectiveness of the supervisees. In their review of the literature, McCrea and Brasseur noted the importance of a supervisor's skill in communication. Adopting an effective communication style for each supervisee was shown to affect the supervisees' willingness to participate in conferences, share ideas and feelings, and positively change clinical behaviors. Ghitter (1987, as cited in McCrea & Brasseur, 2003) reported that when supervisees perceive high levels of unconditional positive regard, genuineness, empathic understanding, and concreteness, their clinical behaviors change in positive directions.

The ability to communicate effectively is viewed by many as an aptitude or an innate skill that people possess without any training. However, many professionals operate at a level of effectiveness far below their potential (Adler, Rosenfeld, & Proctor, 2001). There are also potential barriers to clear and accurate communication (e.g., age, gender, social and economic status, and cultural/

linguistic background). Further information addressing such barriers is included in the sections *Generational Differences* and *Cultural and Linguistic Considerations in Supervision*). Training in interpersonal communication is an important component of supervisory training. Growth in the interpersonal domain will enhance supervisors' proficiencies in interacting with clinicians in a helpful manner.

Standards, Regulations, and Legal Issues

Various external groups provide guidance for or regulation of supervision in speech-language pathology, particularly with respect to students and clinical fellows. ASHA's standards for certification and accreditation, state licensure laws, and federal/state reimbursement programs set minimum standards for the amount of supervision provided to individuals who are not certified SLPs.

At the preprofessional level, the *Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology* (Council on Academic Accreditation in Audiology and Speech-Language Pathology [CAA], 2004) require competent and ethical conduct of faculty, including on-site and off-site faculty. The standards also require programs to demonstrate that "Clinical supervision is commensurate with the clinical knowledge and skills of each student..." (Standard 3.5B; CAA, 2004).

Standards and Implementation Procedures for the Certificate of Clinical Competence address the requirements for direct and indirect supervision of students (CFCC, 2005). The standards require that student supervision be provided by a certified SLP, and that at least 25% of a student's total contact with each client be directly observed. The amount of supervision "should be adjusted upward if the student's level of knowledge, experience, and competence warrants" (CFCC, 2005). Standards for clinical fellows require 36 mentoring activities, including 18 hours of on-site direct client contact observation. Both sets of standards may be updated periodically.

Regulation by state licensure boards is separate from ASHA requirements; therefore, all students, clinical fellows, and certified clinical practitioners must be aware of and adhere to ASHA certification requirements as well as their state's requirements. Licensure laws regulate the provision of SLP services within the state; for SLPs practicing in schools, different or additional standards may also be required. States' requirements for student supervision may in some cases exceed ASHA's requirements.

Supervisors also must be aware of regulations for student supervision issued by payers such as the Centers for Medicare and Medicaid Services (CMS). For services delivered to Medicare beneficiaries under Part B, Medicare guidance explicitly states that the qualified SLP must be in the room at all times and be actively engaged in directing the treatment provided by the student (CMS, 2003, chapter 15, section 230B.1). There is an exception for services to Part A beneficiaries residing in a skilled nursing facility where "line of sight" supervision of the student by the qualified SLP is required instead of "in the room."

The nature of the supervisory relationship includes a vicarious liability for the actions of the supervisee. Supervisors hold full responsibility for the behavior, clinical services, and documentation of the student clinician. For their own protection as well as to foster the growth of students and protect the welfare of clients, supervisors must be fully involved and aware of the performance of the student and address any issues that could affect patient outcomes or satisfaction.

Ethical Considerations in Supervision

ASHA's Code of Ethics (2003) provides a framework for ethical behavior of supervisors across supervisory responsibilities. Principle of Ethics I states that client welfare must always be held paramount. Accordingly, the supervisor must provide appropriate supervision and adjust the amount and type of supervision based on the supervisee's performance. The supervisor ensures that the supervisee fulfills professional responsibilities such as maintaining confidentiality of client information, documenting client records in an accurate and timely manner, and completing other professional activities. In addition, the supervisor has an obligation to inform the client of the name and credentials of individuals (such as students) involved in their treatment.

Principle of Ethics II addresses issues of professional competence, and its rules state that professionals should only engage in those aspects of the profession that are within their scope of competence. Accordingly, supervisors should seek training in the area of effective supervisory practices to develop their competence in this area. Supervisors also have the responsibility to ensure that client services are provided competently by supervisees whether they are students, clinical fellows, or practicing clinicians. In addition, the rules state that treatment delegated to clinical fellows, students, and other nonprofessionals must be supervised by a certified speech-language pathologist.

Principle of Ethics IV addresses the ethical responsibility to maintain "harmonious interprofessional and intraprofessional relationships" and not abuse their authority over students (ASHA, 2003). See the section *The Influence of Power in Supervision* for further discussion of this issue.

Issues in Ethics statements are developed by ASHA's Board of Ethics to provide guidance on specific issues of ethical conduct. Statements related to supervision include *Fees for Clinical Service Provided by Students and Clinical Fellows* (ASHA, 2004a), *Supervision of Student Clinicians* (ASHA, 2004d), and *Responsibilities of Individuals Who Mentor Clinical Fellows* (2007).

Supervisors should also be cognizant of the problems that may arise from developing a social relationship with a supervisee in addition to their supervisory relationship. Although working together may provide opportunities for socialization beyond professional activities, supervisors must be comfortable in addressing a supervisee's performance without being influenced by their relationship outside the work setting.

King (2003) identified situations where ethical misconduct in the area of supervision may occur. Although King's comments were directed to the supervision of students, these concerns can be applied to all supervisory relationships. According to King, situations of potential misconduct can include,

but are not limited to, failure to provide a sufficient amount of supervision based on the performance of the supervisee, failure to educate and monitor the supervisee's protection of patient confidentiality, failure to verify appropriate competencies before delegating tasks to supervisees, failure to demonstrate benefit to the patient based on outcomes, and failure to provide self-assessment tools and opportunities to supervisees.

Supervision by Other Professionals

Increasingly, ASHA-certified SLPs and clinical fellows may work in settings where their direct supervisor may be an administrator or an individual from another profession. Evaluation of clinical skills by that individual is not appropriate, according to ASHA's position statement on *Professional Performance Appraisal by Individuals Outside the Professions of Speech-Language Pathology and Audiology* (ASHA, 1993). Peer appraisal and/or self-evaluation are recommended as alternatives. In addition, guidelines on the *Professional Performance Review Process for the School-Based Speech-Language Pathologist* (ASHA, 2006) were recently developed to help address this frequently occurring situation in schools.

Access to Clinical Externships

Practicing SLPs participate in the training and development of those who are entering the profession. However, pressures within the workplace have created challenges to students gaining access to externship sites (McAllister, 2005). Students are considered by some clinicians and administrators to be a drain on existing resources. The pace of the work, productivity demands, complexity of clients, and program specialization can limit an organization's willingness to embrace the task of student training (McAllister, 2005). In some cases, an externship supervisor's expectations of a student's knowledge and skills may be unrealistic and/or not met. Requirements for specified levels of supervision imposed by regulatory agencies (e.g., CMS) have also been identified as barriers to accepting students.

Staffing shortages can also limit student placement opportunities. Student training is often one of the casualties of inadequate staffing in the workplace. Veteran SLPs have much to offer students and other supervisees, but these individuals may work on a part-time or as-needed basis. Organizations that implement flexible work schedules to retain seasoned employees may refuse student placements because they believe they cannot accommodate the students' scheduling needs (McAllister, 2005). An unfortunate irony exists because sites that do not offer student externship placements are less likely to successfully recruit qualified SLPs.

McAllister (2005) posited the need for innovative solutions in the following areas. A shift in training models may be necessary in some cases to provide more opportunities for student placements. Ingenuity and collaboration between universities and work sites can ultimately produce innovative scheduling, supervisory incentives, and exploration of new supervisory models that may allow for excellent training opportunities. Cooperative partnerships between the universities, work sites, and clinicians are needed to develop collaborative training models appropriate to work site demands and pressures. Universities can play a key role in assisting work sites in experimenting with and evaluating innovative training models and in educating potential and existing supervisors on best practices in clinical education.

Cultural and Linguistic Considerations in Supervision

The population of the United States is becoming increasingly diverse. Supervisors will interact more frequently with individuals from backgrounds that are different from their own. As they interact with others, supervisors will have to take into account culturally based behaviors, values, and belief systems to be successful in their interactions. No universal communication, learning, or behavioral style is used by all people. Many cultural values have a significant impact on how and when individuals choose to communicate, how they behave in various settings, and how they prefer to learn. Differences in cultural values have an impact on the nature and effectiveness of all aspects of clinical interactions, including supervisor-supervisee relationships. Supervisors must take into consideration culturally based behaviors and learning styles of supervisees if their interactions with them are to be successful (Coleman, 2000).

Shapiro, Ogletree, and Brotherton (2002) reported research findings that most faculty were viewed as not being prepared for engaging in the supervisory process even with students from mainstream backgrounds. This problem is even more widespread in view of previous findings that most SLPs do not believe they are prepared to work effectively with clients from culturally and linguistically diverse backgrounds (ASHA, 1985a; Carey, 1992; Coleman & Lieberman, 1995; Keough, 1990). The lack of understanding and/or appreciation for culturally and linguistically diverse clients could also have a significant impact on the nature of interactions these professionals have with other nontraditional students, such as older students or returning students (McAllister, 2005).

Supervisors who supervise individuals from culturally and linguistically diverse backgrounds should develop competencies that will help them engage in appropriate clinical education practices (ASHA, 1998a, 1998b, 2004c, 2005). Many researchers across disciplines have addressed the issue of culturally appropriate clinical intervention strategies (Adler, 1993; N. B. Anderson, 1992, Battle, 1993, Cheng, 1987, Langdon & Cheng, 1992). One of the first suggestions in most of these sources is that the service provider conduct a self-inventory of his or her cultural awareness and sensitivity. Resources for cultural competence awareness assessment may be obtained through ASHA and/or literature review. Recognizing that behavior may be influenced by culture allows supervisors to develop a better understanding of variations among people.

Generational Differences

The coexistence of multiple generations in the workforce presents unique challenges in supervision. Differences in values and expectations of one generation versus another can result in misinterpretations and misunderstandings during supervisor-supervisee interactions. McCready (2007) noted that various authors (Kersten, 2002; Lancaster & Stillman, 2002; and Raines, 2002, 2003) have mentioned that the disparities among generations today are deeper and more complex than in the past. According to Lancaster and Stillman (2002), there are four separate and distinct generations working together today: the Traditionalists (born between 1900 and 1945), the Baby Boomers (born 1946–1964), the Generation Xers (born 1965–1980), and the Millennials (1981–1999). People, places, events, and symbols not only define each of these generational cohorts but

profoundly influence their values and expectations. Supervisors therefore need to be prepared to understand and accommodate attitudes and behaviors that may differ from their own.

McCready (2007) described ways in which supervisors across work settings can bridge the generation gap and facilitate improved communication. One suggestion is to form study groups to investigate the research in this area; the group could then present their findings to a larger group within the work setting (McCready, 2007). The supervisor can also engage in discussions about the generations represented in the work setting and how generational characteristics may and may not apply to specific individuals (McCready, 2007). Such discussion might include generational characteristics that can lead to miscommunication and misunderstandings in interactions with clients and supervisors.

Supervising Challenging Supervisees

Students who are admitted to graduate programs in communication sciences and disorders have successfully passed through a very competitive screening process using a variety of selection criteria such as Graduate Record Examination scores, undergraduate grade point averages, and letters of recommendation. Most of these students perform well in their academic courses and clinical assignments.

However, most training programs periodically encounter students who present special challenges during the supervisory process (Shapiro et al., 2002) and are often referred to as “marginal” students. Dowling (1985, as cited in Dowling, 2001) described marginal students as individuals who “cannot work independently, are unable to formulate goals and procedures, have basic gaps in conceptual understanding, and cannot follow through with suggestions” (p. 162). Given the impact on students, programs, clients, and the professions, working effectively with marginal students deserves serious and systematic consideration (Shapiro et al., 2002). These same issues may apply to supervisees of varying experience levels and in all practice settings.

One characteristic that is frequently reported about these challenging supervisees is their lack of ability to accurately evaluate their skill level (Kruger & Dunning, 1999, as cited in McCrea & Brasseur, 2003). Using the supervisory conference/meeting can be critically important in assisting them in evaluating their own performance (Dowling, 2001). During these meetings, supervisors need to give specific feedback based on data collected about the supervisee's performance and provide concrete assistance in planning and strategy development (Dowling, 2001). Eventually, however, the supervisee must learn to engage in self-analysis and self-evaluation to develop an understanding of his or her own performance.

Summary

This document defines supervision and highlights key issues that reflect the complexity of providing exemplary supervision. Acquiring competency as a supervisor is essential to developing supervisory behaviors and activities that are critical to the training of professionals. Such supervisory training may not be provided as part of graduate education programs; therefore, SLPs must look to continuing education opportunities, peer learning and mentoring, and self-study using literature that focuses on the supervisory process (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994; Shapiro & Anderson, 1989). Although there may be opportunities to learn from other disciplines that also use supervisory practices, preparation in the supervisory

process specific to speech-language pathology is critically important. McCrea and Brasseur (2003) and Dowling (2001) discussed ways in which preparation in the supervisory process can be implemented. The models discussed in these texts range from inclusion of information in early clinical management courses to doctoral level preparation. Training that is included as part of academic and clinical training of professionals and extended to supervisors at off-campus practicum sites will enhance the supervisors' effectiveness (Dowling, 1992; and Dowling, 1993, 1994, as cited in McCrea & Brasseur, 2003). ASHA's *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008b) delineates specific areas of competence deemed necessary to the provision of effective supervision.

Research Directions

Systematic study and investigation of the supervisory process is necessary to expand the evidence base from which increased knowledge about supervision and the supervisory process will emerge. Topics for further research may include the following:

- exploring different supervisory approaches that promote problem solving, self-analysis, and self-evaluation to develop clinical effectiveness;
- identifying essential components of training effective supervisors;
- examining the efficacy of supervisory training on supervisor/supervisee satisfaction and competence;
- identifying the basic behaviors/skills that supervisors should use in their interactions with supervisees that are essential to an effective working relationship;
- examining how supervisory style affects the development of clinical competence;
- examining different methods to develop more efficient models of supervision;
- examining supervisor behaviors that enhance supervisee growth (e.g., examining the process for negotiating and mutually agreeing on targets for change and measuring the impact that supervisor change has on the supervisee's professional growth) or training supervisors to use specific interpersonal skills (e.g, empathy, active listening) and then measuring how such skills enhance supervisee growth (McCrea & Brasseur, 2003);
- examining the effectiveness and efficiency of technology in delivering supervision;
- examining the impact of supervision on client outcomes;
- examining supervisory approaches and communication styles with supervisees in consideration of gender, age, cultural, and linguistic diversity;
- examining aspects of the supervisory process (i.e., understanding, planning, observing, analyzing, and integrating) and the relationship of each to the success of the supervisory experience (McCrea & Brasseur, 2003).

References

- Adler, S. (1993). *Nonstandard language: Its assessment in multicultural communication skills in the classroom*. Boston: Allyn & Bacon.
- Adler, S., Rosenfeld, L. B., & Proctor, R. F. (2001). *Interplay: The process of interpersonal communication*. New York: Harcourt.
- American Speech and Hearing Association. (1978). Current status of supervision of speech-language pathology and audiology [Special Report]. *Asha*, 20, 478-486.
- American Speech-Language-Hearing Association. (1985a). *Clinical management of communicatively handicapped minority language populations* [Position Statement]. Available from www.asha.org/policy.

- American Speech-Language-Hearing Association. (1985b). *Clinical supervision in speech-language pathology and audiology* [Position Statement]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (1993). *Professional performance appraisal by individuals outside the professions of speech-language pathology and audiology* [Position Statement]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (1998a). *Students and professionals who speak English with accents and nonstandard dialects: Issues and recommendations* [Position Statement]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (1998b). *Students and professionals who speak English with accents and nonstandard dialects: Issues and recommendations* [Technical Report]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2002). *Knowledge and skills for supervisors of speech-language pathology assistants*. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2003). *Code of ethics* (Revised). Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2004a). *Fees for clinical service provided by students and clinical fellows* [Issues in Ethics]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2004b). *Guidelines for the training, use, and supervision of speech-language pathology assistants*. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2004c). *Knowledge and skills needed by speech-language pathologists and audiologists to provide culturally and linguistically appropriate services* [Knowledge and Skills]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2004d). *Supervision of student clinicians* [Issues in Ethics]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2004e). *Training, use, and supervision of support personnel in speech-language pathology* [Position Statement]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2005). *Cultural competence* [Issues in Ethics]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2006). *Professional performance review process for the school-based speech-language pathologist* [Guidelines]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2007). *Responsibilities of individuals who mentor clinical fellows* [Issues in Ethics]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2008a). *Clinical supervision in speech-language pathology* [Position Statement]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2008b). *Knowledge and skills needed by speech-language pathologists providing clinical supervision*. Available from www.asha.org/policy.
- Anderson, J. L. (1988). *The supervisory process in speech language pathology and audiology*. Austin, TX: Pro-Ed.
- Anderson, N. B. (1992). Understanding cultural diversity. *American Journal of Speech-Language Pathology*, 1, 11–12.
- Battle, D. (1993). *Communication disorders in multicultural populations*. Boston: Butterworth-Heinemann.
- Carey, A. I. (1992). Get involved: Multiculturally. *Asha*, 34, 3–4.
- Casey, P. (1985). *Supervisory skills self-assessment*. Whitewater: University of Wisconsin.
- Casey, P., Smith, K., & Ulrich, S. (1988). *Self supervision: A career tool for audiologists and speech-language pathologists (Clinical Series No. 10)*. Rockville, MD: National Student Speech Language Hearing Association.

- Centers for Medicare and Medicaid Services *Medicare benefit policy manual*. 2003
Retrieved December 13, 2008, from <http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf>
- Cheng, L. (1987). *Assessing Asian language performance*. Gaithersburg, MD: Aspen Publishers.
- Coleman, T. J. (2000). *Clinical management of communication disorders in culturally diverse children*. Needham Heights, MA: Allyn & Bacon.
- Coleman, T. J., & Lieberman, R. J. (1995, November). *Preparing speech-language pathologists for work with diverse populations: A survey*. Paper presented at the Annual Convention of the American Speech-Language-Hearing Association, Anaheim, CA.
- Council for Clinical Certification in Audiology and Speech-Language Pathology. (2005). *Membership and certification handbook of the American Speech-Language-Hearing Association*. Retrieved December 28, 2007, from www.asha.org/about/membership-certification/handbooks/slp/slp_standards.htm
- Council on Academic Accreditation in Audiology and Speech-Language Pathology. (2004). *Standards for accreditation of graduate education programs in audiology and speech-language pathology programs*. Available from www.asha.org/policy.
- Dowling, S. (1992). *Implementing the supervisory process: Theory and practice*. Englewood Cliffs, NJ: Prentice-Hall.
- Dowling, S. (1995). Conference question usage: Impact of supervisory training. In R. Gillam (Ed.), *The supervisors' forum* (Vol. 2, pp. 11–14). Nashville, TN: Council of Supervisors in Speech-Language Pathology and Audiology.
- Dowling, S. (2001). *Supervision: Strategies for successful outcomes and productivity*. Needham Heights, MA: Allyn & Bacon.
- Dudding, C., & Justice, L. (2004). An e-supervision model: Videoconferencing as a clinical training tool. *Communication Disorders Quarterly*, 25(3), 145–151.
- Keough, K. (1990). Emerging issues for the professions in the 1990s. *Asha*, 32, 55–58.
- King, D. (2003, May 27). Supervision of student clinicians: Modeling ethical practice for future professionals. *The ASHA Leader*, 8, 26.
- Lancaster, L., & Stillman, D. (2002). *When generations collide*. New York: Harper Business.
- Langdon, H. W., & Cheng, L. (1992). *Hispanic children and adults with communication disorders*. Gaithersburg, MD: Aspen Publishers.
- McAllister, L. (2005). Issues and innovations in clinical education. *Advances in Speech-Language Pathology*, 7(3), 138–148.
- McCrea, E. S., & Brasseur, J. A. (2003). *The supervisory process in speech-language pathology and audiology*. Boston: Allyn & Bacon.
- McCready, V. (2007). Generational differences: Do they make a difference in supervisory and administrative relationships? *Perspectives in Administration and Supervision*, 17(3), 6–9.
- Rahim, M. A. (1989). Relationships of leader power to compliance and satisfaction with supervision: Evidence from a national sample of managers. *Journal of Management*, 15, 495–516.
- Robertson, S. C. (1992). *Find a mentor or be one*. Bethesda, MD: American Occupational Therapy Association.
- Robyak, J. E., Goodyear, R. K., & Prange, M. (1987). Effects of supervisors' sex, focus and experience on preferences for interpersonal power bases. *Counselor Education and Supervision*, 26, 299–309.
- Shapiro, D. A. (1994). Interaction analysis and self-study: A single-case comparison of four methods of analyzing supervisory conferences. *Language, Speech, and Hearing Services in Schools*, 25, 67–75.
- Shapiro, D. A., & Anderson, J. L. (1989). One measure of supervisory effectiveness in speech-language pathology and audiology. *Journal of Speech and Hearing Disorders*, 54, 549–557.

- Shapiro, D. A., Ogletree, B. T., & Brotherton, W. D. (2002). Graduate students with marginal abilities in communication sciences and disorders: Prevalence, profiles, and solutions. *Journal of Communication Disorders, 35*, 421–451.
- Spence, S., Wilson, J., Kavanagh, D., Strong, J., & Worrall, L. (2001). Clinical supervision in four mental health professions: A review of the evidence. *Behavior Change, 18*, 135–155.
- Strauss, W., & Howe, N. (1992). *Generations: The history of America's future 1584 to 2069*. New York: Morrow.
- Urish, C. (2004). *Ongoing competence through mentoring*. Bethesda, MD: American Occupational Therapy Association.
- Wagner, B. T., & Hess, C. H. (1999). Supervisors' use of social power with graduate supervisees in speech-language pathology. *Journal of Communication Disorders, 32*, 361–368.

Appendix

Uses of Current Technology for Supervision

E-mail with attachments: The primary benefit of using electronic mail is the speed of delivery versus traditional mail. If contacting the supervisor by phone is difficult, an e-mail message may be sent instead. With e-mail, the supervisor has the option of responding at his or her convenience rather than trying to schedule a phone call or a face-to-face meeting with the supervisee when only a short response may be required. Lesson plans, sample individualized education program goals, diagnostic reports, and so on may be attached and submitted to the supervisor for his or her review and comment.

E-mail lists: Sending messages via e-mail to a closed list of supervisees. Each supervisee has the opportunity to ask questions, pose problems, or ask for suggested resources from peers. This can be extremely powerful in learning from each other's experiences and sharing innovative ideas or tried-and-true therapy techniques.

Instant messaging: The individual can see which other individuals are available at their computer through "buddy" icons and contact them through instant messaging. A group can communicate in an instant messaging conference, or the SLP can converse with his or her supervisor instantly rather than waiting for the supervisor to check e-mail.

Web sites/Web pages: Information pertinent to supervisees (such as frequently asked questions on licensure renewal, guidelines on service delivery options, or frequently used forms) is placed on the supervisor's Web site. The supervisees can access the information when needed. Supervisees can suggest what materials, links, or resources they would find helpful to have uploaded to the supervisor's site.

E-supervision: Using two-way videoconferencing to supervise graduate students in a public school setting is one example of electronic supervision according to Dudding and Justice (2004). The equipment costs of videoconferencing are offset by the productivity in clinical instruction. Dudding and Justice reported that electronic supervision allows for more flexibility in scheduling and a reduction in travel costs while also increasing the student's knowledge and appreciation for technology.

Video software: Embedding a visual message within an e-mail or on a Web site provides access to information when it is needed, and the message can be archived for later reference as well. With the use of video software, the supervisor can easily video record a message while also embedding photos or graphics into the message. The software requires a simple mounted camera on the computer to video record the supervisor's message. The message can be an update on therapy techniques or a short training on the use of new forms, for example. Once recorded, it can be embedded into an e-mail and sent out to all of the supervisees or archived on a Web site to be accessed when needed. This expedites the training process by only recording and delivering the message one time and makes the information available when the supervisee has time to retrieve the information, which can differ for all involved.

Weblogs: Journal entries displayed in reverse chronological order. The supervisor and others can leave comments or statements of support for the supervisee in this interactive format.



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

SCOPE OF PRACTICE IN SPEECH---- LANGUAGE PATHOLOGY

AD HOC COMMITTEE ON THE SCOPE OF PRACTICE IN SPEECH----LANGUAGE
PATHOLOGY

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ABOUT THIS DOCUMENT

This scope of practice document is an official policy of the American Speech--Language--Hearing Association (ASHA) defining the breadth of practice within the profession of speech--language pathology. This document was developed by the ASHA Ad Hoc Committee on the Scope of Practice in Speech--Language Pathology. Committee members were Mark DeRuiter (chair), Michael Campbell, Craig Coleman, Charlette Green, Diane Kendall, Judith Montgomery, Bernard Rousseau, Nancy Swigert, Sandra Gillam (board liaison), and Lemmietta McNeilly (ex officio). This document was approved by the ASHA Board of Directors on February 4, 2016 (BOD 01--2016). The BOD approved a revision in the prevention of hearing section of the document on May 9, 2016 (Motion 07--2016).

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INTRODUCTION

The *Scope of Practice in Speech--Language Pathology* of the American Speech--Language--Hearing Association (ASHA) includes the following: a statement of purpose, definitions of *speech--language pathologist* and *speech--language pathology*, a framework for speech--language pathology practice, a description of the domains of speech--language pathology service delivery, delineation of speech--language pathology service delivery areas, domains of professional practice, references, and resources.

The *speech--language pathologist (SLP)* is defined as the professional who engages in professional practice in the areas of communication and swallowing across the life span. *Communication* and *swallowing* are broad terms encompassing many facets of function. *Communication* includes speech production and fluency, language, cognition, voice, resonance, and hearing. *Swallowing* includes all aspects of swallowing, including related feeding behaviors. Throughout this document, the terms *communication* and *swallowing* are used to reflect all areas. This document is a guide for SLPs across all clinical and educational settings to promote best practice. The term *individuals* is used throughout the document to refer to students, clients, and patients who are served by the SLP.

As part of the review process for updating the *Scope of Practice in Speech--Language Pathology*, the committee revised the previous scope of practice document to reflect recent advances in knowledge and research in the discipline. One of the biggest changes to the document includes the delineation of practice areas in the context of eight domains of speech--language pathology service delivery: collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities,

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technology, and instrumentation; and population and systems. In addition, five domains of professional practice are delineated: advocacy and outreach, supervision, education, research and administration/leadership.

Service delivery areas include all aspects of communication and swallowing and related areas that impact communication and swallowing: speech production, fluency, language, cognition, voice, resonance, feeding, swallowing, and hearing. The practice of speech--language pathology continually evolves. SLPs play critical roles in health literacy; screening, diagnosis, and treatment of autism spectrum disorder; and use of the *International Classification of Functioning, Disability and Health* (ICF; [World Health Organization \[WHO\], 2014](#)) to develop functional goals and collaborative practice. As technology and science advance, the areas of assessment and intervention related to communication and swallowing disorders grow accordingly. Clinicians should stay current with advances in speech--language pathology practice by regularly reviewing the research literature, consulting the [Practice Management section of the ASHA website](#), including the [Practice Portal](#), and regularly participating in continuing education to supplement advances in the profession and information in the scope of practice.

STATEMENT OF PURPOSE

The purpose of the *Scope of Practice in Speech--Language Pathology* is to

1. delineate areas of professional practice;
2. inform others (e.g., health care providers, educators, consumers, payers, regulators, and the general public) about professional roles and responsibilities of qualified providers;
3. support SLPs in the provision of high--quality, evidence--based services to individuals with communication, feeding, and/or swallowing concerns;
4. support SLPs in the conduct and dissemination of research; and
5. guide the educational preparation and professional development of SLPs to provide safe and effective services.

The scope of practice outlines the breadth of professional services offered within the profession of speech--language pathology. Levels of education, experience, skill, and proficiency in each practice area identified within this scope will vary among providers. An SLP typically does not practice in all areas of clinical service delivery across the life cycle. As the ASHA Code of Ethics specifies, professionals may practice only in areas in which they are competent, based on their education, training, and experience.

This scope of practice document describes evolving areas of practice. These include interdisciplinary work in both health care and educational settings, collaborative service delivery wherever appropriate, and telehealth/telepractice that are effective for the general public.

Speech--language pathology is a dynamic profession, and the overlapping of scopes of practice is a reality in rapidly changing health care, education, and other environments. Hence, SLPs in various settings work collaboratively with other school or health care professionals to make sound decisions for the benefit of individuals with communication and swallowing disorders. This *interprofessional collaborative practice* is defined as “members or students of two or more professions associated with health or social care, engaged in learning with, from and about each other” ([Craddock, O’Halloran, Borthwick, & McPherson, 2006, p. 237](#)). Similarly, “interprofessional education provides an ability to

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share skills and knowledge between professions and allows for a better understanding, shared values, and respect for the roles of other healthcare professionals” ([Bridges et al., 2011, para. 5](#)).

This scope of practice does not supersede existing state licensure laws or affect the interpretation or implementation of such laws. However, it may serve as a model for the development or modification of licensure laws. Finally, in addition to this scope of practice document, other ASHA professional resources outline practice areas and address issues related to public protection (e.g., A guide to disability rights law and the Practice Portal). The highest standards of integrity and ethical conduct are held paramount in this profession.

DEFINITIONS OF SPEECH---LANGUAGE PATHOLOGIST AND SPEECH---LANGUAGE PATHOLOGY

Speech--language pathologists, as defined by ASHA, are professionals who hold the ASHA Certificate of Clinical Competence in Speech--Language Pathology (CCC--SLP), which requires a master's, doctoral, or other recognized postbaccalaureate degree. ASHA--certified SLPs complete a supervised postgraduate professional experience and pass a national examination as described in the [ASHA certification standards, \(2014\)](#). Demonstration of continued professional development is mandated for the maintenance of the CCC---SLP. SLPs hold other required credentials where applicable (e.g., state licensure, teaching certification, specialty certification).

Each practitioner evaluates his or her own experiences with preservice education, practice, mentorship and supervision, and continuing professional development. As a whole, these experiences define the scope of competence for each individual. The SLP should engage in only those aspects of the profession that are within her or his professional competence.

SLPs are autonomous professionals who are the primary care providers of speech--language pathology services. Speech--language pathology services are not prescribed or supervised by another professional. Additional requirements may dictate that speech--language pathology services are prescribed and required to meet specific eligibility criteria in certain work settings, or as required by certain payers. SLPs use professional judgment to determine if additional requirements are indicated. Individuals with communication and/or swallowing disorders benefit from services that include collaboration by SLPs with other professionals.

The profession of speech--language pathology contains a broad area of speech--language pathology practice that includes both speech--language pathology service delivery and professional practice domains. These domains are defined in subsequent sections of this document and are represented schematically in **Figure 1**.

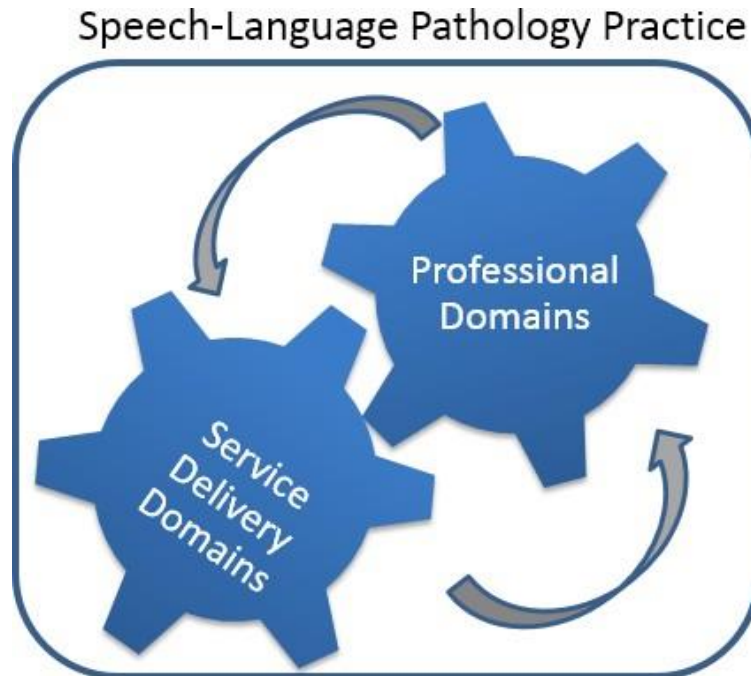


Figure 1. Schematic representation of speech--language pathology practice, including both service delivery and professional domains.

FRAMEWORK FOR SPEECH---LANGUAGE PATHOLOGY PRACTICE

The overall objective of speech--language pathology services is to optimize individuals' abilities to communicate and to swallow, thereby improving quality of life. As the population of the United States continues to become increasingly diverse, SLPs are committed to the provision of culturally and linguistically appropriate services and to the consideration of diversity in scientific investigations of human communication and swallowing.

An important characteristic of the practice of speech--language pathology is that, to the extent possible, decisions are based on best available evidence. ASHA defines evidence--based practice in speech--language pathology as an approach in which current, high--quality research evidence is integrated with practitioner expertise, along with the client's values and preferences (ASHA, 2005). A high--quality basic and applied research base in communication sciences and disorders and related disciplines is essential to providing evidence--based practice and high--quality services. Increased national and international interchange of professional knowledge, information, and education in communication sciences and disorders is a means to strengthen research collaboration and improve services. ASHA has provided a resource for evidence--based research via the [Practice Portal](#).

The scope of practice in speech--language pathology comprises five domains of professional practice and eight domains of service delivery.

Professional practice domains:

- advocacy and outreach
- supervision

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- education
- administration/leadership
- research

Service delivery domains

- Collaboration
- Counseling
- Prevention and Wellness
- Screening
- Assessment
- Treatment
- Modalities, Technology, and Instrumentation
- Population and Systems

SLPs provide services to individuals with a wide variety of speech, language, and swallowing differences and disorders within the above--mentioned domains that range in function from completely intact to completely compromised. The diagnostic categories in the speech--language pathology scope of practice are consistent with relevant diagnostic categories under the WHO's (2014) *ICF*, the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders*, the categories of disability under the Individuals with Disabilities Education Act of 2004 (see also U.S. Department of Education, 2004), and those defined by two semiautonomous bodies of ASHA: the Council on Academic Accreditation in Audiology and Speech--Language Pathology and the Council for Clinical Certification in Audiology and Speech--Language Pathology.

The domains of speech---language pathology service delivery complement the *ICF*, the WHO's multipurpose health classification system ([WHO, 2014](#)). The classification system provides a standard language and framework for the description of functioning and health. The ICF framework is useful in describing the breadth of the role of the SLP in the prevention, assessment, and habilitation/rehabilitation of communication and swallowing disorders and the enhancement and scientific investigation of those functions. The framework consists of two components: health conditions and contextual factors.

HEALTH CONDITIONS

Body Functions and Structures: These involve the anatomy and physiology of the human body. Relevant examples in speech--language pathology include craniofacial anomaly, vocal fold paralysis, cerebral palsy, stuttering, and language impairment.

Activity and Participation: *Activity* refers to the execution of a task or action. Participation is the involvement in a life situation. Relevant examples in speech---language pathology include difficulties with swallowing safely for independent feeding, participating actively in class, understanding a medical prescription, and accessing the general education curriculum.

CONTEXTUAL FACTORS

Environmental Factors: These make up the physical, social, and attitudinal environments in which people live and conduct their lives. Relevant examples in speech--language pathology include the role

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of the communication partner in augmentative and alternative communication (AAC), the influence of classroom acoustics on communication, and the impact of institutional dining environments on individuals' ability to safely maintain nutrition and hydration.

Personal Factors: These are the internal influences on an individual's functioning and disability and are not part of the health condition. Personal factors may include, but are not limited to, age, gender, ethnicity, educational level, social background, and profession. Relevant examples in speech--language pathology might include an individual's background or culture, if one or both influence his or her reaction to communication or swallowing.

The framework in speech--language pathology encompasses these health conditions and contextual factors across individuals and populations. **Figure 2** illustrates the interaction of the various components of the ICF. The health condition component is expressed on a continuum of functioning. On one end of the continuum is intact functioning; at the opposite end of the continuum is completely compromised function. The contextual factors interact with each other and with the health conditions and may serve as facilitators or barriers to functioning. SLPs influence contextual factors through education and advocacy efforts at local, state, and national levels.

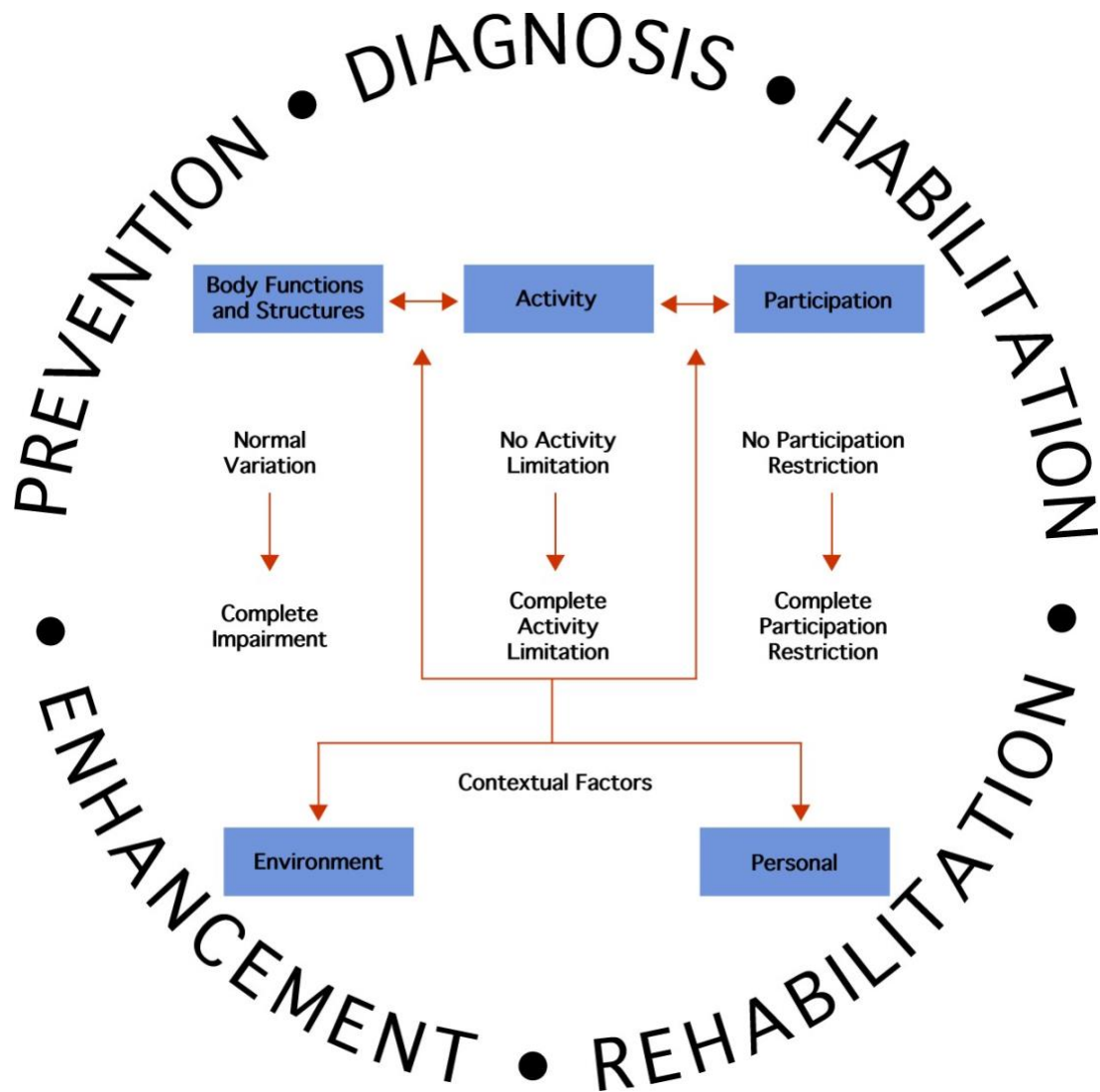


Figure 2. Interaction of the various components of the ICF model. This model applies to individuals or groups.

DOMAINS OF SPEECH---LANGUAGE PATHOLOGY SERVICE DELIVERY

The eight domains of speech---language pathology service delivery are collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems.

COLLABORATION

SLPs share responsibility with other professionals for creating a collaborative culture. Collaboration requires joint communication and shared decision making among all members of the team, including the individual and family, to accomplish improved service delivery and functional outcomes for the individuals served. When discussing specific roles of team members, professionals are ethically and

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legally obligated to determine whether they have the knowledge and skills necessary to perform such services. Collaboration occurs across all speech--language pathology practice domains.

As our global society is becoming more connected, integrated, and interdependent, SLPs have access to a variety of resources, information technology, diverse perspectives and influences (see, e.g., [Lipinsky, Lombardo, Dominy, & Feeney, 1997](#)). Increased national and international interchange of professional knowledge, information, and education in communication sciences and disorders is a means to strengthen research collaboration and improve services. SLPs

- educate stakeholders regarding interprofessional education (IPE) and interprofessional practice (IPP) ([ASHA, 2014](#)) principles and competencies;
- partner with other professions/organizations to enhance the value of speech--language pathology services;
- share responsibilities to achieve functional outcomes;
- consult with other professionals to meet the needs of individuals with communication and swallowing disorders;
- serve as case managers, service delivery coordinators, members of collaborative and patient care conference teams; and
- serve on early intervention and school pre--referral and intervention teams to assist with the development and implementation of individualized family service plans (IFSPs) and individualized education programs (IEPs).

COUNSELING

SLPs counsel by providing education, guidance, and support. Individuals, their families and their caregivers are counseled regarding acceptance, adaptation, and decision making about communication, feeding and swallowing, and related disorders. The role of the SLP in the counseling process includes interactions related to emotional reactions, thoughts, feelings, and behaviors that result from living with the communication disorder, feeding and swallowing disorder, or related disorders.

SLPs engage in the following activities in counseling persons with communication and feeding and swallowing disorders and their families:

- empower the individual and family to make informed decisions related to communication or feeding and swallowing issues.
- educate the individual, family, and related community members about communication or feeding and swallowing disorders.
- provide support and/or peer--to--peer groups for individuals with disorders and their families.
- provide individuals and families with skills that enable them to become self--advocates.
- discuss, evaluate, and address negative emotions and thoughts related to communication or feeding and swallowing disorders.
- refer individuals with disorders to other professionals when counseling needs fall outside of those related to (a) communication and (b) feeding and swallowing.

PREVENTION AND WELLNESS

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SLPs are involved in prevention and wellness activities that are geared toward reducing the incidence of a new disorder or disease, identifying disorders at an early stage, and decreasing the severity or impact of a disability associated with an existing disorder or disease. Involvement is directed toward individuals who are vulnerable or at risk for limited participation in communication, hearing, feeding and swallowing, and related abilities. Activities are directed toward enhancing or improving general well-being and quality of life. Education efforts focus on identifying and increasing awareness of risk behaviors that lead to communication disorders and feeding and swallowing problems. SLPs promote programs to increase public awareness, which are aimed at positively changing behaviors or attitudes.

Effective prevention programs are often community based and enable the SLP to help reduce the incidence of spoken and written communication and swallowing disorders as a public health and public education concern.

Examples of prevention and wellness programs include, but are not limited to, the following:

- **Language impairment:** Educate parents, teachers and other school--based professionals about the clinical markers of language impairment and the ways in which these impairments can impact a student's reading and writing skills to facilitate early referral for evaluation and assessment services.
- **Language--based literacy disorders:** Educate parents, school personnel, and health care providers about the SLP's role in addressing the semantic, syntactic, morphological, and phonological aspects of literacy disorders across the lifespan.
- **Feeding:** Educate parents of infants at risk for feeding problems about techniques to minimize long--term feeding challenges.
- **Stroke prevention:** Educate individuals about risk factors associated with stroke
- **Serve on teams:** Participate on multitiered systems of support (MTSS)/response to intervention (RTI) teams to help students successfully communicate within academic, classroom, and social settings.
- **Fluency:** Educate parents about risk factors associated with early stuttering.
- **Early childhood:** Encourage parents to participate in early screening and to collaborate with physicians, educators, child care providers, and others to recognize warning signs of developmental disorders during routine wellness checks and to promote healthy communication development practices.
- **Prenatal care:** Educate parents to decrease the incidence of speech, hearing, feeding and swallowing, and related disorders due to problems during pregnancy.
- **Genetic counseling:** Refer individuals to appropriate professionals and professional services if there is a concern or need for genetic counseling.
- **Environmental change:** Modify environments to decrease the risk of occurrence (e.g., decrease noise exposure).
- **Vocal hygiene:** Target prevention of voice disorders (e.g., encourage activities that minimize phonotrauma and the development of benign vocal fold pathology and that curb the use of smoking and smokeless tobacco products).
- **Hearing:** Educate individuals about risk factors associated with noise--induced hearing loss and preventive measures that may help to decrease the risk.
- **Concussion/traumatic brain injury awareness:** Educate parents of children involved in contact sports about the risk of concussion.

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- **Accent/dialect modification:** Address sound pronunciation, stress, rhythm, and intonation of speech to enhance effective communication.
- **Transgender (TG) and transsexual (TS) voice and communication:** Educate and treat individuals about appropriate verbal, nonverbal, and voice characteristics (feminization or masculinization) that are congruent with their targeted gender identity.
- **Business communication:** Educate individuals about the importance of effective business communication, including oral, written, and interpersonal communication.
- **Swallowing:** Educate individuals who are at risk for aspiration about oral hygiene techniques.

SCREENING

SLPs are experts at screening individuals for possible communication, hearing, and/or feeding and swallowing disorders. SLPs have the knowledge of—and skills to treat—these disorders; they can design and implement effective screening programs and make appropriate referrals. These screenings facilitate referral for appropriate follow-up in a timely and cost-effective manner. SLPs

- select and use appropriate screening instrumentation;
- develop screening procedures and tools based on existing evidence;
- coordinate and conduct screening programs in a wide variety of educational, community, and health care settings;
- participate in public school MTSS/RTI team meetings to review data and recommend interventions to satisfy federal and state requirements (e.g., Individuals with Disabilities Education Improvement Act of 2004 [IDEIA] and Section 504 of the Rehabilitation Act of 1973);
- review and analyze records (e.g., educational, medical);
- review, analyze, and make appropriate referrals based on results of screenings;
- consult with others about the results of screenings conducted by other professionals; and
- utilize data to inform decisions about the health of populations.

ASSESSMENT

Speech--language pathologists have expertise in the differential diagnosis of disorders of communication and swallowing. Communication, speech, language, and swallowing disorders can occur developmentally, as part of a medical condition, or in isolation, without an apparent underlying medical condition. Competent SLPs can diagnose communication and swallowing disorders but do not differentially diagnose medical conditions. The assessment process utilizes the ICF framework, which includes evaluation of body function, structure, activity and participation, within the context of environmental and personal factors. The assessment process can include, but is not limited to, culturally and linguistically appropriate behavioral observation and standardized and/or criterion-referenced tools; use of instrumentation; review of records, case history, and prior test results; and interview of the individual and/or family to guide decision making. The assessment process can be carried out in collaboration with other professionals. SLPs

- administer standardized and/or criterion-referenced tools to compare individuals with their peers;

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- review medical records to determine relevant health, medical, and pharmacological information;
- interview individuals and/or family to obtain case history to determine specific concerns;
- utilize culturally and linguistically appropriate assessment protocols;
- engage in behavioral observation to determine the individual's skills in a naturalistic setting/context;
- diagnose communication and swallowing disorders;
- use endoscopy, videofluoroscopy, and other instrumentation to assess aspects of voice, resonance, velopharyngeal function and swallowing;
- document assessment and trial results for selecting AAC interventions and technology, including speech--generating devices (SGDs);
- participate in meetings adhering to required federal and state laws and regulations (e.g., IDEIA [2004] and Section 504 of the Rehabilitation Act of 1973).
- document assessment results, including discharge planning;
- formulate impressions to develop a plan of treatment and recommendations; and
- discuss eligibility and criteria for dismissal from early intervention and school--based services.

TREATMENT

Speech---language services are designed to optimize individuals' ability to communicate and swallow, thereby improving quality of life. SLPs develop and implement treatment to address the presenting symptoms or concerns of a communication or swallowing problem or related functional issue. Treatment establishes a new skill or ability or remediates or restores an impaired skill or ability. The ultimate goal of therapy is to improve an individual's functional outcomes. To this end, SLPs

- design, implement, and document delivery of service in accordance with best available practice appropriate to the practice setting;
- provide culturally and linguistically appropriate services;
- integrate the highest quality available research evidence with practitioner expertise and individual preferences and values in establishing treatment goals;
- utilize treatment data to guide decisions and determine effectiveness of services;
- integrate academic materials and goals into treatment;
- deliver the appropriate frequency and intensity of treatment utilizing best available practice;
- engage in treatment activities that are within the scope of the professional's competence;
- utilize AAC performance data to guide clinical decisions and determine the effectiveness of treatment; and
- collaborate with other professionals in the delivery of services.

MODALITIES, TECHNOLOGY, AND INSTRUMENTATION

SLPs use advanced instrumentation and technologies in the evaluation, management, and care of individuals with communication, feeding and swallowing, and related disorders. SLPs are also involved in the research and development of emerging technologies and apply their knowledge in the use of advanced instrumentation and technologies to enhance the quality of the services provided. Some examples of services that SLPs offer in this domain include, but are not limited to, the use of

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- the full range of AAC technologies to help individuals who have impaired ability to communicate verbally on a consistent basis—AAC devices make it possible for many individuals to successfully communicate within their environment and community;
- endoscopy, videofluoroscopy, fiber--optic evaluation of swallowing (voice, velopharyngeal function, swallowing) and other instrumentation to assess aspects of voice, resonance, and swallowing;
- telehealth/telepractice to provide individuals with access to services or to provide access to a specialist;
- ultrasound and other biofeedback systems for individuals with speech sound production, voice, or swallowing disorders; and
- other modalities (e.g., American Sign Language), where appropriate.

POPULATION AND SYSTEMS

In addition to direct care responsibilities, SLPs have a role in (a) managing populations to improve overall health and education, (b) improving the experience of the individuals served, and, in some circumstances, (c) reducing the cost of care. SLPs also have a role in improving the efficiency and effectiveness of service delivery. SLPs serve in roles designed to meet the demands and expectations of a changing work environment. SLPs

- use plain language to facilitate clear communication for improved health and educationally relevant outcomes;
- collaborate with other professionals about improving communication with individuals who have communication challenges;
- improve the experience of care by analyzing and improving communication environments;
- reduce the cost of care by designing and implementing case management strategies that focus on function and by helping individuals reach their goals through a combination of direct intervention, supervision of and collaboration with other service providers, and engagement of the individual and family in self--management strategies;
- serve in roles designed to meet the demands and expectations of a changing work environment;
- contribute to the management of specific populations by enhancing communication between professionals and individuals served;
- coach families and early intervention providers about strategies and supports for facilitating prelinguistic and linguistic communication skills of infants and toddlers; and
- support and collaborate with classroom teachers to implement strategies for supporting student access to the curriculum.

SPEECH---LANGUAGE PATHOLOGY SERVICE DELIVERY AREAS

This list of practice areas and the bulleted examples are not comprehensive. Current areas of practice, such as literacy, have continued to evolve, whereas other new areas of practice are emerging. Please refer to the [ASHA Practice Portal](#) for a more extensive list of practice areas.

1. Fluency

- Stuttering
- Cluttering

2. Speech Production

- Motor planning and execution
- Articulation
- Phonological

3. Language—Spoken and written language (listening, processing, speaking, reading, writing, pragmatics)

- Phonology
- Morphology
- Syntax
- Semantics
- Pragmatics (language use and social aspects of communication)
- Prelinguistic communication (e.g., joint attention, intentionality, communicative signaling)
- Paralinguistic communication (e.g., gestures, signs, body language)
- Literacy (reading, writing, spelling)

4. Cognition

- Attention
- Memory
- Problem solving
- Executive functioning

5. Voice

- Phonation quality
- Pitch
- Loudness
- Alaryngeal voice

6. Resonance

- Hypernasality
- Hyponasality
- Cul--de--sac resonance
- Forward focus

7. Feeding and Swallowing

- Oral phase
- Pharyngeal phase
- Esophageal phase
- Atypical eating (e.g., food selectivity/refusal, negative physiologic response)

8. Auditory Habilitation/Rehabilitation

- Speech, language, communication, and listening skills impacted by hearing loss, deafness
- Auditory processing

Potential etiologies of communication and swallowing disorders include

- neonatal problems (e.g., prematurity, low birth weight, substance exposure);
- developmental disabilities (e.g., specific language impairment, autism spectrum disorder, dyslexia, learning disabilities, attention--deficit disorder, intellectual disabilities, unspecified neurodevelopmental disorders);
- disorders of aerodigestive tract function (e.g., irritable larynx, chronic cough, abnormal respiratory patterns or airway protection, paradoxical vocal fold motion, tracheostomy);

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- oral anomalies (e.g., cleft lip/palate, dental malocclusion, macroglossia, oral motor dysfunction);
- respiratory patterns and compromise (e.g., bronchopulmonary dysplasia, chronic obstructive pulmonary disease);
- pharyngeal anomalies (e.g., upper airway obstruction, velopharyngeal insufficiency/incompetence);
- laryngeal anomalies (e.g., vocal fold pathology, tracheal stenosis);
- neurological disease/dysfunction (e.g., traumatic brain injury, cerebral palsy, cerebrovascular accident, dementia, Parkinson's disease, and amyotrophic lateral sclerosis);
- psychiatric disorder (e.g., psychosis, schizophrenia);
- genetic disorders (e.g., Down syndrome, fragile X syndrome, Rett syndrome, velocardiofacial syndrome); and
- Orofacial myofunctional disorders (e.g., habitual open--mouth posture/nasal breathing, orofacial habits, tethered oral tissues, chewing and chewing muscles, lips and tongue resting position).

This list of etiologies is not comprehensive.

Elective services include

- Transgender communication (e.g., voice, verbal and nonverbal communication);
- Preventive vocal hygiene;
- Business communication;
- Accent/dialect modification; and
- Professional voice use.

This list of elective services is not comprehensive.

DOMAINS OF PROFESSIONAL PRACTICE

This section delineates the domains of professional practice—that is, a set of skills and knowledge that goes beyond clinical practice. The domains of professional practice include advocacy and outreach, supervision, education, research, and administration and leadership.

ADVOCACY AND OUTREACH

SLPs advocate for the discipline and for individuals through a variety of mechanisms, including community awareness, prevention activities, health literacy, academic literacy, education, political action, and training programs. Advocacy promotes and facilitates access to communication, including the reduction of societal, cultural, and linguistic barriers. SLPs perform a variety of activities, including the following:

- Advise regulatory and legislative agencies about the continuum of care. Examples of service delivery options across the continuum of care include telehealth/telepractice, the use of technology, the use of support personnel, and practicing at the top of the license.
- Engage decision makers at the local, state, and national levels for improved administrative and governmental policies affecting access to services and funding for communication and swallowing issues.

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- Advocate at the local, state, and national levels for funding for services, education, and research.
- Participate in associations and organizations to advance the speech--language pathology profession.
- Promote and market professional services.
- Help to recruit and retain SLPs with diverse backgrounds and interests.
- Collaborate on advocacy objectives with other professionals/colleagues regarding mutual goals.
- Serve as expert witnesses, when appropriate.
- Educate consumers about communication disorders and speech--language pathology services.
- Advocate for fair and equitable services for all individuals, especially the most vulnerable.
- Inform state education agencies and local school districts about the various roles and responsibilities of school--based SLPs, including direct service, IEP development, Medicaid billing, planning and delivery of assessment and therapy, consultation with other team members, and attendance at required meetings.

SUPERVISION

Supervision is a distinct area of practice; is the responsibility of SLPs; and crosses clinical, administrative, and technical spheres. SLPs are responsible for supervising Clinical Fellows, graduate externs, trainees, speech--language pathology assistants, and other personnel (e.g., clerical, technical, and other administrative support staff). SLPs may also supervise colleagues and peers. SLPs acknowledge that supervision is integral in the delivery of communication and swallowing services and advances the discipline. Supervision involves education, mentorship, encouragement, counseling, and support across all supervisory roles. SLPs

- possess service delivery and professional practice skills necessary to guide the supervisee;
- apply the art and science of supervision to all stakeholders (i.e., those supervising and being supervised), recognizing that supervision contributes to efficiency in the workplace;
- seek advanced knowledge in the practice of effective supervision;
- establish supervisory relationships that are collegial in nature;
- support supervisees as they learn to handle emotional reactions that may affect the therapeutic process; and
- establish a supervisory relationship that promotes growth and independence while providing support and guidance.

EDUCATION

SLPs serve as educators, teaching students in academic institutions and teaching professionals through continuing education in professional development formats. This more formal teaching is in addition to the education that SLPs provide to individuals, families, caregivers, decision makers, and policy makers, which is described in other domains. SLPs

- serve as faculty at institutions of higher education, teaching courses at the undergraduate, graduate, and postgraduate levels;
- mentor students who are completing academic programs at all levels;

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- provide academic training to students in related disciplines and students who are training to become speech--language pathology assistants; and
- provide continuing professional education to SLPs and to professionals in related disciplines.

RESEARCH

SLPs conduct and participate in basic and applied/translational research related to cognition, verbal and nonverbal communication, pragmatics, literacy (reading, writing and spelling), and feeding and swallowing. This research may be undertaken as a facility--specific effort or may be coordinated across multiple settings. SLPs engage in activities to ensure compliance with Institutional Review Boards and international laws pertaining to research. SLPs also collaborate with other researchers and may pursue research funding through grants.

ADMINISTRATION AND LEADERSHIP

SLPs administer programs in education, higher education, schools, health care, private practice, and other settings. In this capacity, they are responsible for making administrative decisions related to fiscal and personnel management; leadership; program design; program growth and innovation; professional development; compliance with laws and regulations; and cooperation with outside agencies in education and healthcare. Their administrative roles are not limited to speech--language pathology, as they may administer programs across departments and at different levels within an institution. In addition, SLPs promote effective and manageable workloads in school settings, provide appropriate services under IDEIA (2004), and engage in program design and development.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Speech--Language--Hearing Association. (2005). *Evidence--based practice in communication disorders* [Position statement]. Available from www.asha.org/policy.

American Speech--Language--Hearing Association. (2014). *Interprofessional education/interprofessional practice (IPE/IPP)*. Available from www.asha.org/Practice/Interprofessional-Education-Practice/

Bridges, D. R., Davidson, R. A., Odegard, P. S., Maki, I. V., & Tomkowiak, J. (2011). Interprofessional collaboration: Three best practice models of interprofessional education. *Medical Education Online*, *16*. doi:10.3402/meo.v16i0.6035. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC3081249/

Craddock, D., O'Halloran, C., Borthwick, A., & McPherson, K. (2006). Interprofessional education in health and social care: Fashion or informed practice? *Learning in Health and Social Care*, *5*, 220--242. Retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1473-6861.2006.00135.x/abstract>

Individuals With Disabilities Education Act of 2004, 20 U.S.C. § 1400 et seq. (2004).

Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. § 1400 et seq. (2004).

Scope of Practice in Speech--Language Pathology

Lipinski, C. A., Lombardo, F., Dominy, B. W., & Feeney, P. J. (1997, March 1). Experimental and computational approaches to estimate solubility and permeability in drug discovery and development settings. *Advanced Drug Delivery Reviews*, 46(1–3), 3–26. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11259830>

Rehabilitation Act of 1973, 29 U.S.C. § 701 et seq.

U.S. Department of Education. (2004). *Building the legacy: IDEA 2004*. Retrieved from <http://idea.ed.gov/>

World Health Organization. (2014). *International Classification of Functioning, Disability and Health*. Geneva, Switzerland: Author. Retrieved from www.who.int/classifications/icf/en/

RESOURCES

American Speech--Language--Hearing Association. (n.d.). *Introduction to evidence--based practice*. Retrieved from <http://www.asha.org/Research/EBP/>

American Speech--Language--Hearing Association. (n.d.). Practice Portal. Available from <http://www.asha.org/practice-portal/>

American Speech--Language--Hearing Association. (1991). *A model for collaborative service delivery for students with language--learning disorders in the public schools* [Paper]. Available from www.asha.org/policy

American Speech--Language--Hearing Association. (2003). *Evaluating and treating communication and cognitive disorders: Approaches to referral and collaboration for speech--language pathology and clinical neuropsychology* [Technical report]. Available from www.asha.org/policy

Paul, D. (2013, August). A quick guide to DSM--V. *The ASHA Leader*, 18, 52–54. Retrieved from <http://leader.pubs.asha.org/article.aspx?articleid=1785031>

U.S. Department of Justice. (2009). *A guide to disability rights laws*. Retrieved from www.ada.gov/cguide.htm

ASHA PRACTICE PORTAL
PROFESSIONAL ISSUES
CLINICAL EDUCATION AND SUPERVISION
2017

Overview

The scope of this Practice Portal page is the clinical education and supervision of graduate students in audiology and speech-language pathology in university and off-site settings.

Many of the principles included in this page also apply to the mentoring and supervision of speech-language pathology clinical fellows and professionals transitioning to a new area of practice, as well as to the supervision of support personnel.

For information related to mentoring clinical fellows, see [Issues in Ethics: Responsibilities of Individuals Who Mentor Clinical Fellows in Speech-Language Pathology](#) (ASHA, 2013a). For information specific to support personnel, see [audiology assistants](#), [speech-language pathology assistants](#), and [speech-language pathology assistant scope of practice](#) (ASHA, 2013b).

Definition of Terms

The terms *clinical supervisor* and *clinical supervision* are often used in reference to the training and education of student clinicians, recognizing that supervision is part of the training and education process. *Supervision* can be broadly defined as overseeing and directing the work of others. However, clinical supervisors do more than oversee the work of the student clinician. They teach specific skills, clarify concepts, assist with critical thinking, conduct performance evaluations, mentor, advise, and model professional behavior (Council of Academic Programs in Communication Sciences and Disorders [CAPCSD], 2013).

Many professionals involved in the supervisory process suggest that the terms *clinical educator* and *clinical instructor* more accurately reflect what the clinical supervisor does (CAPCSD, 2013). The term *clinical educator* is used here to refer to individuals involved in the clinical training, education, and supervision of audiology and speech-language pathology graduate students at all levels of training.

Key Issues

- [Preparation for the Clinical Educator](#)
- [Goals of Clinical Education](#)
- [Competency-Based Education](#)
- [Anderson's Continuum of Supervision](#)
- [Components of The Clinical Education Process](#)
- [Teaching Methods In Clinical Education](#)
- [Other Methods Used In Clinical Education](#)
- [Assessment of the Student Clinician's Knowledge and Skills](#)

- Effective Remediation
- Special Considerations
- Working With Academic Programs
- Ethics
- Legal/Regulatory Requirements
- Telesupervision
- Interprofessional Education and Interprofessional Practice

Preparation for the Clinical Educator

According to the ASHA Ad Hoc Committee on Supervision's *Final Report on Knowledge, Skills and Training Consideration for Individuals Serving as Supervisors* (ASHA, 2013c):

A prevailing philosophy suggests that competency in clinical service delivery translates into effective clinical supervision. However, leaders in education have long argued that this is a flawed assumption and that effective supervision requires a unique set of knowledge and skills.

The Ad Hoc Committee acknowledges that supervision is a distinct area of practice and, as in other distinct areas, individuals must receive training to gain competence before engaging in the activity. Education in the supervisory process should begin early, with—as a minimum—an introduction to the subject as part of the graduate curriculum and more extensive training readily available to practicing and aspiring supervisors. Effective education for supervision should focus on unique aspects of knowledge and specialized skills for the supervisory process and should not be limited to regulatory aspects (e.g., observation time, clock hours) of the process. (pp. 3–4)

CAPCSD also recognizes that clinical supervision is a distinct area of expertise and practice, and that clinical supervisors of student clinicians need to have the requisite knowledge and skills (CAPCSD, 2013). As such, clinical education requires training to ensure that individuals gain the necessary competence (ASHA, 2013c). ASHA and other stakeholders agree that appropriate training programs need to be developed.

Knowledge and Skills For Clinical Educators

In their final report to the ASHA Board of Directors, the Ad Hoc Committee on Supervision (ASHA, 2013c) outlined the knowledge and skills required of individuals engaging in clinical training.

Overarching Knowledge and Skills

- Knowledge of clinical education and the supervisory process, including teaching techniques, adult learning styles, and collaborative models of supervision
- Skill in relationship development, including the creation of an environment that fosters learning
- Ability to communicate, including the ability to define expectations and engage in difficult conversations

- Ability to collaboratively establish and implement goals, give objective feedback, and adjust clinical education style when necessary
- Ability to analyze and evaluate the student clinician's performance, including gathering data, identifying areas for improvement, assisting with self-reflections, and determining if goals are being achieved
- Skill in modeling and nurturing clinical decision making, including (a) using information to support clinical decisions and solve problems and (b) responding appropriately to ethical dilemmas
- Skill in fostering professional growth and development
- Skill in making performance decisions, including the ability to create and implement plans for improvement and to assess the student's response to these plans
- Ability to adhere to the principles of evidence-based practice and conveying research information to student clinicians

Knowledge and Skills Specific to Student Training in the University Clinic or Off-site Setting

- Ability to connect academic knowledge and clinical application
- Ability to sequence the student's knowledge and skill development

Knowledge and Skills Specific to the Clinical Educator Working With Students in the Culminating Externship in Audiology

- Ability to provide a multifaceted experience across the scope of the profession
- Ability to serve as a liaison between the facility, student, and university
- Skill in guiding the student in reflective practice
- Skill in facilitating the development of workplace navigation skill (e.g., being part of a team and adhering to policies and procedures)

For more detailed information about the knowledge and skills needed by clinical educators, see the [Final Report on Knowledge, Skills and Training Consideration for Individuals Serving as Supervisors](#) (ASHA, 2013c) and CAPCSD'S white paper titled [Preparation of Speech-Language Pathology Clinical Educators](#) (CAPCSD, 2013). See also the American Academy of Audiology's [Clinical Education Guidelines for Audiology Externships](#) (American Academy of Audiology, n.d.)

Training

Both ASHA (2013c) and CAPCSD (2013) suggest the need for systematic approaches to the training and preparation of clinical educators, and both organizations outline the following issues related to the development of training:

- Development of, and options for, the delivery of educational products
- Use of a team of individuals skilled in clinical education as trainers and product developers
- Identification of potential consumers for the training

- Development of outcomes and incentives for those who engage in clinical education training

Training modules and resources are currently under development; this Practice Portal page will reference these modules and resources when they are available.

Goals of Clinical Education

Effective supervision ensures that new clinicians are well prepared and that individuals with communication disorders receive quality services (ASHA, 2013a).

Clinical educators integrate theoretical, evidence-based knowledge with clinical practice to help student clinicians

- acquire fundamental knowledge about normal and disordered communication;
- develop critical thinking and clinical decision-making skills;
- acquire an understanding of clinical practices and methodology and the ability to implement them;
- develop the ability to analyze research and apply evidence to clinical practice;
- become competent in using equipment and technology necessary for diagnosing and treating communication disorders;
- become competent in analyzing assessment and treatment behaviors to evaluate the effectiveness of clinical practices;
- become competent in charting and monitoring patient records;
- develop professional communication skills—both verbal and written;
- develop professional behaviors, including the ability to work with individuals and their families;
- develop skills necessary to function appropriately on an interprofessional team; and
- become competent in medical coding and billing.

Competency-Based Education

Competency-based education focuses on student learning. It is a system of instruction, assessment, grading, and reporting based on students' ability to demonstrate expected learning of knowledge and skills as they progress through their education. The goal of competency-based education is to ensure that students acquire the knowledge and skills they need to be successful in school, in their careers, and in their adult lives (Hidden Curriculum, 2014).

Competency-based approaches to clinical education and assessment of student learning focus more on the knowledge, skills, and competencies that a student demonstrates than on a record of clinical hours obtained. This Practice Portal page is consistent with a competency-based approach to clinical education. See Frank et al. (2007) for a discussion of a competency-based approach in clinical (medical) education.

Anderson's Continuum of Supervision

Anderson's (1988) *Continuum of Supervision* is a conceptual model of supervision often referred to in the communication sciences and disorders (CSD) literature. The model

describes supervision as a continuum of stages (evaluation-feedback, transitional, and self-supervision) that allows a student to move from interdependence to independence. These stages are not time-bound; the student may be at any point along the continuum, based on his or her knowledge and skills, as well as situational variables.

The continuum comprises changes over time in the amount and type of involvement of both supervisor (clinical educator) and student clinician—as the amount of direct supervision (e.g., direct instruction; modeling or demonstration) decreases, the amount of student participation increases (e.g., the student directs by proposing clinical decisions).

Supervisory styles are adjusted in response to the needs of the student, expectations and philosophies of the supervisor and supervisee, and specifics of the situation (e.g., task difficulty; familiarity with the task or procedure; client needs and preferences; setting).

Anderson (1988) emphasizes five components of the supervisory process to facilitate movement of the student along the continuum:

- **Understanding the supervisory process** — discussing the process, understanding respective roles, and sharing expectations and objectives
- **Planning** — joint planning for the clinical process (client and clinician) and the supervisory process (supervisee and supervisor)
- **Observing** — collecting and recording objective data by both supervisor and supervisee
- **Analyzing** — examining and interpreting data in relation to changes in clinician and client
- **Integrating** — integrating content from all components at various points throughout the experience

By actively participating in all aspects of the clinical process—including data collection, problem solving, and strategy development—the student ultimately develops the ability to use the strategies needed to function independently (Dowling, 2001).

Applications and research relevant to these components are discussed in McCrea and Brasseur's (2003) update of Anderson's seminal work.

Components of The Clinical Education Process

The Supervisory Relationship

Success in facilitating clinical and professional development ultimately rests on the relationship between clinical educator and student clinician and on the ability of the clinical educator to communicate effectively with the student clinician.

Effective interpersonal communication requires

- knowledge of and ability to implement the basic principles of effective interpersonal communication;

- appreciation for the importance of listening and the ability to use behaviors that facilitate effective listening (e.g., silent listening, questioning, paraphrasing, empathizing, and supporting);
- knowledge of key principles of conflict resolution and the ability to use conflict resolution strategies appropriately (e.g., active listening, openness to discussion, and allowing for open-ended discussion);
- understanding different learning styles and having the ability to work effectively with each style within the supervisory relationship; and
- understanding different communication styles (e.g., cultural/linguistic, generational, gender) and having the ability to address potential challenges to successful communication related to these differences.

When clinical educators adopt an effective communication style, student clinicians are more willing to participate in conferences, share ideas and feelings, and positively change clinical behaviors (e.g., Hagler, Casey, & DesRochers, 1989; McCready et al., 1996; Pickering, 1987).

Clinical behaviors also change in positive directions when students perceive genuineness, empathetic understanding, positive regard, and concreteness on the part of the clinical educator (Ghitter, 1987 [building on the research of Caracciolo, 1976; Caracciolo, Rigrodsky, & Morrison, 1978a, 1978b; McCrea, 1980; and Pickering, 1979, 1984]).

Promoting And Enhancing Critical Thinking

Critical thinking allows the clinician to access knowledge about the field, determine how that knowledge can be applied in clinical situations, evaluate outcomes, modify his or her thinking, and make appropriate clinical adjustments.

"Educational and professional success require developing one's thinking skills and nurturing one's consistent internal motivation to use those skills" (Facione, 2000, p. 81). The clinical educator must not only teach critical thinking skills but also nurture the *disposition* toward clinical thinking (Gavett & Peapers, 2007). One way to accomplish these objectives is by asking questions that activate the student's knowledge and promote analysis, synthesis, and evaluation of the situation.

Questions can

- provide a model for how practicing clinicians reason;
- provide a structure for student clinicians to connect theory and practice; and
- challenge student clinicians to apply their thinking beyond the specific client or situation (Gavett & Peapers, 2006, 2007; King, 1995).

Feedback

Feedback is an informed (data-based), nonevaluative, objective appraisal of the student clinician's performance intended to improve his or her clinical skills (Ende, 1983). It is given to confirm or reinforce behavior, correct behavior, and promote improvement in

future performance (Barnum, Guyer, Levy, & Graham, 2009; Ende, 1983; Nottingham & Henning, 2014a).

Common types of feedback (Dowling, 2001) include

- **objective data** — nonjudgmental data collected, analyzed and shared with the student clinician
- **narratives** — written descriptions of specific behaviors during a session, along with the clinical educator's impressions (e.g. field notes; Anderson, 1998)
- **rating scales** — ratings on a specified number of clinical skills; although criteria for judgment are sometimes provided, rating scales are subjective by nature and need to be paired with objective data to support the ratings

Giving Feedback

Factors that can influence the effectiveness of feedback include

- timing (immediate or delayed);
- frequency (more or less often);
- tone (positive, negative, or balanced);
- form (spoken or nonspoken); and
- specificity (more or less detailed/specific).

Each feedback exchange can include different combinations of these components; thus, each exchange is unique (Nottingham & Henning, 2014a, 2014b).

Ende (1983) offers the following guidelines for giving feedback:

- Undertake feedback so that the clinical educator and student clinician are working as allies with common goals.
- Ensure that feedback is well-timed and expected—feedback that comes unexpectedly, especially when it is negative, is almost always met with an emotional reaction.
- Base feedback on firsthand data, and phrase it in descriptive, nonevaluative language.
- Focus on specific performances, not generalizations.
- Address decisions and actions of the student clinician, not assumed intentions or interpretations.
- When offering subjective data, label it as such—use "I" statements that focus on the specific behavior and that allow the student to interpret (e.g., "I saw that you reversed the right and left earphones when fitting the headset.").

Receiving Feedback

Factors that can affect how receptive a student clinician is to feedback include

- whether or not the student agrees with the clinical educator;
- the particular learning situation (e.g., if new skills are being learned);

- personalities of the clinical educator and student clinician that can set the tone for their interactions; and
- the timing of feedback (e.g., in the presence of a client/patient or in private).

See Nottingham and Henning (2014b) for a discussion of student preferences with regard to feedback.

Seeking Feedback

Feedback-seeking behavior is a conscious effort to determine the correctness and adequacy of one's own behavior for the purpose of attaining a goal (Ashford & Cummings, 1983). Research suggests that feedback-seeking behavior can facilitate an individual's adaptation, learning, and performance (Crommelinck & Anseel, 2013).

Not all individuals seek feedback, possibly because of differences in the perceived value and costs associated with feedback seeking (Ashford, Blatt, & Vande Walle, 2003). However, given the potential benefits, encouraging feedback seeking is an important educational strategy (Crommelinck & Anseel, 2013; Bose & Gijsselaers, 2013).

Mentoring in Clinical Education

Mentoring is the relationship between two people in which one person is dedicated to the personal and professional growth of the other (Robertson, 1992). In clinical education, mentoring focuses on building skills, influencing attitudes, and cultivating aspirations. Mentors model, advise, tutor, and instill a professional identity in the student clinician.

Some aspects of mentoring are involved in all supervisory relationships and, to varying degrees, at all stages of clinical education, depending on the supervisor's style and the student clinician's experience and skill level. Mentoring is less likely to be addressed when performance growth is the focus (i.e., "direct-active" style of supervision) and is more likely to be addressed in later stages of learning, when "collaborative" or "consultative" styles of supervision are used. Mentoring is most appropriate in the advanced transitional stage and the self-supervision stage of the continuum (Anderson, 1988).

The Influence of Power in Supervision

The clinical educator holds the power of grading, signing off on clinical hours, and conducting performance evaluations. Awareness and understanding of the influence of power can help avoid intimidation and a reluctance by the student clinician to participate actively in the supervisory relationship.

Cultural or linguistic background may influence a student's response to the power dynamic and may result in behaviors that can be interpreted as inappropriate (Coleman, 2000). Seek advice regarding effective strategies for culturally appropriate interactions.

Evaluating The Student Clinician And The Clinical Educator

"The goals of the supervisory process are the professional growth and development of [both] the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients" (Anderson, 1988, p. 12).

To that end, the clinical education process incorporates self-assessment on the part of the student clinician *and* the clinical educator. Self-assessment enhances professional growth and development and provides an opportunity for each person to identify goals and determine whether these goals are being met.

The clinical education process also incorporates *reciprocal evaluations*—this encompasses the clinical educator's evaluation of the student clinician and the student clinician's evaluation of the clinical educator. Reciprocal evaluations are critical to the process and help both individuals improve their skills.

Teaching Methods In Clinical Education

Deliberate Practice

Deliberate practice is a highly structured activity directed at improving performance on a particular task or set of tasks (Ericsson, Krampe, & Tesch-Römer, 1993). It incorporates immediate, specific, and informative feedback, problem-solving and evaluation, and opportunities for repeated performance to improve and refine skills.

Training that utilizes deliberate practice can facilitate acquisition and maintenance of expert performance in a wide variety of fields (e.g., De Bruin, Smits, Rikers, & Schmidt, 2008; Krampe & Ericsson, 1996; Unger, Keith, Hilling, Gielnik, & Frese, 2009), including acquisition of clinical skills (Duvivier et al., 2011; Ericsson, 2004).

Duvivier et al. (2011) identified a number of study habits related to deliberate practice in the behavior of clinical (medical) students at various stages of skill development:

- Tendency to organize work in a structured way
- Increased concentration and attention span
- Tendency to practice
- Tendency to self-regulate learning

As students progressed through the curriculum, their use of these study habits increased, particularly in the areas of planning and organization of work.

Deliberate practice can facilitate acquisition of a broad range of clinical skills in audiology and speech-language pathology, including administering tests and interpreting results; conducting oral motor exams; using technology and equipment; and completing audiologic assessments.

Reflective Practice

Reflective practice involves critical self-analysis, self-evaluation, problem solving, and the ability to modify one's behavior. It is an important tool in practice-based professional learning where clinical skills are acquired through experience rather than from formal classroom teaching.

- **Reflection-on-action** is the process of reflecting on what has been done. It allows the individual to reflect on a prior experience, evaluate how he or she contributed to the outcome, and determine what to do when a similar situation arises (Schön, 1983).

Tools that provide opportunities to reflect on performance include self-evaluation checklists, journals, diaries, portfolios, reviews of video recorded sessions, and clinical educator observations and evaluations.

- **Reflection-in-action** is the process of "thinking on your feet" that allows an individual to make changes in his or her behavior while engaged in a task. It requires critical, in-the-moment evaluation and the ability to identify what is not going well or what needs to be changed and to modify behaviors accordingly (Schön, 1983).

Examples include modifying task instructions or cuing strategies during a therapy session or deciding to forego otoacoustic emissions testing in favor of multifrequency tympanometry to investigate possible causes of a conductive hearing loss.

For more information about reflective practice in clinical education, see Aronson (2011); Geller and Foley (2009); Mann, Gordon, and MacLeod (2009); and Ng (2012).

Supervision, Questioning And Feedback (SQF) Model Of Clinical Teaching

The *Supervision, Questioning and Feedback (SQF) model of clinical teaching* integrates supervision, questioning and feedback into clinical learning experiences. It is designed to help the student clinician become an autonomous clinician with sound clinical reasoning (Barnum et al., 2009).

The SQF model incorporates

- **supervision (S)** that changes in response to the needs of the learner and the situation;
- **strategic questioning (Q)** to facilitate development of clinical reasoning skills by providing a model for thinking; and
- meaningful **feedback (F)** to help shape learning and skill development.

Strategic questioning consists of consciously adapting the timing, order, and phrasing of questions to help the student process information at increasingly more complex levels. In order of complexity, questions require recall of facts; comparison, analysis, synthesis, and application of knowledge; and the ability to evaluate information, formulate plans, infer meaning, and defend decisions (Barnum 2008).

Three types of **feedback** can be utilized—*confirming* lets students know when knowledge and skills are being applied correctly; *corrective* lets them know when these skills are not on target; and *guiding* reinforces and advances current levels of knowledge and skills (Barnum & Guyer, 2015).

Specific **questioning** and **feedback** techniques depend on the clinical situation—the student clinician, the task he or she is trying to complete, the urgency with which the task must be completed, and the consequences for the patient/student/client and for the student clinician (Barnum & Guyer, 2015).

Cognitive Apprenticeship Instructional Model

Cognitive apprenticeship was introduced by Collins, Brown, and Newman (1989) as an instructional model for situated learning, in which students learn to apply skills by performing tasks and solving problems in a variety of authentic contexts.

The cognitive apprenticeship model applies the following teaching methods to promote situated learning:

- **modeling** — demonstrating tasks and explaining internal (cognitive) processes (e.g., decision making)
- **coaching** — observing students as they perform tasks and providing feedback, hints, models, and reminders
- **scaffolding** — tailoring support to students' current level of knowledge and gradually removing support as they become more competent
- **articulation** — encouraging students to verbally express their knowledge, reasoning, or problem solving
- **reflection** — encouraging students to reflect on their own skills and problem-solving abilities as compared with their cognitive model of expertise
- **exploration** — setting general goals for students and encouraging them to formulate and pursue personal goals of interest

Using these methods, the clinical educator makes tacit elements of expert practice explicit so that students gain a deeper understanding of the cognitive processes underlying clinical decision making (Dennen & Burner, 2008).

Other Methods Used In Clinical Education

Simulation

Simulation is a method that replaces or amplifies real client/patient experiences with scenarios designed to replicate real health encounters (Passimant, Sacks, & Huang, 2011). Simulation affords an opportunity to build knowledge and experience by rehearsing in a safe environment (e.g., clinical skills lab), where potential harm to the client/patient is minimized.

The *standardized patient (SP)* is a well-accepted and frequently used simulation tool. The SP is a layperson hired and trained to portray an actual patient within a clinical setting. He or she presents with faculty-defined patient history and physical symptoms and provides a consistent, controlled clinical experience for teaching and assessment purposes. Academic programs in CSD are beginning to employ SPs for clinical education purposes (e.g., Zraick & Allen, 2002; Zraick, Allen, & Johnson, 2003). Other simulation tools include computer avatars and lifelike mannequins (Zraick, n.d.).

Grand Rounds

Grand rounds are formal meetings at which cases are presented to student clinicians, clinical educators, and other medical and allied health professionals, followed by a discussion of each case. Students may review current literature to provide support for test protocols, test interpretation, and treatment options. Grand rounds originated as part of medical residency training but can be used in any clinical education setting to enhance clinical reasoning and decision-making skills.

Problem-based and Case-Based Learning Scenarios

Problem-based learning scenarios are experiences in which groups of students—with guidance from an instructor—learn through solving an open-ended problem by identifying what they know, what they need to know, and where they can access the necessary information to solve the problem.

Case-based learning scenarios are similar but use discussion of case studies and real-life scenarios to help students put their learning into practice in a clinical setting. Students work collaboratively to examine, analyze, and discuss problems related to the case.

Assessment of the Student Clinician's Knowledge and Skills

Assessment is an essential component of any clinical education process. It involves

- defining expected knowledge and skills;
- developing learning goals;
- setting criteria for demonstrating learning;
- gathering and analyzing data regarding performance or verification of clinical outcomes;
- providing feedback; and
- documenting feedback and remediation opportunities.

Setting objectives is fundamental to subsequent evaluation; progress can be measured adequately only if clear objectives have been established and if behaviors relating to those objectives have been quantified (McCrea & Brasseur, 2003).

It is critical that the clinical educator and the student clinician be jointly involved in the evaluation process (Anderson, 1988; McCrea & Brasseur, 2003). Expectations for performance and evaluation tools need to be clarified at the beginning of the supervisory experience (Brasseur, 1989).

Types of Assessment

A variety of assessment mechanisms and techniques are used to evaluate progress in acquiring the necessary knowledge and skills. Assessments are conducted on an ongoing basis throughout training and at the conclusion of a defined instructional period.

Formative Assessment

Formative assessment is ongoing measurement and feedback yielding critical information for monitoring acquisition of knowledge and skill *during the learning process* for the purpose of improving learning.

Formative assessment in clinical education evaluates the individual's critical thinking, decision-making, and problem-solving skills; it typically includes oral and written components as well as demonstrations of clinical proficiency in actual or simulated settings.

Examples of Formative Assessment

- **Observation** – observing the student clinician during sessions and providing feedback (written or verbal) regarding mastery of a skill (e.g., branching to a less difficult task during the session or selecting an appropriate masking level during audiologic testing).
- **Questioning** – engaging the student clinician with questions that encourage open dialogue, critical thinking, problem solving, and exploration of new information.
- **Learning logs** – asking students to reflect on a session or learning experience by summarizing the experience, noting what they learned, posing questions that they still have, evaluating their clinical skills, and providing insight and suggestions for continued performance improvement. Learning logs allow the clinical educator to monitor student progress and provide feedback and concrete suggestions on ways to improve.
- **Proficiency exams** – evaluating student performance on a particular skill (e.g., pure-tone testing) to determine skill level at various points throughout training. Exam performance can help determine the need for additional practice and/or remediation.

Summative Assessment

Summative assessment is the comprehensive evaluation of learning outcomes at the conclusion of a defined instructional period (e.g., end of semester, academic year, or program of study).

Summative assessment in clinical education yields critical information for determining an individual's acquisition of knowledge and achievement of clinical skills, including the ability to integrate academic knowledge with clinical practice.

Summative assessments can serve as gateway measures prior to embarking on a more advanced clinical process stage. They often result in a score or grade that is incorporated into the individual's overall performance.

Examples of Summative Assessment

- **Gateway clinical exams** administered as benchmarks before more complex clinical procedures (or placements) are permitted.
- **Examination of practical skills** (e.g., demonstration of skills in use of technology; demonstrating diagnostic skills using simulated patients).
- **End-of-semester final exams or evaluations.**

- **End-of-program comprehensive written and oral exams.**
- **Culminating demonstrations of learning**, such as
 - *oral presentations* (e.g., case presentations);
 - *capstone projects* (e.g., case studies, surveys, and outcomes-based research) in which theory and knowledge are applied to a real-world setting; and
 - *portfolios of work* (e.g., case reviews, treatment plans, reports, and academic papers) demonstrating evidence of academic and clinical achievements.
- **Standardized tests** (e.g., Praxis® exams).

Pitfalls To Avoid When Assessing Student Performance

It is important for the clinical educator to avoid the following common pitfalls when assessing student performance.

- **Halo Effect** — cognitive bias in which an observer's *overall* (positive or negative) impression of a person influences the evaluation of specific traits (Thorndike, 1920).
- **Central Tendency** — tendency to rate all individuals (or all performances of a particular individual) around the midpoint of the scale; this bias results in a failure to differentiate between individuals or between the skills of a particular individual (Heery & Noon, 2008).
- **Similar-to-Me Effect** — tendency for an individual to give a higher rating to someone who is similar, in some way, to the rater himself or herself (e.g., similar attitudes or demographics; Sears & Rowe, 2003).
- **Judgmental Bias** — tendency (usually subconscious) to judge someone based on factors (e.g., racial, gender, or political bias) unrelated to his or her performance (Kerr, MacCoun, & Kramer, 1996).
- **Leniency/Strictness Error** — error that results when consistently easy or strict criteria are applied in rating an individual, regardless of his or her performance (Lunenburg, 2012).

Clinical educators can use one or more of the following strategies to avoid these pitfalls and ensure objectivity, fairness, and accuracy when assessing student performance:

- Establish clear educational plans and objective goals.
- Set expectations with the student.
- Rate each expected behavior independently.
- Consider specific data to support performance judgments.
- Use full performance rating levels to accurately indicate strengths and areas for improvement.
- Separate oneself from the evaluation—recognize that someone can be different but still perform effectively.
- Conduct in-house reliability training to ensure that all clinical educators use rating systems in a similar manner.

Effective Remediation

Difficult Conversations

Difficult conversations frequently pertain to the student's clinical performance but may also be related to other behaviors such as keeping commitments, being punctual, or demonstrating professionalism. These conversations often involve differing perspectives, opposing opinions, strong emotions, and potentially high-stakes outcomes (Patterson, Grenny, McMillan, & Switzler, 2012; Whitelaw, 2012).

One approach for initiating and resolving difficult conversations is the *learning conversation*. It involves

- learning the story of the participants without assigning blame;
- inviting participants to express their views and feelings; and
- creating a partnership for problem-solving ([Harvard Negotiation Project](#), n.d.; Stone, Patton, & Heen, 2010).

The learning conversation requires willingness on the part of the clinical educator to put aside his or her views and listen to the student, with the goal of understanding and acknowledging the student's perspective. This nonjudgmental listening can provide a safe emotional environment and facilitate the problem-solving process (Luterman, 2006).

Performance Improvement Plan

A *performance improvement plan*—also referred to a *remediation plan*—is a formal process used to help the student clinician improve performance or modify behavior. The need for remediation can stem from performance on clinical examinations that identifies the student's areas of need.

As part of the process, the clinical educator and student clinician identify specific performance and/or behavioral concerns and develop a written plan of action to address these concerns. The following specific steps in developing and implementing performance improvement plans are adapted from the Society for Human Resource Management (2013).

Steps In Developing And Implementing A Performance Improvement Plan

I. Document areas of performance and/or behavior in need of improvement by

- providing objective and specific documentation;
- documenting performance and behavior regularly throughout the term; and
- providing examples for clarification.

II. Develop action plan for improvement that includes

- specific and measurable objectives;
- a timeline for completion of objectives;

- additional resources that might be needed; and
- a statement of consequences if objectives are not successfully met.

III. Meet with student clinician to review plan. Be sure to

- clearly explain areas in need of improvement and the plan of action;
- provide the student with an opportunity to give his or her feedback and modify the plan if needed; and
- sign the plan.

IV. Gather data

- Data specific to each objective are gathered by both student and clinical educator.
- Student maintains log of performance-related self-evaluations.

V. Meet regularly with the student clinician (e.g., weekly, biweekly) to

- provide opportunities for student to seek guidance or ask for clarification of expectations;
- discuss and document progress toward achieving objectives; and
- modify objectives and/or timeline if needed.

VI. Conclude plan when student clinician

- meets all objectives and continues/progresses in his or her training or
- fails to meet objectives, at which time agreed-upon consequences are implemented.

Special Considerations

Students With Disabilities

The rights of students with disabilities are protected by the Americans With Disabilities Act (ADA; 1990) and Section 504 of the Rehabilitation Act of 1973. The ADA and Section 504 of the Rehabilitation Act of 1973 define *individuals with disabilities* as

- persons with a physical or mental impairment that substantially limits one or more major life activities;
- persons who have a history or record of such an impairment; or
- persons who are perceived by others as having such an impairment.

Major life activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning.

The Americans With Disabilities Act (ADA)

The ADA (1990) is comprehensive civil rights legislation that prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone

else to participate in mainstream American life. This includes the opportunity to participate in higher education. Title II of the ADA covers state-funded schools such as universities, community colleges, and vocational schools. Title III of the ADA covers private colleges and vocational schools.

Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 (hereafter, "the Rehabilitation Act") protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any federal department or agency and include many institutions of higher learning, hospitals, nursing homes, mental health centers, and human service programs.

Section 504 of the Rehabilitation Act covers any school that receives federal dollars, regardless of whether it is private or public. A recipient of federal financial assistance may not, on the basis of disability,

- deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits;
- deny access to programs, services, benefits, or opportunities to participate as a result of physical barriers; or
- deny employment opportunities, including hiring, promotion, training, and fringe benefits, for which they are otherwise entitled or qualified (U.S. Department of Education, 1980).

To be protected by Section 504, a student must be a qualified individual with a disability. In addition to meeting the above definition of *individuals with disabilities*—and for purposes of receiving services, education, or training—the term *qualified* means that the student meets essential eligibility requirements, with or without use of a reasonable accommodation.

Discriminatory Conduct

Examples of discriminatory conduct by a college or university include

- denying a qualified individual with a disability admission because of her or his disability;
- excluding a qualified student with a disability from any course, course of study, or other part of its education program or activity because of her or his disability; and
- counseling a qualified student with a disability toward more restrictive career objectives than other students (U.S. Department of Education, 1980).

Reasonable Accommodations

Institutions are required by law to provide *reasonable accommodations*. Specifically, they are required to make reasonable modifications in their practices, policies, and procedures and to provide auxiliary aids and services for individuals with disabilities—unless doing so would (a) fundamentally alter the nature of the goods, services,

facilities, privileges, advantages, and accommodations that they offer or (b) result in an undue financial or administrative burden on the institution.

Colleges and universities are not required to provide personal attendants, individually prescribed devices, readers for personal use or study, or other devices or services of a personal nature, such as tutoring and typing.

A reasonable accommodation for a student with a disability may include appropriate academic adjustments (e.g., modifications to academic requirements) that are necessary to ensure equal educational opportunity.

Examples include

- arranging for priority registration;
- reducing an individual's courseload;
- substituting a course;
- providing notetakers, recording devices, and/or sign language interpreters;
- allowing extended time for taking tests and completing clinic-related tasks (e.g., documentation and preparation);
- equipping school computers with screen-reading, voice recognition, or other adaptive software or hardware;
- modifying the environment to facilitate use of clinical equipment; and
- ensuring wheelchair access to clinical environments (e.g., for both examiner and patient side of sound suites).

The college or university is not required to lower or substantially modify essential requirements. For example, although the college or university may modify elements of the clinical practicum to meet the student's disability-related needs, it is not required to change the substantive requirements of the clinical experience in ways that can potentially interfere with quality of client care.

All students are held to the same standards and expectations. The presence of a disability may help explain how the student performs but does not excuse inadequate performance. All students deserve equal access to realistic performance assessment.

See [Jarrow \(2012\)](#) for a discussion of students with disabilities and information about maintaining essential requirements for all students.

Bilingual Student Clinicians

On occasion, a bilingual student clinician shares the language of the client/patient and/or family. When the clinical educator does not also share the language, a unique set of knowledge and skills is needed to understand, monitor, and evaluate the work of the bilingual student clinician. When this situation arises, it is important to consider the following:

- There may be a relationship between the student clinician and the client/patient stemming from a shared cultural and linguistic background, and this relationship is not an attempt to be exclusionary.

- Bilingual student clinicians who are in the process of being trained as professional service providers are not automatically considered bilingual service providers. Bilingual service providers must have adequate linguistic skills and must be appropriately trained to provide services to the individual with limited English proficiency (see [bilingual service delivery](#) and [collaborating with interpreters, transliterators, and translators](#)).
- The student clinician may be able to serve as an interpreter, transliterator, or translator, but additional consideration is necessary before this additional role is given (see [collaborating with interpreters, transliterators, and translators](#)).
- Although the student clinician may be able to serve appropriately in multiple roles, it must be recognized that the roles of bilingual service provider, interpreter, transliterator, and translator are unique, with each serving a different function and requiring a different set of knowledge and skills (see [collaborating with interpreters, transliterators, and translators](#)).
- The clinical educator and student clinician have a responsibility to collaborate in planning the session, selecting culturally relevant materials, and appropriately administering the services.

Student Clinicians Who Use Non-Standard American English Dialects or Accented Speech

Accents are defined as English pronunciation that is not the result of pathology and that is perceived to be different from the listener's—whether the English was learned as a first, second, or other language. Accents include aspects of speech sound production, prosody, rate, and fluency (Celce-Murcia, Brinton, & Goodwin, 1996), all of which can affect intelligibility. A *dialect* is any variety of a language that is shared by a group of speakers (Wolfram, 1991).

All individuals speak with an accent and/or dialect, whether it is regional or influenced by another native language. Variation is the norm, and no single standard can be appropriately applied in every clinical interaction. Audiologists and speech-language pathologists (SLPs) manage cases across linguistic variation as a matter of routine.

Student clinicians who speak with accents and/or dialects can effectively provide speech, language, and audiological services as long as they have

- the expected level of knowledge in normal and disordered communication;
- the expected level of diagnostic and clinical case management skills, and when necessary; and
- the ability to model the target (e.g., phoneme, grammatical feature, or other aspect of speech and language) that characterizes the particular problem of the client/patient (ASHA, 1998)—modeling can be provided in a variety of ways, given current technology (e.g., computer applications, software, audio and video recordings).

Universities impose the same requirements on all student clinicians and consider the potential means by which students can successfully provide clinical services with the

varied tools and resources now available. According to ASHA (1998), "the nonacceptance of individuals into higher education programs or into the professions solely on the basis of the presence of an accent or dialect is discriminatory" (p. 1).

When there are concerns about the impact of a student clinician's accent on the delivery of clinical services, the following strategies (ASHA, 2011) are offered to increase the likelihood of success:

- Provide early support, including opportunities for students to raise concerns.
- Offer an accent modification/intelligibility enhancement plan.
- Avoid communicating inferiority (e.g., by offering accent modification/intelligibility enhancement by a fellow student or allowing fellow students to observe the session).
- Be respectful of what the student brings to the profession (e.g., an understanding of culturally and linguistically diverse issues germane to the CSD discipline).
- Focus on the client's/patient's perception of accent—what matters is whether he or she can understand and learn from a student clinician with an accent.
- Address client/patient concerns—a client/patient or family member may indicate concerns about working with a student clinician who has an accent.
- Choose external placement sites with care (e.g., choose outside placements with clinical educators who are aware of and sensitive to the influence of cultural and linguistic diversity in the professions).
- Acquisition of self-awareness by students is key (e.g., being aware of a student's accent and its clinical impact and having resources to rely upon in various situations).
- Seek outside support and guidance—assess the support given to students with accents through exit interviews; ask for suggestions on improving the approach for future students.

Cultural Influences On Clinical Education

Both the service provider and the client/patient bring a unique combination of cultural variables to the clinical interaction, including ability, age, sex, beliefs, ethnicity, experience, gender, gender identity, linguistic background, national origin, race, religion, sexual orientation, and socioeconomic status.

Just as audiologists and SLPs are required to consider each client's/patient's or caregiver's cultural and linguistic characteristics and values in order to provide the most effective services (ASHA, 2004), the clinical educator also considers those of the student clinician (Herd & Moore, 2012). Clinical educators and student clinicians demonstrate [cultural competence](#) as they relate to each other and to the diverse populations they serve (ASHA, 2013d).

Culturally competent clinical educators successfully perform the following tasks:

- Discuss differences in cultures and the effect of differences on the relationship between clinical educator and student clinicians (Gardner, 2002).

- Discuss the unique influence of an individual's cultural and linguistic background that may necessitate adjustments in clinical approaches and interactions (e.g., interview style, assessment tools, and therapeutic techniques, feedback mechanisms, and critical evaluations).
- Gain an understanding of cultural norms and linguistic profiles—for example, what may appear to be an "unnecessary" amount of time "wasted" before beginning the session may actually reflect an awareness of the value of introductory talk in building rapport and showing respect before beginning the formal task.
- Give thoughtful attention to issues related to who speaks which language(s) (e.g., clinical educator, student clinician, client/patient, or family member). Such thoughtful attention provides opportunities for a collaborative relationship between student clinician and clinical educator (Muñoz, Watson, Yarbrough, & Flahive, 2011).
- Engage in discussions about expectations of performance and provide clear statements of evaluation criteria, including the influence of each person's cultural background.

Generational Differences

Generational differences can present unique challenges in clinical education. Four distinct generations (traditionalists, baby boomers, generation Xers, and millennials) are currently working together in potentially stressful, competitive environments (Lancaster & Stillman, 2002). Each generation is defined by people, places, events, and symbols that profoundly influence expectations and values.

Different expectations and values between and among generations can result in misinterpretations and misunderstandings between clinical educator and student clinician in a clinical setting. McCready (2007) describes a number of ways to bridge the generation gap and facilitate improved communication, including

- increasing knowledge and understanding of potential generational differences, including defining events and values;
- avoiding the assumption that all members of a particular generation have a "collective personality;"
- developing an appreciation of potential strengths of each generation (e.g., technological experience and expertise);
- talking about generational differences in orientation meetings, in-service presentations, study groups, and the like;
- sharing generational stories; and
- having discussions with colleagues and student clinicians about generational characteristics that might lead to misunderstandings.

Working With Academic Programs

Student clinicians typically gain practical experience in the field by "interning" at one or more external practicum sites (e.g., schools, rehabilitation centers, skilled nursing facilities, private practices, hospitals). Academic programs work together with external practicum sites to help provide these experiences.

Clinical Affiliation Agreements

The *clinical affiliation agreement* is a formal contract between an academic institution (college or university) and an external practicum site. Most academic programs require a clinical affiliation agreement before sending students to external practicum sites.

The clinical affiliation agreement identifies the responsibilities and liabilities of each party and ensures an appropriate learning experience for the student clinician. Agreements typically include the responsibilities listed in the boxed information below:

Mutual responsibilities of the academic institution and practicum site

- Determine the length of time that the agreement will be in effect and options for renewal
- Agree on terms for appropriate discipline or dismissal of a student clinician
- Provide reasonable accommodations to student clinicians with disabilities so that they can perform essential job functions and acquire the necessary clinical knowledge and skills

Responsibilities of the academic institution

- Select qualified student clinicians
- Advise student clinicians of their rights and responsibilities under the agreement
- Require student clinicians to comply with the site's health status requirements and provide appropriate documentation
- Ensure that student clinicians have the necessary professional liability insurance
- Educate student clinicians regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Provide the practicum site with expected learning objectives for the student clinician and necessary evaluation forms

Responsibilities of the practicum site

- Provide student clinicians and academic institution with the rules and policies of the practicum site
- Provide student clinicians with the necessary experiences to attain learning objectives
- Maintain student records and protect the confidentiality of these records as dictated by the Family Educational Rights and Privacy Act (FERPA, 1973)
- Gather data regarding clinical performance
- Evaluate performance and provide feedback to the student clinician and academic institution
- Provide the student clinician with any necessary credentialing information (e.g., requirements for provisional licensure from the state)

Administrative Tasks Prior To Student Clinician Placement

The practicum site needs to complete a number of tasks prior to student clinician placement, including those listed below:

- Obtain any necessary approvals from the facility for serving as a clinical educator and placement site.
- Determine if the university offers or requires clinical educators to have taken university or professional development courses on clinical supervision or specific clinical topics.
- Review the agreement that the facility has established with the university.
- Contact human resources staff members at the facility regarding requirements and orientation processes, including
 - procuring required ID badges;
 - ensuring that student background checks, if required, are complete;
 - ensuring that students complete required facility orientations; and
 - ensuring that immunization requirements have been met.
- Confirm dates for student clinician practicum.
- Schedule periodic "check-in" meetings with the university clinic director.
- Facilitate site visits by university clinical faculty over the course of the student clinician's placement.
- Confirm grade submission policies and procedures.

Stipends

There is no official ASHA policy regarding payment of students for clinical practicum. However, because it is acceptable to charge for supervised services provided by students, it follows that it is acceptable to pay students in practicum settings. See [*Issues in Ethics: Ethical Issues Related to Clinical Services Provided by Audiology and Speech-Language Pathology Students*](#) (ASHA, 2013e) for more details.

Students work with their academic program and practicum site to determine whether a stipend is available and/or appropriate. Important considerations include

- the academic program's policy on student stipends;
- compliance with state licensing or other regulatory agency policy; and
- the potential impact of the stipend on the student's financial aid package.

Even if a student is being paid a stipend, he or she requires the appropriate level of supervision and teaching necessary for training. Make clients, patients, and families aware that services are being rendered by a student clinician under the supervision of a credentialed and/or licensed practitioner.

Clinical Educator Compensation

It is not uncommon for clinicians serving as external practicum site clinical educators to be offered incentives or compensation for the additional work involved in being a clinical educator. ASHA does not have a policy on payment of externship clinical educators. Some academic institutions may offer compensation in the form of a stipend or in-kind

services (e.g., continuing education opportunities) or, for example, a "thank you" lunch at the end of the semester.

In some cases, the employer (practicum site) might offer compensation or incentives to the employee for working with student clinicians. For example, when practical, the employee may be given a temporarily reduced caseload while working with a student clinician.

If the audiologist or SLP receives payment from the university for serving as an externship clinical educator, he or she will need to disclose this to the employer. As the direct beneficiary of this payment, the individual will also need to declare the income when filing his or her personal income taxes.

Ethics

Clinical educators who are members of ASHA are expected to abide by the [Code of Ethics](#) (ASHA, 2010r) and have the unique opportunity to reinforce and model the importance of the Code of Ethics to their student clinicians.

There are also a number of Issues in Ethics Statements published by ASHA's Board of Ethics that provide guidance in addressing some of the challenges inherent in clinical education. See [Ethical Issues Related to Clinical Services Provided by Audiology and Speech-Language Pathology Students](#) (ASHA, 2013e) and [Issues in Ethics: Supervision of Student Clinicians](#) (ASHA, 2010) for more details.

Clinical educators and mentors working with speech-language pathology clinical fellows can also review [Issues in Ethics: Responsibilities of Individuals Who Mentor Clinical Fellows in Speech-Language Pathology](#) (2013a) for guidance.

Legal/Regulatory Requirements

Certification Standards

The standards for certification for audiology and speech-language pathology are established by audiologists and SLPs, respectively, who are members of ASHA's Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC). It is important for clinical educators to be familiar with the Standards and Implementation Procedures for the [Certificate of Clinical Competence in Audiology](#) (CCC-A) and the [Certificate of Clinical Competence in Speech-Language Pathology](#) (CCC-SLP) when working with students interested in seeking ASHA certification.

Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA)

To embark on a career as an ASHA-certified audiologist or SLP, students must complete the necessary entry-level graduate degree from a program accredited by the [Council on Academic Accreditation in Audiology and Speech-Language Pathology](#) (CAA; ASHA, 2014).

Medicare Coverage Of Students And Clinical Fellows

Clinical educators must comply with Medicare guidelines related to coverage of student and clinical fellowship services. ASHA has compiled information about these regulations in the following sources:

- [Medicare Coverage of Students: Audiology](#)
- [Medicare Coverage of Students & Clinical Fellows: Speech-Language Pathology](#)

Medicaid Coverage

Audiology and speech-language pathology are recognized as covered services under the Medicaid program. The federal government establishes broad guidelines, and each state then administers its own program. Review and approval is conducted by the federal Centers for Medicare & Medicaid Services (CMS).

Medicaid coverage of services provided "under the direction of" a qualified professional varies by state. See [Medicaid Coverage of Speech-Language Pathologists and Audiologists](#) for professional and state-specific information.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a law designed to improve the efficiency and effectiveness of the nation's health care system and health care operations. HIPAA

- protects health insurance coverage when someone loses or changes his or her job;
- addresses issues such as pre-existing conditions;
- includes provisions for the privacy and security of health information;
- specifies electronic standards for the transmission of health information; and
- requires unique identifiers for providers.

See the [Health Insurance Portability and Accountability Act \(1996\)](#) for additional information and resources.

Student Clinicians and HIPAA

HIPAA regulations apply to all [covered entities](#). These include health care operations or systems "conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers."

Student clinicians providing services in such health care settings will need to learn about HIPAA regulations and should be introduced to the facility's HIPAA policies and procedures. Facilities may require that student clinicians receive HIPAA training as part of their orientation. Just as any employee in the facility, student clinicians are expected to abide by HIPAA's Privacy Rule which applies to all forms of protected health information (PHI) whether oral, paper, or electronic.

Family Educational Rights and Privacy Act (FERPA)

[FERPA](#) (1973) protects the privacy of student education records and applies to all schools that receive funds under an applicable program of the U.S. Department of

Education. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 years or attends an institution beyond the high school level.

Student Clinicians and FERPA

Rights of students receiving services in the practicum setting. In education practicum settings (i.e., schools), student clinicians under the supervision of a qualified professional may generally be considered a "school official" with a "legitimate educational interest" and, as such, may have access to an individual's education records under this legislation. FERPA requires that schools specify the criteria for determining which parties are school officials and what the school considers to be a legitimate educational interest. Student clinicians should be made aware of their responsibilities under FERPA not to disclose personally identifiable information from education records unless authorized to do so, either with parental consent or under one of the conditions in FERPA permitting disclosure without consent. For more information, see [FERPA General Guidance for Students](#).

Rights of the student clinician. The education records of student clinicians are also protected under FERPA; the student clinician has the right to access his or her own education records, seek to have those records amended, control the disclosure of personally identifiable information from the records, and file a complaint with the school or department if he or she feels that these rights have been violated.

Although there are some exceptions, the university generally may not disclose personal identifiable information from the student clinician's educational records without the student's written consent. One exception is when the information is of legitimate educational interest. A clinical practicum site might be allowed access to a student clinician's personal identifiable information and must protect the confidentiality of this information, along with any other educational records generated during the practicum experience (e.g., performance evaluations and grades). For more information, see [FERPA General Guidance for Students](#).

Telesupervision

Telesupervision of student clinicians occurs when a qualified professional observes, from a distance, the delivery of services by the student and provides feedback or assistance as needed. Telesupervision offers the potential to expand students' access to clinical placements and to reduce travel and scheduling conflicts for clinical educators. Although telesupervision and telepractice are related due to their use of technology, ASHA's definition of *telepractice* does not include supervision.

See [ASHA's resource on telepractice](#) for information on technology, security, licensure, and other tips.

Regulations and Laws

The use of telesupervision as an alternative to in-person supervision may depend on the policies, regulations, and/or laws of various stakeholders such as universities,

clinical settings, ASHA, state licensure boards, and state and federal laws and regulations.

Increasingly, state licensure laws include a definition of *telepractice* and regulations related to it, which may or may not include guidance regarding telesupervision. States may vary in terms of whether they specifically address the issue of supervising students from a distance.

Ethical Responsibilities

The clinical educator has an ethical responsibility for the welfare of the individual receiving clinical services and must determine if telesupervision is an appropriate means to supervise a particular student clinician in view of the type of setting, client population, and level of independence of the individual delivering the service.

When implementing telesupervision practice and policies, consider the security of the telesupervision transmission in light of relevant state and federal laws such as HIPAA and FERPA. Policies about safety, liability, and whether a certified and/or licensed professional needs to be on site are also important and relevant considerations.

Knowledge and Skills

Like telepractice, delivering supervision services from a distance requires additional knowledge and skills for issues such as managing technology, complying with licensure and security requirements, providing feedback, and so forth. Training may be necessary for clinical educators regarding how to provide telesupervision so that quality and effectiveness of the supervision is equivalent to in-person supervision.

Tips And Considerations For Telesupervision

ASHA offers several guidelines for the implementation of telesupervision:

- Conduct a trial prior to the scheduled observation to identify and resolve technical and logistical issues (e.g., connectivity location of the microphone and camera).
- Always have an alternate means for the telesupervisor and clinician to communicate in case there is a problem with connectivity or equipment.
- The telesupervisor shares his or her web camera when being introduced to the client/student/patient at the beginning of the session but may stop sharing the web camera after introductions in order to minimize distractions.
- Providing the background case information as well as an outline for the test plan/lesson plan in advance helps to plan camera/microphone placement so that the telesupervisor can have an optimal view of the client/student/patient and materials.
- If online feedback or instructions are being provided during the session, the telesupervisee can receive communications via an earpiece to avoid distracting the client/student/patient.

Interprofessional Education and Interprofessional Practice

According to the World Health Organization (WHO; 2010), "Interprofessional education (IPE) occurs when two or more professions learn about, from, and with each other to enable effective collaboration and improve . . . outcomes" (p. 7). IPE is an essential first step in preparing professionals to work collaboratively in response to client/student/patient needs.

Interprofessional practice (IPP) allows workers from a variety of professional backgrounds to work together with clients/students/patients, families, caregivers, and communities to provide the highest quality and most comprehensive services possible (WHO, 2010).

Interprofessional education and collaborative practice align with national efforts toward a more interprofessional and collaborative service delivery model that centers on the individual and family with the aim of educating populations, improving health and safety, and enhancing the overall cost effectiveness of educational and health care services.

Clinical educators have the opportunity to engage in IPE/IPP and can reinforce best practices in this area. ASHA has compiled a number of [interprofessional education/interprofessional practice \(IPE/IPP\) resources](#). Clinical educators and CF mentors may want to familiarize themselves with [Core Competencies for Interprofessional Collaborative Practice](#), a report published by an expert panel of the Interprofessional Education Collaborative (IPEC, 2011), as well as ASHA's [Interprofessional Education \(IPE\): Final Report, Ad Hoc Committee on Interprofessional Education](#) (ASHA, 2013f).

References

American Academy of Audiology. (n.d.). *Clinical education guidelines for audiology externships*. Available from <http://www.audiology.org/publications-resources/document-library/clinical-education-guidelines-audiology-externships>

American Speech-Language-Hearing Association. (1991). *Students and professionals who speak English with accents and nonstandard dialects: Issues and recommendations* [Position Statement]. Available from <http://www.asha.org/policy/PS1998-00117/>

American Speech-Language-Hearing Association. (2004). *Knowledge and skills needed by speech-language pathologists and audiologists to provide culturally and linguistically appropriate services*. [Knowledge and Skills Document]. Available from <http://www.asha.org/policy/KS2004-00215/>

American Speech-Language-Hearing Association. (2010a). *Code of ethics* [Ethics Document]. Available from <http://www.asha.org/Code-of-Ethics/>

American Speech-Language-Hearing Association. (2010b). *Issues in ethics: Supervision of student clinicians* [Issues in Ethics Statement]. Available from <http://www.asha.org/Practice/ethics/Supervision-of-Student-Clinicians/>

American Speech-Language-Hearing Association. (2011). *The clinical education of students with accents* [Professional Issues Statement]. Available from <http://www.asha.org/policy/PI2011-00324/>

American Speech-Language-Hearing Association. (2013a). *Issues in ethics: Responsibilities of individuals who mentor clinical fellows in speech-language pathology* [Issues in Ethics Statement]. Available from <http://www.asha.org/Practice/ethics/Responsibilities-of-Individuals-Who-Mentor-Clinical-Fellows-in-Speech-Language-Pathology/>

American Speech-Language-Hearing Association. (2013b). *Speech-language pathology assistant scope of practice* [Scope of practice document]. Available from <http://www.asha.org/policy/SP2013-00337>

American Speech-Language-Hearing Association. (2013c). *Knowledge, skills and training considerations for individuals serving as supervisors* [Final report, Ad Hoc Committee on Supervision]. Available from <http://www.asha.org/uploadedFiles/Supervisors-Knowledge-Skills-Report.pdf> [PDF]

American Speech-Language-Hearing Association. (2013d). *Issues in ethics: Cultural and linguistic competence* [Issues in Ethics Statement]. Available from <http://www.asha.org/Practice/ethics/Cultural-and-Linguistic-Competence/>

American Speech-Language-Hearing Association. (2013e). *Issues in ethics: Ethical issues related to clinical services provided by audiology and speech-language pathology students* [Issues in Ethics Statement]. Available from <http://www.asha.org/Practice/ethics/Ethical-Issues-Related-to-Clinical-Services-Provided-by-Audiology-and-Speech-Language-Pathology-Students/>

American Speech-Language-Hearing Association. (2013f). *Interprofessional education: Final report, Ad Hoc Committee on Interprofessional Education*. Available from <http://www.asha.org/uploadedFiles/Report-Ad-Hoc-Committee-on-Interprofessional-Education.pdf>

American Speech-Language-Hearing Association. (2014). *Council on Academic Accreditation in Audiology and Speech-Language Pathology Handbook. Section III. Standards for accreditation of graduate education programs in audiology and speech-language pathology*. Retrieved from www.asha.org/Academic/accreditation/Accreditation-Handbook/

Americans With Disabilities Act of 1990, 42 U.S.C. § 126 (1990).

Anderson, J. (1988). *The supervisory process in speech-language pathology and audiology*. Boston, MA: College-Hill.

Anderson, N. (1998). Providing feedback to preservice teachers of reading in field settings. *Reading Research and Instruction*, 37, 123–136.

Aronson, L. (2011). Twelve tips for teaching reflection at all levels of medical education. *Medical Teacher*, 33, 200–205.

Ashford, S. J., & Cummings, L. L. (1983). Feedback as an individual resource: Personal strategies of creating information. *Organizational Behavior and Human Performance*, 32, 370–398.

- Ashford, S. J., Blatt, R., & Vande Walle, D. (2003). Reflections on the looking glass: A review of research on feedback-seeking behavior in organizations. *Journal of Management*, 29, 773–799.
- Barnum, M. G. (2008). Questioning skills demonstrated by approved clinical instructors during clinical field experiences. *Journal of Athletic Training*, 43, 284–292.
- Barnum, G. M., & Guyer, M. S. (2015, April). *The SQF model of clinical supervision*. Paper presented at the Annual Conference of the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD), Newport Beach, CA.
- Barnum, G. M., Guyer, M. S., Levy, L. S., & Graham, C. (2009). The supervision, questioning, and feedback model of clinical teaching: A practical approach. In T. G. Wiedner (Ed.), *The athletic trainer's pocket guide to clinical teaching* (pp. 85–99). Thorofare, NJ: SLACK.
- Bose, M. M., & Gijsselaers, W. H. (2013). Why supervisors should promote feedback-seeking behaviour in medical residency. *Medical Teacher*, 35(11), e1573–e1583.
- Brasseur, J. (1989). The supervisory process: A continuum perspective. *Language, Speech, and Hearing Services in Schools*, 20, 274–295.
- Caracciolo, G. (1976). *Perceptions by speech pathology student-clinicians and supervisors of interpersonal conditions and professional growth during the supervisory contract* (Doctoral dissertation, Columbia University Teachers College). *Dissertation Abstracts International*, 37, 4411B.
- Caracciolo, G. L., Rigrodsky, S., & Morrison, E. B. (1978a). Perceived interpersonal conditions and professional growth of master's level speech-language pathology students during the supervisory process. *ASHA*, 20, 467–477.
- Caracciolo, G. L., Rigrodsky, S., & Morrison, E. B. (1978b). A Rogerian orientation to the speech-language pathology supervisory relationship. *ASHA*, 20, 286–290.
- Celce-Murcia, M., Brinton, D. M., & Goodwin, J. M. (1996). *Teaching pronunciation: A reference for teachers of English to speakers of other languages*. Cambridge, England: Cambridge University Press.
- Coleman, T. J. (2000). *Clinical management of communication disorders in culturally diverse children*. Needham Heights, MA: Allyn & Bacon.
- Collins, A., Brown, J. S., & Newman, S. E. (1989). Cognitive apprenticeship: Teaching the crafts of reading, writing, and mathematics. In L. B. Resnick (Ed.), *Knowing, learning, and instruction: Essays in honor of Robert Glaser* (pp. 453–494). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Council of Academic Programs in Communication Sciences and Disorders. (2013). *White paper: Preparation of speech-language pathology clinical educators*. Retrieved from <http://scotthall.dotster.com/capcsd/wp-content/uploads/2014/10/Preparation-of-Clinical-Educators-White-Paper.pdf>

- Crommelinck, M., & Anseel, F. (2013). Understanding and encouraging feedback-seeking behaviour: A literature review. *Medical Education*, 47, 232–241.
- De Bruin, A. B., Smits, N., Rikers, R. M., & Schmidt, H. G. (2008). Deliberate practice predicts performance over time in adolescent chess players and drop-outs: A linear mixed models analysis. *British Journal of Psychology*, 99, 473–497.
- Dennen, V. P., & Burner, K. J. (2008). The cognitive apprenticeship model in educational practice. In J. M. Spector, M. D. Merrill, J. van Merriënboer, & M. P. Driscoll (Eds.), *Handbook of research on educational communications and technology* (pp. 425–439). New York, NY: Lawrence Erlbaum Associates.
- Dowling, S. (2001). *Supervision: Strategies for successful outcomes and productivity*. Needham Heights, MA: Allyn & Bacon.
- Duvivier, R. J., van Dalen, J., Muijtjens, A. M., Moolaert, V. R., van der Vleuten, C. P., & Scherpbier, A. J. (2011). The role of deliberate practice in the acquisition of clinical skills [Open Access article]. *BMC Medical Education*, 11(1), 101. Retrieved from <http://www.biomedcentral.com/1472-6920/11/101>
- Ende, J. (1983). Feedback in clinical medical education. *Journal of the American Medical Association*, 250, 777–781.
- Ericsson, K. A. (2004). Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains. *Academic Medicine*, 79(10), S70–S81.
- Ericsson, K. A., Krampe, R. T., & Tesch-Römer, C. (1993). The role of deliberate practice in the acquisition of expert performance. *Psychological Review*, 100, 363–406.
- Facione, P. A. (2000). The disposition toward critical thinking: Its character, measurement, and relationship to critical thinking skill. *Informal Logic*, 20(1), 61–84.
- Family Educational Rights and Privacy Act of 1973. 20 U.S.C. § 1232g (1973).
- Frank, J. R., Snell, L. S., Cate, O. T., Holmboe, E. S., Carraccio, C., Swing, S. R., . . . Harris, K. A. (2010). Competency-based medical education: Theory to practice. *Medical Teacher*, 32, 638–645.
- Gardner, R. (2002). Cross cultural perspectives in supervision. *Western Journal of Black Studies*, 26, 98–106.
- Gavett, E., & Peapers, R. (2006, November). *Developing critical thinking in student clinicians: The role of questions*. Paper presented at the Annual Convention of the American Speech-Language Hearing Association, Miami Beach, FL.
- Gavett, E., & Peapers, R. (2007). Critical thinking: The role of questions. *Perspectives on Issues in Higher Education*, 10, 3–5.
- Geller, E., & Foley, G. (2009). Broadening the "ports of entry" for speech-language pathologists: A relational and reflective model for clinical supervision. *American Journal of Speech-Language Pathology*, 18, 22–41.

Ghitter, R. (1987). Relationship of interpersonal and background variables to supervisee clinical effectiveness. In S. Farmer (Ed.), *Proceedings of a National Conference on Supervision—Clinical supervision: A coming of age* (pp. 49–56). Jekyll Island, GA: Council of University Supervisors of Practicum in Speech-Language Pathology and Audiology.

Hagler, P., Casey, P., & DesRochers, C. (1989). Effects of feedback on facilitative conditions offered by supervisors during conferencing. In D. Shapiro (Ed.), *Proceedings of the 1989 National Conference on Supervision: Supervision Innovations* (pp. 155–158). Sonoma, CA: Council of Supervisors in Speech-Language Pathology and Audiology.

Harvard Negotiation Project. (n.d.). Program on negotiation: Harvard Law School. Retrieved from http://www.pon.harvard.edu/category/research_projects/harvard-negotiation-project/

Health Insurance Portability and Accountability Act of 1996. Pub. L. No. 104-191, 110 Stat. 1938 (1996).

Heery, E., & Noon, M. (2008). *A dictionary of human resource management*. New York, NY: Oxford University Press.

Herd, C., & Moore, R. (2012). Multicultural issues: Supervision and multicultural issues: Supervisors and supervisees. *Perspectives on Administration and Supervision*, 22, 33–39.

Hidden Curriculum. (2014, August 26). In S. Abbott (Ed.), *The glossary of education reform*. Retrieved from <http://edglossary.org/hidden-curriculum>

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, DC: Author. Retrieved from <http://www.aacn.nche.edu/education-resources/ipcreport.pdf>

Jarrow, J. (2012, February). Students with disabilities in classroom and clinic: Business as usual. *Access Academics and Research*. Retrieved from <http://www.asha.org/Academic/questions/Students-With-Disabilities-in-Classroom-and-Clinic--Business-as-Usual/>

Kerr, N. L., MacCoun, R. J., & Kramer, G. P. (1996). Bias in judgment: Comparing individuals and groups. *Psychological Review*, 103, 687–719.

King, A. (1995). Designing the instructional process to enhance critical thinking across the curriculum. *Teaching of Psychology*, 22(1), 1–17.

Krampe, R. T., & Ericsson, K. A. (1996). Maintaining excellence: Deliberate practice and elite performance in young and older pianists. *Journal of Experimental Psychology: General*, 125, 331–359.

Lancaster, L. C., & Stillman, D. (2002). *When generations collide: Who they are, why they clash, how to solve the generational puzzle at work*. New York, NY: Harper Business.

- Lunenburg, F. C. (2012). Performance appraisal: Methods and rating errors. *International Journal of Scholarly Academic Intellectual Diversity*, 14(1), 1–9.
- Luterman, D. (2006, March 21). The counseling relationship. *The ASHA Leader*.
- Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Science Education*, 14, 595–621.
- McCrea, E. (1980). *Supervisee ability to self-explore and four facilitative dimensions of supervisor behavior in individual conferences in speech-language pathology* (Doctoral dissertation, Indiana University, 1980). *Dissertation Abstracts International*, 41, 2134B. (University Microfilms No. 80-29, 239)
- McCrea, E. S., & Brasseur, J. A. (2003). *The supervisory process in speech-language pathology and audiology*. Boston, MA: Allyn & Bacon.
- McCready, V. (2007). Generational differences: Do they make a difference in supervisory and administrative relationships? *Perspectives on Administration and Supervision*, 17, 6–9.
- McCready, V., Roberts, J. E., Bengala, D., Harris, H., Kingsley, G., & Krikorian, C. (1996). A comparison of conflict tactics in the supervisory process. *Journal of Speech, Language, and Hearing Research*, 39, 191–199.
- Muñoz, M. L., Watson, J. B., Yarbrough, L., & Flahive, L. K. (2011, April 26). Monolingual supervision of bilingual student clinicians: Challenges and opportunities. *The ASHA Leader*.
- Ng, S. L., & Jennings, M. B. (Eds.). (2012). Lessons from reflective learning in theory, research, and practice. *Seminars in Hearing*, 33(2), 115–212. doi:10.1055/s-002-23256
- Nottingham, S., & Henning, J. (2014a). Feedback in clinical education, Part I: Characteristics of feedback provided by approved clinical instructors. *Journal of Athletic Training*, 49(1), 49–57.
- Nottingham, S., & Henning, J. (2014b). Feedback in clinical education, Part II: Approved clinical instructor and student perceptions of and influences on feedback. *Journal of Athletic Training*, 49(1), 58–67.
- Passiment, M., Sacks, H., & Huang, G. (2011). *Medical simulation in medical education: Results of an AAMC survey*. Washington DC: Association of American Medical Colleges.
- Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2012). *Crucial conversations: Tools for talking when stakes are high*. New York, NY: McGraw-Hill.
- Pickering, M. (1979). *Interpersonal communication in speech-language pathology clinical practicum: A descriptive humanistic perspective* (Doctoral dissertation, Boston University School of Education, 1979). *Dissertation Abstracts International*, 40, 2140B. (University Microfilms No. 79-23, 892)

Pickering, M. (1984). Interpersonal communication in speech-language pathology supervisory conferences: A qualitative study. *Journal of Speech and Hearing Disorders*, 49, 189–195.

Pickering, M. (1987). Interpersonal communication and the supervisory process: A search for Ariadne's thread. In M. Cargo & J. Pickering (Eds.), *Supervision in human communication disorders: Perspectives on a process* (pp. 203–225). San Diego, CA: College-Hill Press.

Rehabilitation Act of 1973, Section 504. Pub. L. No. 93-112, 87 Stat. 394 (Sept. 26, 1973), codified at 29 U.S.C. § 701.

Robertson, S. C. (1992). *Find a mentor or be one*. Bethesda, MD: American Occupational Therapy Association.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York, NY: Basic Books.

Sears, G. J., & Rowe, P. M. (2003). A personality-based similar-to-me effect in the employment interview: Conscientiousness, affect- versus competence-mediated interpretations, and the role of job relevance. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, 35(1), 13–24.

Society for Human Resource Management. (2013). How to establish a performance improvement plan. Retrieved from <http://www.shrm.org/templatestools/howtoguides/pages/performanceimprovementplan.aspx>

Stone, D., Patton, B., & Heen, S. (2010). *Difficult conversations: How to discuss what matters most*. New York, NY: Penguin.

Thorndike, E. L. (1920). The constant error in psychological ratings. *Journal of Applied Psychology*, 4, 25–29.

Unger, J. M., Keith, N., Hilling, C., Gielnik, M. M., & Frese, M. (2009). Deliberate practice among South African small business owners: Relationships with education, cognitive ability, knowledge, and success. *Journal of Occupational and Organizational Psychology*, 82(1), 21–44.

U.S. Department of Education. (1980). (34 C.F.R. 100.3 [b]; 34 C.F.R. 100.3 [b]; 34 C.F.R. 100.3 [c]). Available from <https://www2.ed.gov/policy/rights/reg/ocr/edlite-34cfr100.html>

U.S. Department of Education. (1980). (34 C.F.R. 104.42 [a]; 34 C.F.R. 104.43 [c]; 34 C.F.R. 104.47 [b]). Available from <https://www2.ed.gov/policy/rights/reg/ocr/edlite-34cfr104.html>

Whitelaw, G. M. (2012). Administration: Leadership challenges: Difficult conversations. *Perspectives on Administration and Supervision*, 22, 40–44. doi:10.1044/aas22.1.40

Wolfram, W. (1991). *Dialects and American English*. Englewood Cliffs, NJ: Prentice Hall.

World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. Geneva, Switzerland: Author. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HP_N_10.3_eng.pdf?ua=1

Zraick, R. I. (n.d.). The use of standardized patients in communication sciences and disorders. Rockville, MD: American Speech-Language-Hearing Association. Retrieved from <http://www.asha.org/Academic/questions/Use-of-Standardized-Patients-in-CSD/>

Zraick, R. I., & Allen, R. M. (2002). Using standardized patients to train and test speech-language pathology students. The innovative professor in communication disorders. *Perspectives on Issues in Higher Education*, 1, 17–19.

Zraick, R. I., Allen, R. M., & Johnson, S. B. (2003). The use of standardized patients to teach and test interpersonal and communication skills with students in speech-language pathology. *Advances in Health Sciences Education*, 8, 237–248.

Appendix E: Self-Assessment of Competencies in Supervision

Name:

Setting:

Date Completed:

As noted on ASHA's Clinical Education and Supervision Practice Portal, "the clinical education process incorporates self-assessment on the part of the student clinician *and* the clinical educator. Self-assessment enhances professional growth and development and provides an opportunity for each person to identify goals and determine whether these goals are being met." This tool was developed by the 2016 ASHA Ad Hoc Committee on Supervision Training (AHCST) to assist all audiologists and speech-language pathologists engaged in supervision in conducting a self-assessment of the knowledge and skills for supervision identified by the Ad Hoc Committee on Supervision (ASHA, 2013). Use this tool to rate your competencies and to develop your goals for training in order to improve your abilities as a clinical educator, preceptor, mentor, or supervisor.

Instructions: Put a checkmark in the box that describes your perceived level of competency for each of the overall knowledge and skills listed on pages 2–6. These items pertain to all audiologists and speech-language pathologists engaged in supervision. The items listed on pages 7–11 are knowledge and skills that are specific to five constituent groups—that is, clinical educators of graduate students, preceptors of audiology externs, mentors of Clinical Fellows, supervisors of support personnel, and supervisors of those individuals transitioning to a new area of practice or those reentering the profession (ASHA, 2013). Complete the self-assessment only for the group(s) for which you engage in supervision. On the final page is space for you to plan any needed training in supervision that is based on your goals.

Example: If you are a mentor of a Clinical Fellow, you would assess your competency on the items listed on pages 2–6 as well as your competency on the additional items listed on page 9.

Acknowledgments: The 2016 AHCST would like to acknowledge two sources that served as examples of formats for this tool: *The American Occupational Therapy Association Self-Assessment Tool for Fieldwork Educator Competencies* and *The Clinical Educator Self-Evaluation Tool: Clinical Instruction Strategies* (Reuler, Messick, Gavett, McCready, & Raleigh, 2011).



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Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

I. Supervisory Process and Clinical Education	0	1	2	3
A. I possess knowledge of collaborative models of supervision.				
B. I possess knowledge of adult learning styles.				
C. I possess knowledge of teaching techniques (e.g., reflective practice, questioning techniques).				
D. I define the supervisor and supervisee roles and responsibilities appropriate to the setting.				
E. I adhere to research/evidence-based practice, convey that information/analysis to the supervisee, and encourage the supervisee to seek applicable research and outcomes data and to use methods for measuring treatment outcomes.				

What are your strengths and items needing improvement in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

II. Relationship Development and Communication Skills	0	1	2	3
A. I develop a supportive and trusting relationship with supervisee.				
B. I create an environment that fosters learning, and I explore personal strengths and needs of supervisee.				
C. I transfer decision-making and social power to the supervisee, as appropriate.				
D. I educate the supervisee about the supervisory process.				
E. I define expectations, goal setting, and requirements of the relationship.				
F. I define and demonstrate expectations for interpersonal and modes of communication.				
G. I define and demonstrate evidence of cultural competence and appropriate responses to different communication styles.				
H. I demonstrate recognition of and access to appropriate accommodations for supervisees with disabilities.				
I. I engage in difficult conversations when appropriate regarding supervisee performance.				
J. I demonstrate use of technology, when appropriate, for remote supervision.				

What are your strengths and items needing improvement and goals in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

III. Establishment/Implementation of Goals	0	1	2	3
A. I develop goals/objectives with the supervisee that allow for growth in critical thinking and problem solving.				
B. I set personal goals to enhance supervisory skills.				
C. I observe sessions, and I collect and interpret data with the supervisee.				
D. I give the supervisee objective feedback to motivate and improve performance.				
E. I understand the levels and use of questions to facilitate learning.				
F. I adjust supervisory style based on level and needs of supervisee.				
G. I review relevant paperwork and documentation.				

What are your strengths and items needing improvement in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ Got It!

IV. Analysis and Evaluation	0	1	2	3
A. I examine collected data and observation notes to identify patterns of behavior and targets for improvement.				
B. I assist the supervisee in conducting self-reflections until independence is achieved.				
C. I assess supervisee performance.				
D. I determine if progress is being made toward the supervisee's goals.				
E. I modify or add to goals if needed.				

What are your strengths and items needing improvement and goals in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

V. Clinical and Performance Decisions	0	1	2	3
A. I model/guide the supervisee to respond to ethical dilemmas.				
B. I model/guide the supervisee to apply regulatory guidance in service delivery.				
C. I model/guide the supervisee to access payment/reimbursement for services.				
D. I guide the supervisee in use of reflective practice techniques to modify performance.				
E. I provide guidance regarding both effective and ineffective performance.				
F. I determine if progress is being made toward goals.				
G. I identify issues of concern about supervisee performance.				
H. I create and implement plans for improvement.				
I. I assess the supervisee's response to plans and determine next steps.				

What are your strengths and items needing improvement in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently, but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

VI. Specific Additional Competencies for Clinical Educators of Graduate Students	0	1	2	3
A. I connect academic knowledge and clinical procedures.				
B. I sequence the student's knowledge and skills development.				
C. I facilitate the student's ability to respond to various clinical settings and supervisory expectations.				
D. I build professional identity and engagement.				
E. I facilitate the student's use of information to support clinical decision making and problem solving.				
F. I understand the relationship defined by the agreement between the university and the clinic site, and I adhere to the requirements (when applicable).				

What are your strengths and items needing improvement in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

VII. Specific Additional Competencies for Preceptors of Audiology Externs	0	1	2	3
A. I understand the relationship defined by the agreement between the university and the clinic site, and I adhere to the requirements.				
B. I develop a multifaceted experience for the extern within the scope of the profession.				
C. I serve as an effective liaison in the relationship between the university, the student, and the facility.				
D. I provide ongoing assessment and objective (data-based) feedback, including the use of any reporting tools provided by the university.				
E. I allow the student to develop increasing independence in the externship.				
F. I collaborate with other supervisors, where and when applicable, to ensure meaningful and relevant educational experiences for the student.				
G. I guide the student in reflective practice (goal setting, self-monitoring, knowing when to request immediate vs. delayed supervisory intervention, and using data to guide clinical decisions) to encourage flexibility, growth, and independence.				
H. I facilitate the student's use of information to support clinical practice (problem solving, accessing evidence-based tools/information, and engaging in professional development).				
I. I assist in the development of workplace navigation skills, including becoming a part of the team and adhering to the policies and procedures of the facility.				
J. I establish and maintain professional boundaries and appropriate relationships.				
K. I foster a professional identity and engagement.				
L. I guide the student in developing advocacy skills for clients, for the student him/herself, and for the profession.				

What are your strengths and items needing improvement in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

VIII. Specific Additional Competencies for Mentors of Clinical Fellows in Speech-Language Pathology	0	1	2	3
A. I accept and adhere to ASHA roles and responsibilities for mentoring Clinical Fellows (reference the <i>Roles and Responsibilities of CF Mentor</i> document from ASHA).				
B. I establish goals for the Clinical Fellowship (CF) experience through a collaborative process of development/assessment.				
C. I provide appropriate balance of direct observation and other monitoring activities consistent with the Clinical Fellow's skills and goals while maintaining compliance with ASHA CF guidelines.				
D. I provide ongoing assessment and objective (data-based) feedback, including the use of any required reporting tool.				
E. I provide opportunities to achieve independence in the workplace.				
F. I guide the Clinical Fellow in reflective practice (goal setting, self-monitoring, knowing when to request immediate vs. delayed intervention, and using data to guide clinical decisions) to encourage flexibility, growth, and independence.				
G. I facilitate the Clinical Fellow's use of information to support clinical practice (problem solving, accessing evidence-based tools/information, and professional development).				
H. I assist in the development of workplace navigation skills, including becoming a part of the team and adhering to the policies and procedures of the facility.				
I. I establish and maintain professional boundaries and appropriate relationships.				
J. I foster a professional identity and engagement.				
K. I guide the Clinical Fellow in developing advocacy skills for clients, for the Clinical Fellow him/herself, and for the profession.				

What are your strengths and items needing improvement in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

IX. Specific Additional Competencies for Supervisors of Support Personnel	0	1	2	3
A. I model and develop appropriate relationships with the support personnel and within the organizational structure.				
B. I understand, and communicate to others in the setting, respective roles and responsibilities, including appropriate ASHA guidelines and state regulations.				
C. I facilitate collaboration with multiple/joint supervisors.				
D. I adapt to changes in the service delivery environment.				
E. I hold appropriate credentialing for the professional and supervisory roles.				
F. I assign responsibilities to support personnel on the basis of skills assessment.				
G. I analyze existing skills of the support personnel.				
H. I match/develop skills with job assignments.				
I. I delegate responsibilities effectively.				
J. I evaluate support personnel through performance-based measures rather than developmental assessment.				
K. I conduct ongoing and measurable competency assessment.				
L. I identify needs for basic and continuing education, and I develop a plan.				
M. I know and ensure compliance with state, federal, regulatory, and ASHA guidelines for duties and responsibilities, reimbursement, and legal and ethical repercussions in relation to the scope of practice of the supervisor.				
N. I facilitate efficiency, team building, and interprofessional relationships.				
O. I focus on client-centered care.				
P. I empower support personnel to work at their top potential and to continue to develop relevant additional skills.				

What are your strengths and areas needing improvement in this area?

What are your goals to improve your competencies in this area?

Rating Scale			
0	1	2	3
Not Yet	Occasionally/ <i>Just Starting</i>	Frequently but Sporadically/ <i>Getting There</i>	Consistently/ <i>Got It!</i>

X. Specific Additional Competencies for Supervisors of Individuals Transitioning to a New Area of Practice or Reentering the Profession	0	1	2	3
A. I explore existing skills and knowledge, including transferable skills.				
B. I identify the need for continuing education and training, and I develop a plan for achieving necessary skills/knowledge.				
C. I assist in the development of workplace navigation skills, including becoming part of the team and adhering to the policies and procedures of the facility.				
D. I promote self-reflection to learn new skills and hone existing skills.				
E. I provide ongoing collaborative assessment.				

What are your strengths and items needing improvement in this area?

What are your goals to improve your competencies in this area?

PLAN FOR CONTINUING EDUCATION

Competency Areas to Be Addressed <i>(include constituency group, where applicable)</i>	Independent Study	Academic coursework	Conference presentation	Publication	Mentorship	Other	Date Training Completed

References

American Occupational Therapy Association. (2009). *Self-assessment tool for fieldwork educator competency*. Available from [http://www.aota.org/-/media/Corporate/Files/EducationCareers/Educators/Fieldwork/Supervisor/Forms/Self-Assessment%20Tool%20FW%20Ed%20Competency%20\(2009\).pdf](http://www.aota.org/-/media/Corporate/Files/EducationCareers/Educators/Fieldwork/Supervisor/Forms/Self-Assessment%20Tool%20FW%20Ed%20Competency%20(2009).pdf)

American Speech-Language-Hearing Association. (n.d.). *Clinical Education and Supervision* (Practice Portal). Available from [http://www.asha.org/Practice-Portal/Professional-Issues/Clinical- Education-and-Supervision/](http://www.asha.org/Practice-Portal/Professional-Issues/Clinical-Education-and-Supervision/)

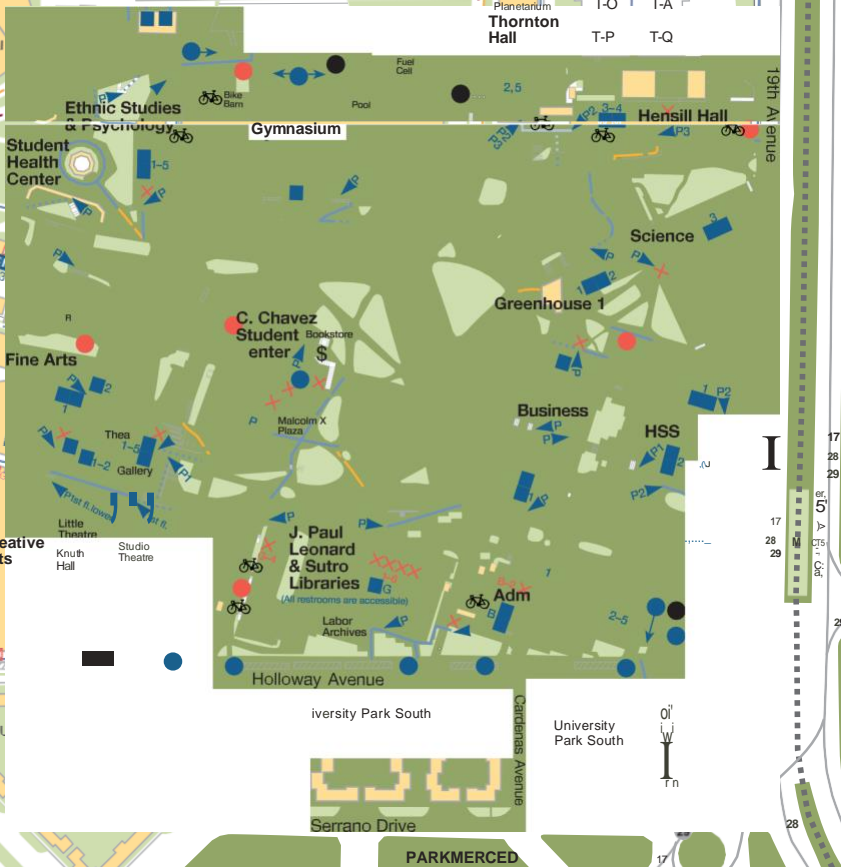
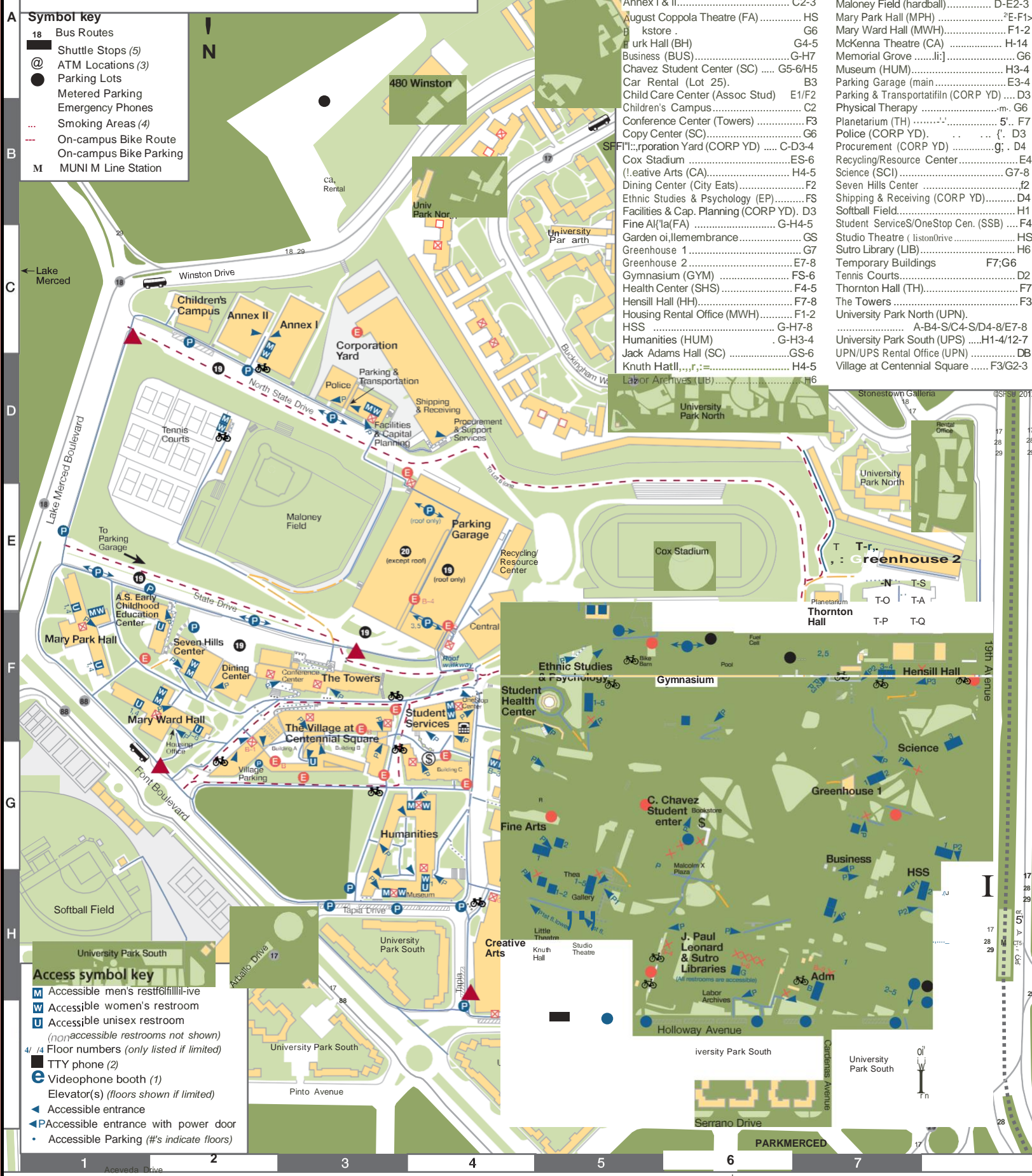
American Speech-Language-Hearing Association. (2013). *Knowledge, skills and training consideration for individuals serving as supervisors* [Final report, Ad Hoc Committee on Supervision]. Available from <http://www.asha.org/uploadedFiles/Supervisors-Knowledge-Skills-Report.pdf> [PDF]

American Speech-Language-Hearing Association. (May 2016). *A plan for developing resources and training opportunities in clinical supervision* [Final report, Ad Hoc Committee on Supervision Training]. Available from www.asha.org

Reuler, E., Messick, C., Gavett, E., McCready, V. & Raleigh, L. (2011, March). *Evidence-based practice for clinical education: What do we know and what can we do?* Proceedings of the Annual Conference of the Council of Academic Programs in Communication Sciences and Disorders, St. Pete Beach, FL.

- ### Symbol key
- 18 Bus Routes
 - Shuttle Stops (5)
 - ATM Locations (3)
 - Parking Lots
 - Metered Parking
 - Emergency Phones
 - Smoking Areas (4)
 - On-campus Bike Route
 - On-campus Bike Parking
 - MUNI M Line Station

Administration (ADM)	..... H7	Maloney Field (hardball)	..... D-E2-3
Annex I & II	..... C2-3	Mary Park Hall (MPH)	..... 2E-F1-8
August Coppola Theatre (FA)	..... HS	Mary Ward Hall (MWH)	..... F1-2
Bookstore	..... G6	McKenna Theatre (CA)	..... H-14
Burk Hall (BH)	..... G4-5	Memorial Grove	..... G6
Business (BUS)	..... G-H7	Museum (HUM)	..... H3-4
Chavez Student Center (SC)	..... G5-6/H5	Parking Garage (main)	..... E3-4
Car Rental (Lot 25)	..... B3	Parking & Transportation (CORP YD)	..... D3
Child Care Center (Assoc Stud)	..... E1/F2	Physical Therapy	..... m. D6
Children's Campus	..... C2	Planetarium (TH)	..... 5'.. F7
Conference Center (Towers)	..... F3	Police (CORP YD)	..... D3
Copy Center (SC)	..... G6	Procurement (CORP YD)	..... G; D4
Cox Stadium	..... ES-6	Recycling/Resource Center	..... E4
Creative Arts (CA)	..... H4-5	Science (SCI)	..... G7-8
Dining Center (City Eats)	..... F2	Seven Hills Center	..... f2
Ethnic Studies & Psychology (EP)	..... FS	Shipping & Receiving (CORP YD)	..... D4
Facilities & Cap. Planning (CORP YD)	..... D3	Softball Field	..... H1
Fine Arts (FA)	..... G-H4-5	Student Services/OneStop Cen. (SSB)	..... F4
Garden of Remembrance	..... GS	Studio Theatre (Liston Drive)	..... H6
Greenhouse 1	..... G7	Sutro Library (LIB)	..... HS
Greenhouse 2	..... E7-8	Temporary Buildings	..... F7;G6
Gymnasium (GYM)	..... FS-6	Tennis Courts	..... D2
Health Center (SHS)	..... F4-5	Thornton Hall (TH)	..... F7
Hensill Hall (HH)	..... F7-8	The Towers	..... F3
Housing Rental Office (MWH)	..... F1-2	University Park North (UPN)	.....
HSS	..... G-H7-8	University Park South (UPS)	..... H1-4/12-7
Humanities (HUM)	..... G-H3-4	UPN/UPS Rental Office (UPN)	..... DB
Jack Adams Hall (SC)	..... GS-6	Village at Centennial Square	..... F3/G2-3
Knuth Hall	..... H4-5		
Labor Archives (LAB)	..... H6		



- ### Access symbol key
- Accessible men's restroom
 - Accessible women's restroom
 - Accessible unisex restroom
 - (non-accessible restrooms not shown)*
 - Floor numbers (only listed if limited)
 - TTY phone (2)
 - Videophone booth (1)
 - Elevator(s) (floors shown if limited)
 - Accessible entrance
 - Accessible entrance with power door
 - Accessible Parking (#s indicate floors)

- ### Access path symbol key*
- Accessible Route-This path generally conforms to accessibility standards.
 - Partially Accessible Route-This path generally conforms to accessibility standards, but there may be excessive cross-slope (over 2%) or other irregularities along a portion of the path. These routes, though they may not be a straight or direct line, are more likely to be used than the accessible route. Lighter shade indicates path continues underneath overhang.

*Note: The map and information on pathways are limited by the scale. The accessible route should be clear to a person at a location, while the dashed line is intended to indicate where keener observation may be necessary to locate the accessible route. Pathways are generally asphalt and subject to weathering, erosion, uplifting, and other changes that may create navigational issues. SFSU is committed to maintaining the accessible route. Please report any irregularities to Disability Programs and Resource Center, 415-338-2472 (voice, TTY).

COMMUNICATIVE DISORDERS PROGRAM CALENDAR
SPRING 2017
JANUARY 23 - MAY 25

JAN 20 (Fri) 9-12:00 Room TBD	MANDATORY CD ORIENTATION MEETING FOR ALL CD STUDENTS
JAN 20 (Fri)	CLINICAL PRACTICUM FEES DUE (\$35.00 for CD CLINIC & AAC LAB materials, paid at Bursar in Student Services Bldg)
JAN 23 (Mon)	FIRST DAY OF INSTRUCTION
JAN 23-FEB 3	All CD 711, CD 713, CD 880 & CD 884 Clinics and seminars meet for orientation with clinical educators. Clinic aide unexcused absentees will be replaced by clinic aides on waiting list after FIRST meeting.
JAN 23-Jan 26	ADVISING FOR ALL CD GRADUATE AND UNDERGRADUATE STUDENTS FOR SUMMER/FALL 2017
JAN 23 & JAN 24	GROUP ADVISING FOR Su/F'17 (GRADUATE STUDENTS) 12-1 PM, BH149
JAN 25 & JAN 26	GROUP ADVISING FOR Su/F'17 (UNDERGRADUATE STUDENTS) 12-1 PM, BH149
JAN 27th-MAY 12 Rooms TBD	CD 725.01 for Spring '17 School Interns (Fridays 12:00-1:00) CD 712.01 for Spring '17 Medical Interns (Fridays 12:00-1:00)
FEB 3 (Fri)	MS Comps Exam in Computer Lab (BH 214)
FEB 6 (Mon)	Su'17 & F'17 Internship and Clinic Aide Requests completed on-line (CD 715 and CD881/882) by 4 PM. Clinical Educators: Spring 2017 Client/Clinician updated schedules due to Ms. Mallorie Desimone. CLINIC OPENS. All clinicians MUST have paid their clinical practicum & AAC lab fees to Bursar.
FEB 17 (Fri)	CD Graduates in Spring 2017: Application for Award of Degree/Graduation Form due to Graduate Division in Administration Building, Room 250. Also check to be sure you have an approved ATC on file.
FEB 27-MAR 3	Proposed Semester Objectives due (unless alternate date given by clinical educator).
MAR 1- MAR 3	CSUN 32nd Annual International Technology and Persons with Disabilities Convention, San Diego
MAR 6 (Mon)	MS COMPS Retakes
MAR 10 (Fri)	SPR/SU 2017 Graduates Meeting re: ePortfolios/ASHA & CA License 12:00-1:00 PM Room TBA
MAR 16-19	CSHA California Speech-Language-Hearing Association Annual Convention, Pasadena
MAR 20-24	SPRING RECESS (campus closed)
MAR 23-25	AAC by the BAY (location TBA)
MAR 27-31	MID-TERM CLINIC EVALUATION WEEK. Make appointments with clinical educators.
MAR 29-APR 1	CABE California Association for Bilingual Education Annual Convention, Anaheim
MAR 31 (Fri)	Cesar Chavez Day (campus closed)
APR 5-8	AAA American Academy of Audiology Annual Convention, Indianapolis, IN
APR 14 (Fri)	MS COMPS/THESIS Reception 12:00-1:00 BH149
APR 18 (Tues)	SPR 17 CD 880 1 st Year Grads Meeting/End-of-Semester Review 12:00-12:30 Room 160
APR 20-22	CAPCSD Council for Academic Programs in CSD Annual Conference, New Orleans, MS
TBD (Sat)	NSSLHA TENTH ANNUAL SPRING CONFERENCE/JOB FAIR
MAY 5 (Fri)	LAST DAY OF CLINIC (Due to Ms. Mallorie Desimone: signed Final Therapy Reports (F-24), Recommendations for Client (F-25) and Summer Client Availability Forms.
MAY 8-12	CLINIC EVALUATION WEEK-Make up sessions scheduled w/approval of clinical educator.
MAY 16 (Tues)	CD 715 and CD 882 CLINIC GRADES DUE (may be faxed to Dr. Laura Epstein [CD 715] and Drs. Teresa Gray/Nancy Robinson [CD 882] @ 415.338.0916). LAST DAY OF INSTRUCTION. All clinicians must submit Semester Clock Hrs form (SC-10) to their clinical educator. CLINICAL EDUCATORS submit final KASA Forms and SC-10 Clinic Clock Hour Forms to Dr. Patti Solomon-Rice. All final ASHA & CA License paperwork DUE, signing by individual appointments.
MAY 18-25	FINAL EXAM WEEK
MAY 28 (Sun)	CD Program Graduation

Clinical Practicum fees cover the lab for each semester. Please obtain payment form from Mallorie Desimone in BH 114 and pay \$35.00 directly to Bursar in the Student Services Building.

**CD 880.02
ADVANCED COMMUNICATION THERAPY
CLASS NUMBER 1885
SPRING 2017**

**WEDNESDAYS @ 9:00 AM – 12:00 PM
CHILDRENS CAMPUS
NORTH STATE DRIVE and LAKE MERCED BLVD**

Instructor: Patti Solomon-Rice, Ph.D. CCC-SLP
Office Hours: Mondays/Tuesdays 1:00 – 3:00 PM and by appointment
Office: Burk Hall 101
Phone: (415) 338 - 7652
E-mail: psolomon@sfsu.edu

COURSE DESCRIPTION AND PREREQUISITES

Supervised clinical methods and practice in advanced communication rehabilitation. A series of clinical experiences addressing various issues related to the communicative wellness of clients. May be repeated for a total of 10 units. Prerequisites: CD 668 or equivalent.

KNOWLEDGE BASE THEME

“Preparing reflective and innovative professionals as leaders who ensure the educational development of diverse populations within our dynamic educational context”
(San Francisco State University Knowledge Base Statement).

GOALS AND OBJECTIVES

Upon completion of the course, students must demonstrate skills in the acquisition of:

- (1) critical thinking skills;
- (2) evidenced-based clinical decision-making skills;
- (3) persistent problem-solving skills;
- (4) ability to communicate clearly and respectfully to clients and families without using unnecessary jargon;
- (5) ability to apply person and family-centered practices when serving clients;
- (6) ability to communicate with clinical instructor and fellow clinicians in an open and constructive manner;
- (7) ability to make appropriate adaptations for clients’ linguistic and cultural backgrounds;
- (8) ability to produce professional writing (that is nevertheless understandable to the clients/families);
- (9) ability to maintain a professional demeanor.

ASHA STANDARD V-B

The applicant for certification must complete a program of study that includes supervised clinical experiences sufficient in breadth and depth to achieve the following skills outcomes in the major categories of Evaluation, Intervention, and Interaction and Personal Qualities.

Clinical Skills will be evaluated in the following areas when relevant:

1. Articulation
2. Fluency
3. Voice and resonance including respiration and phonation
4. Receptive and expressive language (phonology, morphology, syntax, semantics, and pragmatics) in speaking, listening, reading, writing, and manual modalities
5. Hearing, including impact on speech and language
6. Swallowing (oral pharyngeal, esophageal, and related functions, including oral function for feeding; orofacial myofunction)
7. Cognitive aspects of communication (attention, memory, sequencing, problem-solving, executive functioning)
8. Social aspects of communication (including challenging behavior, ineffective social skills, lack of communication opportunities)
9. Communication modalities (including oral, manual, augmentative and alternative communication techniques and assistive technologies)

Summary of Skills Outcomes

According to ASHA, the student must complete a program of study that includes supervised clinical experiences sufficient in breadth and depth to achieve the following skills outcomes:

Evaluation (in one or more of the above nine areas):

- Conduct screening and prevention procedures (including prevention activities)
- Collect case history information and integrate information from clients/patients, family, caregivers, teachers, relevant others, and other professionals
- Select and administer appropriate evaluation procedures, such as behavioral observations, non-standardized and standardized tests, and instrumental procedures
- Adapt evaluation procedures to meet client/patient needs
- Interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention
- Complete administrative and reporting functions necessary to support evaluation
- Refer clients/patients for appropriate services

Intervention:

- Develop setting-appropriate intervention plans with measurable and achievable goals that meet clients'/patients' needs. Collaborate with clients/patients and relevant others in the planning process.
- Implement intervention plans (involve clients/patients and relevant others in the intervention process)
- Select or develop and use appropriate materials and instrumentation for prevention

and intervention

- Measure and evaluate clients'/patients' performance and progress

Interaction and Personal Qualities:

- Communicate effectively, recognizing the needs values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers and relevant others
- Collaborate with other professionals in case management
- Provide counseling regarding communication and swallowing disorders to clients/patients and relevant others
- Adhere to ASHA Code of Ethics and behave professionally

REQUIRED READING

Goldfarb, R. & Serpanos, Y.C. (2014). *Professional writing in speech-language pathology and audiology - 2nd Edition*. San Diego, CA: Plural Publishing. ISBN 978-1-59756-554-7

Clinician's Handbook (August 2016)

Readings/handouts posted on iLearn

SUPPLEMENTAL READING

Moon Meyer, S. (2004). *Survival guide for the beginning speech-language clinician – 2nd Edition*. Austin, TX: Pro-Ed. ISBN 978-0-8907-9981-9

Roth, F.P. & Worthington, C.K. (2016). *Treatment resource manual for speech-language pathology – 5th Edition*. Clifton Park, NY: Cengage Learning. ISBN 978-1-285-85115-0

Shipley, K.G. & McAfee, J.G. (2016). *Assessment in speech-language pathology: A resource manual – 5th Edition*. Clifton Park, NY: Cengage Learning. ISBN: 978-1-285-19805-7

ASSIGNMENTS

- Assignments and due dates are indicated in syllabus and iLearn
- Assignment details and samples are posted on iLearn
- All required documents and templates can be downloaded from department website <http://www.sfsu.edu/~comdis/startclinic.html>

GRADING CRITERIA

Students will meet with the clinical educator to discuss their grades in the middle and at the end of the semester. You can also request meetings with the clinical educator throughout the semester to discuss your progress. You will be evaluated according to KASA standards. Department grading standards for clinical performance can be found on pg. 13 of the Clinician's Handbook.

- A: Demonstrates advanced proficiency for skill level (beginning or intermediate clinician).
- B: Demonstrates basic proficiency for skill level (beginning or intermediate clinician).
- C: Demonstrates below basic proficiency for skill level (beginning or intermediate clinician).
- D: Demonstrates far below basic proficiency for skill level (beginning or intermediate clinician).

Note: Final grade may be reduced by one letter grade if all reports are not submitted in the correct form and by the due date.

SEMESTER CLINIC SCHEDULE

We will follow the semester schedule posted on the syllabus and iLearn. Assignments and due dates can be found in the syllabus and on iLearn.

WEEKLY REQUIREMENTS FOR GRADUATE CLINICIANS

1. Clinicians should arrive at least 15 minutes before the Wednesday session time.

This ensures punctuality. Use this time to communicate with others, get settled, set up, get materials, etc.

2. All clinicians and aides are required to attend weekly staff meetings.

If you cannot attend a staff meeting, you must inform Patti. The weekly schedule is:

9:00-10:55	Therapy session
11:00-noon	Staff meeting

3. Email a weekly SOAP Note to the instructor by Friday noon of each therapy week.

SOAP Notes must be emailed to Patti by Friday noon with or before the submission of the next week's ITP.

4. Email a brief note to the client's teacher and parent by Friday noon of each therapy week; copy Patti.

An email must be sent to the client's teacher and parent by Friday noon and copied to Patti, briefly stating how the client is progressing towards meeting the semester's objectives during the most recent session.

5. Email a weekly ITP (SC-03) to the instructor by Monday noon of each therapy week.

An Intended Therapy Plan (ITP) for each weekly session must be emailed to Patti by Monday noon each week. If revisions are needed, Patti will email details about ITP revisions by Monday evening. If requested, the revised ITP must be emailed to Patti by 8:00 AM on Tuesday.

6. Students must notify the center, the client's teacher and Patti of an excused absence; no unexcused absences are allowed. Notify the center by leaving a phone message at the front desk; email the teacher and Patti.

It is essential that you keep a record of the contact information of the people above. Make sure contact information is easily accessible to you on or off campus.

ASSIGNMENTS, THERAPY ACTIVITIES, AND STAFF MEETING TOPICS
(See iLearn for clinic schedule and due dates)

*The clinical educator reserves the right to make changes to the course syllabus and/or calendar.

Week and Date	Assignments Due	Therapy Activities and Staff Meeting Topics
Week 1 1/25	<p>Deadlines when meeting with clients: SOAP Notes due Fridays at noon</p> <p>E-mail to teacher/parent due Fridays at noon (copy Patti)</p> <p>ITPs due Mondays at noon</p> <p>Patti to review assignments and provide feedback by Monday afternoon/early evening</p>	<p>Meet at CD Clinic BH 138 Syllabus review Clinic procedures Clinic documents Grading procedures and criteria Clinic aide guidelines Client file review</p>
Week 2 Monday 1/30 3:00 – 5:00	<p>Client File Review form completed and emailed to Patti by 1/30 at noon</p>	<p>Meet at CD Clinic BH 138 Video of language facilitation between SLP & toddler Initial session preparation: Intended Therapy Plan SOAP note Parent interview guidelines Child history form Preschool observation form Receiving supervisor feedback Schedule of activities Tour of center – therapy rooms and classrooms (as possible)</p>
Week 3 2/8	<p>Parent interviews completed this week via phone or in person; include results in Friday SOAP notes</p>	<p>CLINIC OPENS Meet at Children’s Campus Begin assessments Hr 1: observe and establish rapport in classroom Hr 2: formal assessment in quiet location of classroom/client room</p> <p>Student clinician reflections Initial client impressions</p>

		Language stimulation techniques for toddlers Language and speech analysis
Week 4 2/15	Protocols scored this week; include results in Friday SOAP notes	Meet at Children’s Campus Complete assessments Hr 1: obtain spontaneous speech and language sample in classroom/client room Hr 2: complete formal assessment in quiet location of classroom/client room Writing behavioral objectives ITP therapy template ITP therapy sample Large group pre-literacy and phonological awareness guidelines and activities Story reading guidelines Therapy observation checklist
Week 5 2/22	Language sample transcribed; spontaneous language sample analyzed; spontaneous speech samples analyzed; typed report with transcription and analysis emailed to Patti by 2/20 at noon Scored protocols handed in to Patti for review during 2/22 staff meeting Analysis of spontaneous language and speech sample included in Friday SOAP note	Push-in, pull-out, small and large group sessions begin 9:00 – 9:45: push-in therapy/snack 9:45 – 10:15: pull-out therapy 10:20 – 10:35: small group therapy 10:40 – 10:55: pre-literacy large group Proposed semester objectives Teaching target behaviors Teaching strategies Data collection
Week 6 3/1	Proposed Semester’s Objectives (SC-06) emailed to Patti by 2/27 at noon CHAT handouts (do not review before client session)	Background sections of final therapy report CHAT student self-rating pre-test and training 11:15 – 12:00
Week 7 3/8	Proposed Semester’s Objectives revisions emailed to Patti by 3/6 at noon Background sections of Final Therapy Report emailed to Patti by 3/6 at noon	Complete CHAT form Mid-semester parent conference guidelines Therapy activities and materials Sign up for mid-term evaluations

Week 8 3/15	<p>Background sections of Final Therapy Report revisions emailed to Patti by 3/13 at noon</p> <p>Clinic Aide reflections emailed to Patti by 3/13 at noon</p> <p>Mid-semester parent conference results included in Friday SOAP notes</p>	<p>Complete CHAT form</p> <p>Mid-semester parent conferences completed this week</p> <p>Mid-term evaluations</p>
3/22	NO CLINIC SPRING BREAK	
Week 9 3/29		Complete CHAT form Therapy sharing: see handout on iLearn
Week 10 4/5		Complete CHAT forms SLP apps
Week 11 4/12		Complete CHAT form Home carryover programs Final therapy reports (F-24A) Clinic recommendations form (F-25)
Week 12 4/19		Complete CHAT form Final conference guidelines
Week 13 4/26	<p>Home Carryover Program reports emailed to Patti by 4/24 at noon</p> <p>Final Therapy Reports (F-24A) emailed to Patti by 4/24 at noon</p>	<p>Clinic Aides lead Pre-Literacy Group</p> <p>Complete CHAT form End of Semester forms: SC-10 and SC-10.5 Social/ecological survey given to teachers</p>
Week 14 5/3	<p>Home Carryover Program revisions emailed to Patti by 5/1 at noon</p> <p>Final Therapy Report revisions emailed to Patti by 5/1 at noon</p> <p>End-of-semester parent conference results included in SOAP notes</p>	<p>LAST DAY OF CLINIC Complete Home Carryover Programs with clients</p> <p>End-of-semester parent conferences completed this week in person</p> <p>Complete CHAT form Complete CHAT student self-rating post-test Social/ecological survey collected from teachers Sign-up for final evaluations</p>

		Final evaluation reflections form Complete on-line course evaluation.
Week 15 5/10	Clinic Aide reflections and one-two page report emailed to Patti by 5/8 at noon To Mallorie: 1) Signed Final Therapy Reports 2) Recommendations for Client (F-25) 3) Summer 2017 Client Availability form	Meet at Patti's office BH 101 for final evaluations: 1) Record releases, evaluation protocols and signed SOAP notes in client files 2) Sign de-identified copy of FTR for client file 3) Recommendations for Client (F-25) 4) Summer 2017 Client Availability form 5) Sign Clinic Hours Forms (SC-10) 6) Sign Clinic Aide observation forms (SC-10.5) 7) Complete SC-12 form 8) Final reflections 9) KASA form/signatures 10) Clinic Aide grade

A. UNIVERSAL DESIGN FOR LEARNING AND ACCOMMODATIONS

San Francisco State University implements the principals of Universal Design for Learning to make course concepts accessible and skills attainable regardless of learning style, physical, or sensory abilities. San Francisco State University complies with the regulations of the Americans with Disabilities Act of 1990 and offers accommodations to students with disabilities. If you are in need of a classroom accommodation, please make an appointment with the instructor to discuss this. All information will be held in the strictest confidence.

If you are a student with disabilities requiring special accommodation in this course, you must be registered with the Disability Programs and Resource Center (DPRC). The Disability Programs and Resource Center is available to facilitate the reasonable accommodations process. The DPRC is located in Student Services Bldg. (SSB) 110. This office can be reached by telephone at 338-2472 (voice/TTY) or by e-mail at dprc@sfsu.edu. Your counselor will give you a letter, which you must deliver to the instructor in person, at which time an appointment will be arranged to discuss appropriate accommodations. This must be accomplished during the first three weeks of the semester.

B. STUDENT CONDUCT

The University is committed to maintaining a safe and healthy living and learning environment for students, faculty, and staff. Each member of the campus community must choose behaviors that contribute toward this end.

Students are expected to adhere to SFSU's student code of conduct. Consistent tardiness, rudeness, or inappropriate behavior may result in immediate expulsion from the course. The Standards for Student Conduct can be found in the SFSU Bulletin:
<http://www.sfsu.edu/~bulletin/current/supp-reg.htm#ppg339>

C. ACADEMIC INTEGRITY

The Department of Special Education and Communicative Disorders expects that all students maintain the highest level of academic integrity in every course, clinic, field experience, internship, culminating experience, and other professional settings. Academic integrity is based on the guiding values and principles that students will pursue scholarly and creative activities in an honest and responsible manner consistent with the SFSU Standards for Student Conduct.

Students who engage in academic dishonesty (e.g., cheating on exams or assignments, plagiarism, unauthorized collaboration) will receive an immediate penalty according to the instructor's grading policy. These incidents will then be reported to the Department Chairperson, Associate Dean of the Graduate College of Education, and ultimately referred to the Office of Student Conduct for further review to determine any additional sanctions.

For student obligations related to Academic dishonesty:
<http://conduct.sfsu.edu/academic-dishonesty>

For definition and examples of plagiarism: <http://conduct.sfsu.edu/plagiarism>




D. OBSERVATION OF RELIGIOUS HOLIDAYS

When religious holidays require students to be absent from class activities, the student needs to inform the instructor, in writing, during the first two weeks of the class each semester. The student will not be penalized, but it is his/her responsibility to make up the work missed.

CD Clinical Instructors Forum








Welcome to the SFSU CD Instructors' Forum!

In this site, you will find information to support you through the instruction and supervisory process. This site will also serve as a forum for us to share information, post questions, and exchange ideas.

- [News forum](#)
- [Click here to post messages for your fellow instructors in the CD program Forum](#)
-  [Clinician Handbook August 2016 File](#)
-  [Clinical Educator Handbook Fall 2016 File](#)
-  [Spring 2017 CD Program Calendar File](#)

Section 1

CD 884 and CD 880 Forms and Documents for Report Writing

-  [F-22 Final Assessment Report Template \(De-Identified for Students\) File](#)
-  [F-22 Final Assessment Report Template \(Identified for Clients\) File](#)
-  [F-24 Final Therapy Report Template \(De-Identified for Students\) File](#)
-  [F-24 Final Therapy Report \(Identified for Clients\) File](#)
-  [SC-03a - ITP Template for Assessment Sessions File](#)
-  [SC-03 ITP Template for Therapy Sessions File](#)
-  [F-21 SOAP Template File](#)
-  [Dx/Tx Report Guidelines File](#)
-  [Sample ITP File](#)

Section 2

Orientation: Weeks 1 and 2





In the first 2 weeks of the semester, instructors meet with their students prior to seeing clients. During this orientation period, clinic procedures and documents are reviewed with the students. Students are also assigned clients during this time and review their clients' files.

-  [A guide for reviewing client files](#)

Review grading procedures and criteria with your students during the first week. Students are graded according to the KASA criteria which is found below.

-  [KASA: for midterm and final grades File](#)



Below are some documents you may find useful for giving feedback to students throughout the semester.

-  [A form for providing descriptive feedback to students. File](#)
-  [A form for providing quantitative feedback \(child client\) File](#)
-  [A form for providing quantitative feedback \(adult client\) File](#)
-  [These are suggestions for students to make better use of feedback from clinical instructors. File](#)

Section 3

Clinic Opens: Weeks 3 and 4

During the third week of the semester, clients begin to attend clinic. Assessment sessions are typically conducted during weeks 3 and 4 which consist of administrations of standardized tools, collection of speech and language samples, and completion of dynamic assessment methodology. For those working with child clients, initial parent conferences are usually arranged during this time. For those working with adult clients, conferences are arranged with the client and spouse/caretaker during this time. Staff meetings will focus on the discussing initial clinical impressions of the client and his/her needs.

-  [Sample ITP File](#)
-  [Sample SOAP Note File](#)

Section 4

Therapy Planning: Weeks 5 and 6

During these two weeks, students analyze their assessment results and submit their Proposed Semester's Objectives, which consist of objectives for the semester and incremental steps to meet the objectives. Students must consider baseline skills, as well as how much progress is anticipated during the semester.

-  [SC-06 Proposed Semester Objectives File](#)

Section 5

Administrative: Weeks 7 and 8

1. Clinic instructors should schedule individual meetings with their students to evaluate their mid-term performance. The (K)nowledge (A)nd (S)kills (A)cquisition Short Form (see below) should be used for this purpose. The KASA form should be signed by both the clinic instructor and student clinician and submitted to the Clinic Director at the end of the semester.

2. On-campus student clinicians should meet with parents and caregivers (child clients), or with the client and spouse/caretaker (adult clients) to discuss assessment results and therapy objectives for the semester. These meetings should be held during the normally scheduled therapy time.

3. Learning Outcome Variables (LOV Notes) are due. You will receive LOV forms with instructions via e-mail.

4. Background sections of Final Therapy Reports are due to the clinic instructor for review and editing.

-  [KASA: for midterm and final grades File](#)

Section 6

Preparation of Final Therapy Reports: Weeks 9 and 10

De-identified Final Therapy Reports are due to the Office Manager at the end of week 14 of the semester.

Section 7





Weeks 11 through 13

Students should continue developing Final Therapy Reports and schedule final meetings of the semester with caregivers to discuss progress and recommendations.

REMINDERS:

1. Client Recommendation Forms (F-25) and Client Availability Forms for the next semester are due to the Office Manager at the end of week 14.



2. New record release forms, completed test protocols, and signed SOAP notes should be placed in the client file at the end of week 15.

-  [F-25 Client Recommendation Form File](#)
-  [Summer 2017 Adult General Client Availability Form File](#)
-  [Summer 2017 Adult Neuro Client Availability Form File](#)
-  [Summer 2017 Child Client Availability Form File](#)

Section 8

For instructors of CD 715 (Student teaching practicum) & CD 881/882 (Off-campus Medical Internship)

If you are supervising student teachers or medical interns, please distribute this form to your students. They use this form to evaluate the quality of their student teaching or imedical nternship experience. Instruct them to return the form to Dr. Epstein for CD 715 or Dr. Robinson for CD 881/882 (summer and fall semester) or Dr. Graham for CD 881/882 (spring semester) during clinic evaluation week toward the end of the semester.

-  [off-campus supervisors' evaluation File](#)
-  [off-campus supervisor's evaluation File](#)

Section 9

End of Semester Wrap-Up: Weeks 14 and 15

IMPORTANT DATES






1. MAY 5th: Last day of clinic
2. MAY 8th to MAY 12th: Clinic Evaluation Week; schedule make-up sessions

DOCUMENTS! DOCUMENTS! DOCUMENTS!

1. MAY 5th to OFFICE MANAGER: a) Client Recommendation Forms, and b) Summer 2017 2017 Client Availability Forms
2. MAY 5th to CLIENT FILE: a) Record releases, b) test protocols, c) signed/initialed SOAP SOAP notes, d) de-identified Final Therapy Reports
3. MAY 12th to CLINIC DIRECTOR: a) Final signed KASA forms, b) CD 711 and CD 713 713 grades for reporting by designated full-time faculty (fall and spring only), c) Clinic Clock Clock Hours form (SC-10)
4. MAY 12th to OFFICE MANAGER: Identified Final Therapy Reports

NOTE: Separate SC-10 must be submitted for each disorder (Speech-Lang-Hearing)

-  [F-25 Client Recommendation Form File](#)

-  [SC-10 Clinical Clock Hours Form File](#)
-  [SC-10 Clinical Clock Hours Form File](#)
-  [SC 10.5 Record of Observation Hours File](#)
-  [Campus Solutions Submitting Grades File](#)
-  [Campus Solutions Submitting Grade Exceptions](#)

Materials Room Inventory 2013**Assessments**

Item	Quantity
ABA-2	1
ABCD	1
ABI Cognitive-Linguistic Assessment	1
ABS (Adaptive Behavior Scale)	1
ADD (Aphasia Discrimination In Depth)	1
ADP (Aphasia Dx Profile)	1
APAT	1
Aphasia Language Performance Scales	1
Auditory Processing Abilities Test	1
Austin Spanish Articulation Test	1
BASA (Boston Assessment of Severe Aphasia)	1
The Basic Concept Inventory	1
BDAE (#2, #3)	2
BLT-2 (Bankson Language Test)	2
Boehm-3	1
Boehm-3 Preschool	1
Boston Naming Test	1
Bracken Third Edition	1
BTHI	1
CAAP	2
CADL-2	2
CAML (Coarticulation Assessment in Meaningful Language)	1
CASL	2
CCC-2 (Children's Communication Checklist-2)	1
CELF-2 Preschool	3
CELF-2 Preschool Spanish	1
CELF-4	4
CELF-4 Screener	2
CELF-4 Spanish	1
Contextual Test of Articulation	1
CPAC-S (Contextual Probes of Articulation Competence)	1
CREVT (Comprehensive Receptive & Expressive Vocabulary Test)	1
CRIL Morphology	1
CRIL Pragmatics	1
CRIL Professionals Guide	1
CRIL Semantics	1
CRIL Syntax	1
CSBS (Communicative & Symbolic Behavior Scales)	3
CTOPP2	1
DELV (Diagnostic Evaluation of Language Variation)	2

Developmental Guidelines + Test for Apraxia of Speech and Oral Apraxia: Children's Battery	1
Developmental Indicators for the Assessment of Learning	1
Developmental Test of Visual Perception	1
DTLA-4 (Detroit Test of Learning Aptitude)	1
EOWPVT-4	2
EOWPVT-4 SBE	1
EVT 2 Form A	2
EVT 2 Form B	2
Examining for Aphasia	1
Fisher-Logeman Test of Articulation Competence	1
Fluharty	6
Frenchay Dysarthria Assessment	1
GAEL-C (Grammatical Analysis of Elicited Language-Complex Sentence Level)	1
GAEL-P (Grammatical Analysis of Elicited Language-PreSentence Level)	2
GFTA-2 (Goldman Fristoe 2 Test of Articulation)	5
Goldman-Fristoe-Woodcock Auditory Skills Test Battery	1
GORT 5	1
Guide to Analysis of Language Transcripts	1
HAPP-3	2
KLPA	2
KSPT	1
LAC3	1
LARK	1
LAT (LinguiSystems Articulation Test)	1
Let's Be Social-Language Based Social Skills-Preschool	1
Let's Talk Inventory for Children	1
Listening Comprehension Test 2	1
Listening Test (Age 6-11)	2
LPT Revised (Language Processing Test)	2
LSAT	2
MCDI-II (MacArthur-Bates Communicative Development Inventories)	1
MacArthur Communicative Development Inventory: Level III	1
MacArthur Communicative Development Inventories: User's Guide & Technical Manual	1
McDonald Deep	2
MIRBI (Mini Inventory of Right Brain Injury)	1
MRT-6	1
MTDDA (Minnesota Test of Different Diagnosis of Aphasia)	1
NSST (Northwestern Syntax Screening Test)	1
OASES	1
OWLS-II	1
PAT-3 (Photo Articulation Test)	2
PAT 2 (Phonological Awareness Test)	2
Phonological Awareness Test (Hear Builder)	1

PICA	1
PLS-5	4
PLS-5 Manipulative Kits (One in Spanish)	5
PLS-5 Spanish	1
PPVT-4 Form A	2
PPVT-4 Form B	2
Predictive Reading Profile	1
Qualitative Reading Inventory-3	1
RCBA-2	1
Reel 3 (Receptive-Expressive Emergent Language Test)	1
RICE	2
Right Hemisphere Language Battery	1
RITLS (Rhode Island Test of Language Structures)	4
Rivermead Behavioral Memory Test	1
ROWPVT-4	2
ROWPVT-4 Spanish	1
SCATBI	1
Slingerland Scening Tests for Identifying Children with Specific Language Disability FORM A, B, C	1
Slingerland Scening Tests for Identifying Children with Specific Language Disability FORM A	1
Slingerland Scening Tests for Identifying Children with Specific Language Disability FORM B (Revised)	1
Slingerland Scening Tests for Identifying Children with Specific Language Disability FORM C	1
Slingerland Scening Tests for Identifying Children with Specific Language Disability FORM D	1
SNAP (Strong Narrative Assessment Procedure)	1
Social Langugae Development Test (Elementary)	2
Social Langugae Development Test (Adolescent)	1
SPAT-D II	2
SPELT-P 2	1
SPELT-3	1
SPI (Stuttering Prediction Instrument)	1
Spanish Language Assessment Procedues	1
SSI-4 Stitteromg Severity Instrument	
(STAMP) Spanish Test for Assessing Morphological Prod.	1
The Stocker Probe Technique	1
The Story Grammar Marker	1
TAAS (Test of Auditory Analysis Skills)	1
TACL-3	1
TALS (Test of Awareness of Language Segments)	5
TAPS-3	2
TAPS-3: SBE	1
TARPS (Test of Auditory Reasoning & Processing)	1
TAWF (Test of Adolescent/Adult Word Finding)	1

TELD-3	1
The Templin-Darley Tests of Articulation	1
TLC-E (Test of Language Competency)	3
TOAL-4	2
TOLD-4	1
Token Test for Children	4
TOMAS (Test of Morpheme Acquisition in Spanish)	1
TOPL (Test of Pragmatic Language)	1
TOPS (Test of Problem Solving)	2
TOPS (Test of Problem Solving-Elementary)	1
TOSS-P (Test of Semantic Skills-Primary)	2
TOSS-I (Test of Semantic Skills-Intermediate)	1
TOWK (Test of Word Knowledge)	2
TOWL-4 (Test of Written Language)	1
TPAS (Test of Phonological Awareness in Spanish)	3
TSA (Test of Syntactic Abilities)	1
TWF-II (Test of Word Finding)	1
TWS (Test of Written Spelling)	1
Upper Extension EOWPVT	1
UTLD (Utah Test of Language Development)	1
WAB-R (Western Aphasia Battery)	2
WABC (Wiig Assessment of Basic Concepts)	4
Weiss Comprehensive Articulation Test	1
Wepman Auditory Discrimination Test	1
WIAT	2
Word Test-2 Adolescent	1
Word Test-2 Elementary	1
WRAML (Wide Range Assessment of Memory and Learning)	1
WRAT	1
WRMT-III A&B	1

Cards

Item	Quantity
Adjectives Fun Deck	1
Articulation S	1
Analogies Fun Deck	3
Auditory Memory for Short Stories	2
Association Cards	1
Auditory Closure Fun Deck	2

Auditory Memory for Rhyming Words Fun Deck	1
Auditory Rhyme Time Fun Deck	2
Articulation & Phonology	1
Action-Agent Fun Deck	1
Basic Sorting	2
Basic Concepts in Motion	1
Before & After Fun Deck	1
Busy Babies Describing Cards	2
Contractions Fun Deck	1
Changing Statements to Questions	1
Changing Verbs to Nouns	2
Changing Nouns to Adjectives	1
Conditional Following Directions	1
Compound Words	2
Cause and Effect	1
Compare & Contrast Fun Deck	1
Classifying Fun Deck	2
Classifying with Seasons	1
Comparatives Fun Decks	1
Conjunctions	1
Can Do Oral-Motor	1
Do and Does Fun Deck	1
Function Match-Ups	2
Focus on Manners	2
Fact or Opinion?	1
Following Directions Fun Deck	1
How? Fun Deck	2
Homonyms Fun Deck	1
Homonyms Photo Fun Deck	1
Has & Have Fun Deck	2
Happy Face Verbs Fun Deck	1
If... Then...	1
Irregular Plurals	2
Is & Are Fun Deck	1
Idioms Fun Deck	1
Imagination Questions Fun Deck	1
Let's Name Things Fun Deck	1
Listening for Absurdities	2
Let's Predict Fun Deck	1
Multiple Meanings	1
My, Mine, Me	1
Mini-Mysteries	1
Metaphors and Similes	1

Name That Category	1
Name That Around The Home	1
Name That Animal Category!	1
Opposities	1
Practicing Pragmatics	1
Plurals	1
Photo Feelings	1
Part of Whole	1
Phonemic Awareness	2
Pis & Pals Preposition Fun!	1
Present Progressive Verbs	1
Possessives Fun Deck	1
Regular Past Tense Verb	2
Syllable Drilling	2
Saw & Seen Fun Deck	1
States & Abbreviations	1
Sentence and Fragments	1
Synonyms Photo	1
Synonyms	1
Subjects & Predicates	1
Shadow Match-Ups	1
Story Starters Fun Deck	1
Serial Recall	1
Snooky Snail Goes to Work Fluency Cards	1
Story Retell	1
Sentence Building	1
Things That Go Together	1
That's Silly!	2
Tell Me How! Tell Me Why!	1
Understanding Double Negatives	1
Using Proper and Common Nouns	1
Understanding Inferences	2
Using His, Her, & Their	1
Using "I and Me"	1
Understanding Negation	1
Voice Adventures	2
"What?" Question and Answer Cards	2
"When?" Questions and Answer Cards	2
"Where?" Questions and Answer Cards	2
"Who?" Questions and Answer Cards	2
"Why?" Questions and Answer Cards	2
Was & Were Fun Deck	2
What Are They Asking?	2

Which Is?	2
What's Missing?	2
Webber Photo Cards Things To Wear	2
Webber Phot Cards Food	2
Webber Photo Cards Everyday Go-Togethers	2
Webber Photo Cards Animals	2
Webber Photo Cards What Doesn't Belong	1
Webber Photo Cards Occupations	1
Webber Photo Cards Around the Home	1
Webber Photo Cards Sports Go-Togethers	1
Webber Photo Cards Verbs	3
What Doesn't Belong?	1
We and Us	1
"WH" Questions At Home	1
"WH" Questions At School	1
What Would You Do In The Community If...	1
What Would You Do At Home If...	1
What's Wacky?	1
What's Different?	1
"What's Being Said?"	1
Who Needs This?	1
What Makes Sense?	1
Webber Phonological Awareness Photo Cards Discrimination of Rhyming Words	1
Yes or No?	1

Artic Cards

Item	Quantity
Mirror Practice Set I	1
Mirror Practice Set II	1
Photo Articulation Library Set I	2
Photo Articulation Library Set II	2
Photo Articulation Library Set III	2
Random Cards (Large Ziplock bag, cards individually packed)	1
Vocalic R Shuffle Playing Cards	1
Webber Articulation Cards Set I	2
Webber Articulation Cards Set II	2
Webber Articulation Cards Set III	2
Webber Articulation Cards Set 3	1
Webber Classifying Cards	1
Webber Photo Cards Emotion	1
Webber Photo Cards Social Issues	1

Webber Verbs and More! Cards	1
Webber Vocalic R	1

Artic Cards Individual Set

Item	Quantity
Artic Photos Fun Deck "B" Initial, Medial, Final	1
Artic Photos Fun Deck "CH" Initial, Medial, Final	2
Say and Do Action Artic Cards "CH" Sound	2
Artic Photos Fun Deck "F" Initial, Medial, Final	2
Say and Do Action Artic Cards "F" Sound	1
Artic Photos Fun Deck "G" Initial, Medial, Final	1
Say and Do Action Artic Cards "G" Sound	2
Artic Photos Fun Deck "J" Initial, Medial, Final	2
Say and Do Action Artic Cards "K" Sound	2
Artic Photos Fun Deck "L" Blends	1
Artic Photos Fun Deck "L" Initial, Medial, Final	2
Say and Do Action Artic Cards "L" Sound	1
Artic Photos Fun Deck "M" Initial, Medial, Final	2
Artic Photos Fun Deck "P" Initial, Medial, Final	2
Say and Do Action Artic Cards "P" Sound	2
Artic Photos Fun Deck "R" Blends	1
Artic Photos Fun Deck "R" Initial, Medial, Final	2
Artic Photos Fun Deck "S" Initial, Medial, Final	1
Say and Do Action Artic Cards "S" Sound	1
Artic Photos Fun Deck "SH" Initial, Medial, Final	2
Say and Do Action Artic Cards "SH" Sound	2
Artic Photos Fun Deck "T" Initial, Medial, Final	1
Artic Photos Fun Deck "TH" Initial, Medial, Final	2
Say and Do Action Artic Cards "TH" Sound	2
Webber Articulation Cards "TH" Sound	1
Artic Photo Cards Fun Deck "V" Initial, Medial, Final	1
Artic Photos Fun Deck "Z" Initial, Medial, Final	2

Artic Books/Flip Books/Fish & Say

Item	Quantity
Absolutely R-Tic	1
Artic Calendar Capers	1
Artic Chipper Chat	1
Artic Curriculum I & II	1

Artic Lab	1
Artic and Language Activites	1
Artic Pix	1
Artic Quickies, CH	1
Artic Quickies, F	1
Artic Quickies, G	1
Artic Quickies, K	1
Artic Quickies, L	1
Artic Quickies, L Blends	1
Artic Quickies, R	1
Artic Quickies, R Blends	1
Artic Quickies, Vocalic R	1
Artic Quickies, S	1
Artic Quickies, SH	1
Artic Quickies, TH	1
Artic Riddle Races	1
Artic To Go	1
Articulation Dominoes	1
Articulation Stories for Younger Students	1
Articulation Worksheets	1
Awesome Artic Sound Loaded CH, SH, TH Artic Activites Worksheet	1
Awesome Artic Sound Loaded L Artic Activities Worksheet	1
Awesome Artic Sound Loaded S Artic Activies Worksheet	1
Basic Skills Card	1
The Big Book of S-Clusters	2
Bubble Pop Game Sheets	1
Chippy Plays With Cars	1
CrossChat Reproductive Articulation Puzzles	1
Dot to Dot and Color by Number Artic Worksheets	1
Early Articulation Roundup!	1
Early Developing Sounds	1
Easy Does It for Articulation	1
The Entire World of R Curriculum Book (with cards)	1
The Entire World of R Instructional Workbook	1
"Fish & Say" CH	1
"Fish & Say" D	1
"Fish & Say" F	1
"Fish & Say" L	1
"Fish & Say" Opposites	1
"Fish & Say" R	1
"Fish & Say" Rhyming Time	1
"Fish & Say" S	1
"Fish & Say" SH	1

"Fish & Say" S, R, L Blends	1
"Fish & Say" TH	1
"Fish & Say" Verbs	2
Fold and Say Artic Stories	1
Games To Go	1
Here's How to Handle /L/	1
Here's How to Handle /R/	1
Here's How to Handle /S/	1
The L Book	1
Pic-A-Drill S	1
Pic-A-Drill R	1
Rhyming Riddles for Artic	1
"Say and Do" Artic Game Boards for S, R, & L Blends	2
"Say and Do" G Worksheets	1
"Say and Do" R Worksheets	1
"Say and Do" S Worksheets	1
Say & Glue for Language & Listening Fun Sheets	1
Say and Sing Musical Words and Songs for S, R, L and Blends	1
See It! Say It! Artic Reps	1
Sound Connections for S and Z	1
Speech Steps Reproductive Drills for Artic and Language	1
Special & Holiday Open-Ended Artic Worksheets	1
Spotlight on Articulation K/G	1
Sound-Loaded Scenes for Articulation	1
Sound Reading	1
Webber Artic Fun Sheets	1
Webber Artic Fun Sheets 2	1
Webber Artic Fun Sheets 3	1
Webber's Jumbo Articulation Drill Book (#2 is missing)	2
Webber Jumbo Artic Drill Book Add-on Volume 3	2
What's Different?	2
Year-Round Literature for Language and Artic	1

Grammar/Syntax

Item	Quantity
100% Grammar	1
Apple Tree	1
Apple Tree Pre-Post Test Booklet	1
Apple Tree 1 Student Workbook	1
Apple Tree 2 Student Workbook	1

Apple Tree 3 Student Workbook	1
Apple Tree 4 Student Workbook	1
Apple Tree 5 Student Workbook	1
Apple Tree 6 Student Workbook	1
Fun Deck & Do Grammar, Reasoning, and Semantics	2
Fun Deck & More Grammar, Reasoning, and Semantics	1
Fun Deck & Say Grammar, Reasoning, and Semantics	1
Grammar Games	1
Grammar Tickle Stories	1
HandTalkers for Grammar (Book form, Binder form)	2
Help for Grammar	1
Just for Me! Grammar	1
No Glamour-Grammar	1
Spotlight on Grammar Nouns	1
Teaching Morphology Development (Box)	1
TSA Syntax Program Pronominalization 1: Nominative & Objective Pronouns (Green)	1
TSA Syntax Program Pronominalization 2: Possessive Adjectives (Green)	1
TSA Syntax Program Pronominalization 3: Reflexive Pronouns (Green)	1
TSA Syntax Program Verb Processes 1: Verb Sequences in Conjoined Structures (Tan)	1
TSA Syntax Program Verb Processes 3: The Passive Voice (Tan)	1
TSA Syntax Program Relativization 2: Relative Pronouns & Adverbs (Blue)	1
TSA Syntax Program Relativization 3: Embedding (Blue)	1
TSA Syntax Program Question Formation: Answer Environments (Orange)	1
TSA Syntax Program Question Formation: Wh-Words (Orange)	1
TSA Syntax Program Complementation 1: Infinitives and Gerunds (Orange)	1
TSA Syntax Program Negation (Pink)	1
TSA Syntax Program Determiners (Magenta)	1
Yesterday's Verbs Regular & Irregular Past Tense	2

Accent Modification

Item	Quantity
MEEC Mastering Effective English Communication Intonation Patterns of American English	1
MEEC Mastering Effective English Communication Vowel System of American English	1
MEEC Mastering Effective English Communication CD Series	1
MIAE CD Series Mastering Idioms of American English Vol. I Front Vowels	1
POEC Test Plates/Manual CD/MIAE CDs	1
Quick Take Along Mini Books	1

Pragmatics

Item	Quantity
Early Developmental Milestones	1
Early Language Development	1
Fold and Say Social Skills	1
Go-To Guide for Social Skills	1
HearBuilder Following Directions Professional Edition	1
Room 28 A Social Language Program	1
Say and Do Early Social Scenes for School	1
Say and Do Positive Pragmatic Game Boards	1
Say and Do Positive Pragmatic Game Boards Fun Sheet	1
Say and Do Social Scenes for Home, School, and Community	1
Scripting Junior Social Skills Role-Play Elementary	1
Simply Social at School	1
Social Language Development Scenes Adolescent	1
Social Skills Chipper Chat (Red Box)	1
That's Life Social Language	1

Sequencing

Item	Quantity
DotBot Sequencing Activities	1
Draw Me a Story	1
Fairytale Sequencing	1
Functional Sequencing Activity Sheets for Daily Living Skills	2
HearBuilder Sequencing Professional Edition	2
Sequencing Cut and Paste Activities	1
Sequences Galore Pictorials Activities to teach 2, 3, and 4 step sequencing	4
Sequencing Pictures	1
Sequencing Simple Stories How to Give your Dog a Bath	1
Short Story Sequencing	1
Spotlight On Listening Comprehension Sequencing	1
Twisted Tommy	1

Phonology

Item	Quantity
Basic Concept & Vocabulary Round-Up	2
Bombardment Bonanza!	1
Early Phonological Awareness Stories Tully Turtle	1

Funnel Toward Phonics	1
The Giant Book of Phonology	2
Go-To Guide for Phonological Awareness	1
HandTalkers for Word Meaning	1
Have You Ever? Interactive Books for Phonology (8 pack)	1
HearBuilder Phonological Awareness Professional Awareness	1
Minimal Contrast Stories with Activities	1
Muddy Buddies An Interactive Reading-Rhyming Book	1
No-Glamour Reading Syllables	1
Phonemics Awareness in Young Children	1
Phono Friends Stories and Activities	1
Phonological Awareness Chipper Chat (Green Box)	1
Phonology Fold, Say & Do Stories and Activities	1
Phonology Terapy Activities #3-10	1
Say and Do Phonemic Awareness Stories & Activities	2
Say and Do Phonology Game Boards for Speech & Language	1
Say & Glue Phonology & Artic Fun Sheets	1
Sounds Abound Listening, Rhyming, and Reading	2
The Source for Phonological Awareness	1
Tall Paul An Interactive Reading-Rhyming Book	1
Tic-Tac-Read & Match Book 1	1
Tic-Tac-Read & Match Book 2	1
Webber Phonology Cards	1
Webber Photo Phonology	1
Webber Photo Phonology Minimal Pair Cards Fun Sheets	1

Aphasia

Item	Quantity
Aphasia Therapy Efficacy Studies	1
Clinician Controlled Auditory Stimulation or Aphasic Adults	1
Cognitive Reorganization A Stimulus Handbook 3rd Edition	1
Discripto-Cards for Adult Aphasia	1
Discripto-Cards for Aphasia	1
Discripto-Cards for Functional Language and Cognition	1
Functional Therapy Guide: More than a Workbook	1
Just for Adults Yes/No Questions	1
Language Rehabilitation Verbal Expression	1
The Long-Term Care Companion Communication Goals & Activities for Adults	2
PRK Photo Resource Kit Nouns	1
PRK Photo Resource Kit Prepositions	1
PRK Photo Resource Kit Verbs	1

Photo Packs for Aphasia (6)	1
Reminiscence Calendar & Activites	1
Reminiscence Cards and Activites	1
The Source for Apraxia Therapy	2
The Source for Dysarthria	2
The Source for Development of Executive Functions	1
The Source for Executive Function Disorders	1
TopiCards for Adults	1
Workbook for Reasoning Skills Exercises for Cognitive Facilitation	1

Autism

Item	Quantity
Augumentative and Alternative Communication: Assessment and Intervention Strategies	1
Autism A Guide for Educators, Clinicans, and Parents	1
Autism & PPD Adolescent Social Skills Lessons Interacting	1
Autism & PPD Basic Reading Comprehension Kit	1
Autism & PPD Concept Development Animals	1
Autism & PPD Intermediate Social Skills Lessons	2
Autism & PPD More Picture Stories & Langugae Activites What Questions	1
Autism & PPD Photo Cards Wh-Questions	1
Autism & PPD Social Skills Lessons Behavior	1
Autism & PPD Social Skills Lessons Community	1
Autism & PPD Social Skills Lessons Home	1
Autism & PPD Social Skills Lessons School	3
Autism in Adolescents & Adults	1
Langugae Lab (Box)	1
The Scerts Model Volume I: Assessment *Missing 5, 8	8
The Scerts Model Volume II: Program Planning & Intervention *Missing 5, 7	8
Webber Big Nouns Photo Cards	1

Language General

Item	Quantity
100% Language Intermediate	1
100% Langugae Primary	1
Chipper Chat Open-Ended Game Boards	1
Descripto Bingo	1

Guide to Communication Milestones	2
Guide to Counseling for SLPs	1
Guide to Evidence-Based Practice	1
Guide to RTI Response to Intervention	1
Gray's Anatomy for Students Flash Cards	1
Help Vol. I Auditory Discrimination/Reception/Association/Memory	1
Help Vol. II Specific Word Finding, Categorization, Wh-Questions, Grammar *#1 Missing	1
Help 1 Auditory Discrimination Question Comprehension Association Auditory Memory	2
Help 2 Specific Word Finding Categorization Wh-Questions Grammar	2
Help 3 Concepts Paraphrasing Critical Thinking Social Language	2
Help 4 Defining and Describing Written Language Talking about Language Word Play and Humor	2
Help 5 Processing Information Comparing and Contrasting Math Language Self-Expression	1
Mad Libs for President (2 Books)	1
No-Glamour Language & Reasoning	2
No-Glamour Sentence Structure	1
Primary Think Spots	1
Search & Find Picture Puzzle Books	2
Sharpening Counseling Skills	1
Social Language Training	1
Sparc for Attributes	1

Child Apraxia

Item	Quantity
Early Apraxia of Speech Stories Places	1
Early Apraxia of Speech Stories Words With Equal Emphasis	1
Easy Does It for Apraxia-Preschool Materials Book	1
Easy Does It for Apraxia-Preschool Terapy Manual	1

Language School Age

Item	Quantity
101 Language Activities	1
Auditory Adventures Activity Pack (Orange Box)	2
Figurative Language Card Games	1
Help for Middle School	1
Interactive Concept Pictures	1

Make-n-Takes 8 Great Storybooks for Sound & Language Play	1
More Make-n-Takes 8 Great Storybooks for Sound & Language Play	1
The Listening Test	1
Say and Do Language Unit Worksheets Vol. I	1
Say and Do Language Unit Worksheets Vol. II	1
"What's Wrong With This Picture?" Scenes	2

Vocabulary

Item	Quantity
100% Vocabulary	1
Adolescent Functional Vocabulary for Activities of Daily Living Gregory Goes to the Mall	1
Basic Vocabulary	1
Can You Listen With Your Eyes?	1
Early Vocabulary	1
Getting a Fix on Vocabulary	1
Hidden Pictures for Vocabulary Development	1
Key Concepts for Grades 4-6	1
Key Concepts for Grades 7-8	1
My Learning Library	1
No-Glamour Idioms	1
No-Glamour Vocabulary Cards	1
SeaMantics Thinking Activities for Semantic Development	1
Sequence Plus Sequence Pictures with Vocabulary	1
Scissors, Glue, and Vocabulary, Too!	1
Social Stories Learning Centers	1
Spotlight on Vocabulary Associations Level 2	1
Spotlight on Vocabulary Concepts	2
Spotlight on Vocabulary Categories	1
Story Comprehension To Go	1
Vanilla Vocabulary	1
Vanilla Vocabulary featuring Gunny and Ivan A Visualized/Verbalized Vocabulary Book Level II	1
Vocab-U-Themes Basic Vocabulary Pictures with Language Activities	2
Vocabulary & Syntax Roundup!	1
Vocabulary Building with Antonyms, Synonyms, Homophones, and Homographs	1
Vocabulary Stories for Toddlers In the Kitchen	1
Word Feats Elementary Heaping Helpings of Hearty Vocabulary	1
Word of the Day	1

"WH"

Item	Quantity
Answering Questions	1
Ask & Answer "WH" Fun Sheets	1
Fold & Say" WH" Question Scenes	1
"WH" Chipper Chat	1
WH Programs (Binder)	1
WH-Questions Intermediate Level and Advanced Level	1

Basic Concepts

Item	Quantity
Basic Concept Stories!	1
Basic Concept Workbook	1
Webber Basic Concepts (blue)	2
WFIP 2 Word-Finding Intervention Program 2nd Edition	1
Who? What? When? Where? Why? Interference Questions Cards on Rings (5 Sets)	1

Language

Item	Quantity
CLIP Cognitive-Linguistic Improvement Program	2
Pack of Photos (Clear Plastic)	1
SR-Cognition	1
Visualizing and Verbalizing	1
Walc 1 Workbook of Activities for Language and Cognition	1
Walc 2 Workbook for Activities for Language and Cognition	1
Walc 3 Workbook of Activities for Language and Cognition	1
Walc 5 Workbook of Activities for Language and Cognition	1

Auditory Processing

Item	Quantity
Auditory Memory for Quick Stories	1
Auditory Processing Chipper Chat	1
Building Auditory Direction Skills	1
Central Auditory Processing Therapy	1
HearBuilder Auditory Memory Professional Edition	1
Hearing Conservation	1

Langugae Rehabilitation Auditory Comprehension	1
Leap Into Listening!	1
The Linamood	1
Say and Do Auditory Lessons	

Stuttering Therapy

Item	Quantity
50 Great Activities for Children who Stutter	1
Easy Does It for Fluency Intermediate	2
Easy Does It for Fluency Preschool/Primary	2
Fluency DAF Kit	1
Fluency Flips	1
Generating Fluent Speech	1
Snooky the Snail's Preschool Fluency Worksheets	1
Snooky Snail's Fluency Game Boards	1
The Source for Stuttering and Cluttering	1
Systematic Fluency Training or Young Children 3rd Edition	1
Working with People who Stutter A Lifespan Approach	1

Oral Motor

Item	Quantity
Can-Do Oral-Motor Fun and Games	1
Can-Do Oral-Motor Game Boards	2
LEPS Language Evoking Photographic Stories	1
Oral-Motor Activities for School-Aged Children	1
Oral-Motor Activities for Young Children	1
Oral-Motor in Articulation Therapy	1
The Source for Oral-Facial Exercises	1
The Source for Dysarthria	2
Whistle Pop Kisses & Lollipop Wishes	4

Reading

Item	Quantity
ADLR Auditory Discrimination and Lip Reading Skills Inventory	1

Get Ready for the Code A	1
Explore the Code 1	2
Explore the Code 2	2
Explore the Code 3	2
Explore the Code 4	1
Explore the Code 5	1
Explore the Code 6	1
Beyond the Code 1	1
Beyond the Code 3	1
Drawing Conclusions (Box of Cards)	1
Finding Cause and Effect (Box of Cards)	1
Finding the Sequence (Box of Cards)	1
Making Inferences (Box of Cards)	1
Using Context Clues	1
HearBuilder Story Retell Test	1
No-Glamour Reading Comprehension	1
The Source for Learning & Memory Strategies	1
Spotlight on Reading Comprehension Comparing and Contrasting	1
Spotlight on Reading Comprehension Figurative Language and Exclusion	1
Spotlight on Reading & Listening Comprehension Level 2 Making Inferences & Drawing Conclusions	1
Spotlight on Reading & Listening Comprehension Level 2 Fact & Opinion	1

Writing Stories

Item	Quantity
125 Ways to be a Better Writer	1
The Behavior Disorder IEP Companion	1
I Think! I can!	1
Webber Story Builder Bookmark (large size, small size)	2
What's Your Story?	1
Working Out with Writing	1
The Writing Lab Approach to Language Instruction and Intervention	1

Voice

Item	Quantity
Boone Voice Program for Children Kit	3
The Sound of Your Voice (Tapes)	1

Awards & Reinforcers

Item	Quantity
Assessment in Speech-Language Pathology	2
Language Sampling, Analysis, and Training	1
Reinforcers To Go	1
Speech and Language Diploma	1
Webber Awards & Certificates for Speech-Language Pathologists	1

Games

Item	Quantity
3-scene Sequencing Cards	1
4-scene Sequencing Cards	2
6-scene Sequencing Cards	1
10 Quick Play Folder Games	1
100 Irregular Verbs in Sentences	1
Ask and Answer Curious Kids	2
Ask & Answer Social Skills Games	1
Brain Quest Fruit Dominoes	1
Card Games for Little Kids	1
The Classification Game	1
Classifying Picture Cards	1
Color Cards Sequencing Cause & Effect	2
Color Cards Sequencing Social Situations	1
Color Cards Prepositions	1
Color Cards Verbs	1
Color Cards What's Wrong?	1
Creative Games for Learning	1
Developmental Stage Organizer	1
The Entire World of Celebrations of Seasons Sequence Cards	1
Flamingo Bingo and Lotto! The Fun Game of Position Words	1
From Rags to Riches The Fun Idioms Game	1
Giant Game Pawns	1
Go for the Dough The Game of Word Meanings and More!	1
Gram's Cracker A Grammar Game	1
Grammar Gumballs	1
Granny's Candies The Delicious Game of Word Meanings!	1
Granny's Candies Vocabulary and Figurative Language Cards and Activity Book	1

Homonyms for Me 1-2-3	1
Hopping Frogs (#2)	1
I Spy a Mouse in the House Picture Rhymes	1
Jeppers Peppers The "Ask and Answer" Question Game	1
Kaufman Speech Praxis Treatment Kit for Children	1
Learning Games	1
Look Who's Listening!	1
MagneTalk Match-Up Adventure Kit	2
Merry-Go-Sound S, CH, R, SH, L, TH	1
The Mighty Mouth Game	1
Opposites Picture Cards	1
Oral-Motor Alien Fun	1
Original Memory Game	1
Patterning Match-Ups	1
Phonological Awareness Fun Park Game with Electric Spinner	1
Primer Words Know with Progress Test Sheets Flash Cards	1
Problem-Solving Picture Cards Daily Living Situations for Adults with Disabilities	1
Quick Wit ...the uncommon game of common sense	1
Roll n' Talk An Open-Ended Dice Game	1
Rhymng Picture Cards	1
Say and Do Artic Bingo "K" Sound	1
Say and Do Artic Bingo "L" Sound	1
Say and Do Artic Bingo "R" Sound	1
Say and Do Artic Bingo "S" Sound	1
Say and Do Artic Bingo "S, R, L" Blends	1
Say and Do Artic Bingo "SH & CH" Sound	1
Say and Do Artic Bingo "TH" Sound	1
See it, Say it Sound Production	1
Social Sequences	1
Step by Step A Sequencing Game	1
Synonyms Bingo	1
Talk and Toss Magnetic Die	1
Tense Sequencing	1
Token Tower	1
Topple	1
Turtle Talk Fluency and Language Game	1
Verb Tenses	1
Vocab Bingo	1
Webber Functional Communication	1
Webber Functional Photo Cards Around the Facility	1
Webber Functional Photo Cards Assistive Devices	1
Webber Phonological Awareness Bingo	1
Webber Photo Lotto Around the Home and Food	1

Webber Photo Lotto Things to Wear and Animals	1
Webber Vocalic R Bingo	1
WH Bingo	2
WH Question Blast Off!	2
Whoosh! The Action Verb Game	1
Word Families with Silly Sentences Fun Deck	1
Write-on Wet Erase Holiday & Seasonal Gameboards for Speech & Language	1

Magnet Books/Large Story Books

Item	Quantity
Articulation/Language/Development Games From /b/ TO /z/ including /ch/, /sh/, and /th/	1
In the City A Giant Step Talkabout Book	1
In the Country A Giant Step Talkabout Book	1
Interactive Big Books Anterior/Posterior Contrasts	1
Interactive Big Books S Clusters	1
Interactive Sing-Along Big Book Cool Camping Fun	1
Interactive Sing-Along Big Book Little Bo Peep	1
Interactive Sing-Along Big Book This Old Man	1
MagneTalk Match-Up Fantasy Adventures	1
MRT6 (Metropolitan Readiness Test, 6th Edition) Story Comprehension Big Book	1
"Sort and Say" 4-Step Sequencing	1
"Sort and Say" Cluster Reduction Clowns	1
"Sort and Say" Early Action Words	1
"Sort and Say" Early Before and After	1
"Sort and Say" Early Classifying	1
"Sort and Say" Early Go-Togethers	1
"Sort and Say" Early Memory Matching	1
"Sort and Say" Early Opposites	1
"Sort and Say" Early Rhymes	1
"Sort and Say" "F" Sound	1
"Sort and Say" Final Consonant Deletion Dogs	1
"Sort and Say" First 100 Sight Words and Sentence Maker	1
"Sort and Say" Following Directions	1
"Sort and Say" Fronting Frogs	2
"Sort and Say" "L" Sound	1
"Sort and Say" Let's Find and Name Things	1
"Sort and Say" Magnetic Mealtime	1
"Sort and Say" Money	1
"Sort and Say" Move Your Body!	1
"Sort and Say" Positions	1

"Sort and Say" "S" Sound	1
"Sort and Say" Short and Long Vowels	1
"Sort and Say" Spanish Early Classifying	1
"Sort and Say" Stopping Starfish	1
"Sort and Say" Survival Sign	1
"Sort and Say" Telling Time	2
"Sort and Say" What?	1
"Sort and Say" What's Missing?	1
"Sort and Say" When?	1
"Sort and Say" Where?	1
"Sort and Say" Who?	1
"Sort and Say" Why?	1
What we do day by day	1



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Clinical Supervision in Speech-Language Pathology and Audiology

Committee on Supervision

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About This Document

The following position paper, developed by the Committee on Supervision, was adopted by the American Speech-Language-Hearing Association through its Legislative Council in November 1984 (LC 8-84). Members of the Committee included Elaine Brown-Grant, Patricia Casey, Bonnie Cleveland, Charles Diggs (ex officio), Richard Forcucci, Noel Matkin, George Purvis, Kathryn Smith, Peggy Williams (ex officio), Edward Wills, and Sandra Ulrich, Chair. Also contributing were the NSSLHA representatives Mary Kawell and Sheran Landis. The committee was under the guidance of Marianna Newton, Vice President for Professional and Governmental Affairs.

Contributions of members of the ASHA Committee on Supervision for the years 1976–1982 are acknowledged. Members of the 1978–1981 Subcommittee on Supervision (Noel Matkin, Chair) of the Council on Professional Standards in Speech-Language Pathology and Audiology are also acknowledged for their work from which the competencies presented herein were adapted.

Resolution

WHEREAS, the American Speech-Language-Hearing Association (ASHA) needs a clear position on clinical supervision, and

WHEREAS, the necessity for having such a position for use in student training and in professional, legal, and governmental contexts has been recognized, and

WHEREAS, the Committee on Supervision in Speech-Language Pathology and Audiology has been charged to recommend guidelines for the roles and responsibilities of supervisors in various settings (LC 14-74), and

WHEREAS, a position statement on clinical supervision now has been developed, disseminated for both select and widespread peer review, and revised; therefore

RESOLVED, that the American Speech-Language-Hearing Association adopts “Clinical Supervision in Speech-Language Pathology and Audiology” as the recognized position of the Association.

Introduction

Clinical supervision is a part of the earliest history of the American Speech-Language-Hearing Association (ASHA). It is an integral part of the initial training of speech-language pathologists and audiologists, as well as their continued professional development at all levels and in all work settings.

ASHA has recognized the importance of supervision by specifying certain aspects of supervision in its requirements for the Certificates of Clinical Competence (CCC) and the Clinical Fellowship Year (CFY) (ASHA, 1982). Further, supervisory requirements are specified by the Council on Professional Standards in its standards and guidelines for both educational and professional services programs (Educational Standards Board, ASHA, 1980; Professional Services Board, ASHA, 1983). State laws for licensing and school certification consistently include requirements for supervision of practicum experiences and initial work performance. In addition, other regulatory and accrediting bodies (e.g., Joint

Commission on Accreditation of Hospitals, Commission on Accreditation of Rehabilitation Facilities) require a mechanism for ongoing supervision throughout professional careers.

It is important to note that the term **clinical supervision**, as used in this document, refers to the tasks and skills of clinical teaching related to the interaction between a clinician and client. In its 1978 report, the Committee on Supervision in Speech-Language Pathology and Audiology differentiated between the two major roles of persons identified as supervisors: clinical teaching aspects and program management tasks. The Committee emphasized that although program management tasks relating to administration or coordination of programs may be a part of the person's job duties, the term **supervisor** referred to "individuals who engaged in clinical teaching through observation, conferences, review of records, and other procedures, and which is related to the interaction between a clinician and a client and the evaluation or management of communication skills" (Asha, 1978, p. 479). The Committee continues to recognize this distinction between tasks of administration or program management and those of clinical teaching, which is its central concern.

The importance of supervision to preparation of students and to assurance of quality clinical service has been assumed for some time. It is only recently, however, that the tasks of supervision have been well-defined, and that the special skills and competencies judged to be necessary for their effective application have been identified. This Position Paper addresses the following areas:

- tasks of supervision
- competencies for effective clinical supervision
- preparation of clinical supervisors

Tasks of Supervision

A central premise of supervision is that effective clinical teaching involves, in a fundamental way, the development of self-analysis, self-evaluation, and problem-solving skills on the part of the individual being supervised. The success of clinical teaching rests largely on the achievement of this goal. Further, the demonstration of quality clinical skills in supervisors is generally accepted as a prerequisite to supervision of students, as well as of those in the Clinical Fellowship Year or employed as certified speech-language pathologists or audiologists.

Outlined in this paper are 13 tasks basic to effective clinical teaching and constituting the distinct area of practice which comprises clinical supervision in communication disorders. The committee stresses that the level of preparation and experience of the supervisee, the particular work setting of the supervisor and supervisee, and client variables will influence the relative emphasis of each task in actual practice.

The tasks and their supporting competencies which follow are judged to have face validity as established by experts in the area of supervision, and by both select and widespread peer review. The committee recognizes the need for further validation and strongly encourages ongoing investigation. Until such time as more rigorous measures of validity are established, it will be particularly important for the tasks and competencies to be reviewed periodically through quality assurance procedures. Mechanisms such as Patient Care Audit and Child Services Review

**Competencies for
Effective Clinical
Supervision**

System appear to offer useful means for quality assurance in the supervisory tasks and competencies. Other procedures appropriate to specific work settings may also be selected.

The tasks of supervision discussed above follow:

1. establishing and maintaining an effective working relationship with the supervisee;
2. assisting the supervisee in developing clinical goals and objectives;
3. assisting the supervisee in developing and refining assessment skills;
4. assisting the supervisee in developing and refining clinical management skills;
5. demonstrating for and participating with the supervisee in the clinical process;
6. assisting the supervisee in observing and analyzing assessment and treatment sessions;
7. assisting the supervisee in the development and maintenance of clinical and supervisory records;
8. interacting with the supervisee in planning, executing, and analyzing supervisory conferences;
9. assisting the supervisee in evaluation of clinical performance;
10. assisting the supervisee in developing skills of verbal reporting, writing, and editing;
11. sharing information regarding ethical, legal, regulatory, and reimbursement aspects of professional practice;
12. modeling and facilitating professional conduct; and
13. demonstrating research skills in the clinical or supervisory processes.

Although the competencies are listed separately according to task, each competency may be needed to perform a number of supervisor tasks.

13.0 Task: Establishing and maintaining an effective working relationship with the supervisee.

Competencies required:

- 13.1 Ability to facilitate an understanding of the clinical and supervisory processes.
- 13.2 Ability to organize and provide information regarding the logical sequences of supervisory interaction, that is, joint setting of goals and objectives, data collection and analysis, evaluation.
- 13.3 Ability to interact from a contemporary perspective with the supervisee in both the clinical and supervisory process.
- 13.4 Ability to apply learning principles in the supervisory process.
- 13.5 Ability to apply skills of interpersonal communication in the supervisory process.
- 13.6 Ability to facilitate independent thinking and problem solving by the supervisee.
- 13.7 Ability to maintain a professional and supportive relationship that allows supervisor and supervisee growth.
- 13.8 Ability to interact with the supervisee objectively.
- 13.9 Ability to establish joint communications regarding expectations and responsibilities in the clinical and supervisory processes.
- 13.10 Ability to evaluate, with the supervisee, the effectiveness of the ongoing supervisory relationship.

2.0 Task: Assisting the
supervisee in developing clinical
goals and objectives.

Competencies required:

- 2.1 Ability to assist the supervisee in planning effective client goals and objectives.
 - 2.2 Ability to plan, with the supervisee, effective goals and objectives for clinical and professional growth.
 - 2.3 Ability to assist the supervisee in using observation and assessment in preparation of client goals and objectives.
 - 2.4 Ability to assist the supervisee in using self-analysis and previous evaluation in preparation of goals and objectives for professional growth.
 - 2.5 Ability to assist the supervisee in assigning priorities to clinical goals and objectives.
 - 2.6 Ability to assist the supervisee in assigning priorities to goals and objectives for professional growth.
- 3.0 Task: Assisting the supervisee in developing and refining assessment skills.
- Competencies required:
- 3.1 Ability to share current research findings and evaluation procedures in communication disorders.
 - 3.2 Ability to facilitate an integration of research findings in client assessment.
 - 3.3 Ability to assist the supervisee in providing rationale for assessment procedures.
 - 3.4 Ability to assist supervisee in communicating assessment procedures and rationales.
 - 3.5 Ability to assist the supervisee in integrating findings and observations to make appropriate recommendations.
 - 3.6 Ability to facilitate the supervisee's independent planning of assessment.
- 4.0 Task: Assisting the supervisee in developing and refining management skills.
- Competencies required:
- 4.1 Ability to share current research findings and management procedures in communication disorders.
 - 4.2 Ability to facilitate an integration of research findings in client management.
 - 4.3 Ability to assist the supervisee in providing rationale for treatment procedures.
 - 4.4 Ability to assist the supervisee in identifying appropriate sequences for client change.
 - 4.5 Ability to assist the supervisee in adjusting steps in the progression toward a goal.
 - 4.6 Ability to assist the supervisee in the description and measurement of client and clinician change.
 - 4.7 Ability to assist the supervisee in documenting client and clinician change.
 - 4.8 Ability to assist the supervisee in integrating documented client and clinician change to evaluate progress and specify future recommendations.
- 5.0 Task: Demonstrating for and participating with the supervisee in the clinical process.

Competencies required:

- 5.1 Ability to determine jointly when demonstration is appropriate.
- 5.2 Ability to demonstrate or participate in an effective client-clinician relationship.
- 5.3 Ability to demonstrate a variety of clinical techniques and participate with the supervisee in clinical management.
- 5.4 Ability to demonstrate or use jointly the specific materials and equipment of the profession.
- 5.5 Ability to demonstrate or participate jointly in counseling of clients or family/ guardians of clients.

6.0 Task: Assisting the supervisee in observing and analyzing assessment and treatment sessions.

Competencies required:

- 6.1 Ability to assist the supervisee in learning a variety of data collection procedures.
- 6.2 Ability to assist the supervisee in selecting and executing data collection procedures.
- 6.3 Ability to assist the supervisee in accurately recording data.
- 6.4 Ability to assist the supervisee in analyzing and interpreting data objectively.
- 6.5 Ability to assist the supervisee in revising plans for client management based on data obtained.

7.0 Task: Assisting the supervisee in development and maintenance of clinical and supervisory records.

Competencies required:

- 7.1 Ability to assist the supervisee in applying record- keeping systems to supervisory and clinical processes.
- 7.2 Ability to assist the supervisee in effectively documenting supervisory and clinically related interactions.
- 7.3 Ability to assist the supervisee in organizing records to facilitate easy retrieval of information concerning clinical and supervisory interactions.
- 7.4 Ability to assist the supervisee in establishing and following policies and procedures to protect the confidentiality of clinical and supervisory records.
- 7.5 Ability to share information regarding documentation requirements of various accrediting and regulatory agencies and third-party funding sources.

8.0 Task: Interacting with the supervisee in planning, executing, and analyzing supervisory conferences.

Competencies required:

- 8.1 Ability to determine with the supervisee when a conference should be scheduled.
- 8.2 Ability to assist the supervisee in planning a supervisory conference agenda.
- 8.3 Ability to involve the supervisee in jointly establishing a conference agenda.
- 8.4 Ability to involve the supervisee in joint discussion of previously identified clinical or supervisory data or issues.
- 8.5 Ability to interact with the supervisee in a manner that facilitates the supervisee's self-exploration and problem solving.

- 8.6 Ability to adjust conference content based on the supervisee's level of training and experience.
- 8.7 Ability to encourage and maintain supervisee motivation for continuing self-growth.
- 8.8 Ability to assist the supervisee in making commitments for changes in clinical behavior.
- 8.9 Ability to involve the supervisee in ongoing analysis of supervisory interactions.
- 9.0 Task: Assisting the supervisee in evaluation of clinical performance.
Competencies required:
 - 9.1 Ability to assist the supervisee in the use of clinical evaluation tools.
 - 9.2 Ability to assist the supervisee in the description and measurement of his/her progress and achievement.
 - 9.3 Ability to assist the supervisee in developing skills of self-evaluation.
 - 9.4 Ability to evaluate clinical skills with the supervisee for purposes of grade assignment, completion of Clinical Fellowship Year, professional advancement, and so on.
- 10.0 Task: Assisting the supervisee in developing skills of verbal reporting, writing, and editing.
Competencies required:
 - 10.1 Ability to assist the supervisee in identifying appropriate information to be included in a verbal or written report.
 - 10.2 Ability to assist the supervisee in presenting information in a logical, concise, and sequential manner.
 - 10.3 Ability to assist the supervisee in using appropriate professional terminology and style in verbal and written reporting.
 - 10.4 Ability to assist the supervisee in adapting verbal and written reports to the work environment and communication situation.
 - 10.5 Ability to alter and edit a report as appropriate while preserving the supervisee's writing style.
- 11.0 Task: Sharing information regarding ethical, legal, regulatory, and reimbursement aspects of the profession.
Competencies required:
 - 11.1 Ability to communicate to the supervisee a knowledge of professional codes of ethics (e.g., ASHA, state licensing boards, and so on).
 - 11.2 Ability to communicate to the supervisee an understanding of legal and regulatory documents and their impact on the practice of the profession (licensure, PL 94-142, Medicare, Medicaid, and so on).
 - 11.3 Ability to communicate to the supervisee an understanding of reimbursement policies and procedures of the work setting.
 - 11.4 Ability to communicate a knowledge of supervisee rights and appeal procedures specific to the work setting.
- 12.0 Task: Modeling and facilitating professional conduct.
Competencies required:
 - 12.1 Ability to assume responsibility.
 - 12.2 Ability to analyze, evaluate, and modify own behavior.
 - 12.3 Ability to demonstrate ethical and legal conduct.

Preparation of Supervisors

- 12.4 Ability to meet and respect deadlines.
- 12.5 Ability to maintain professional protocols (respect for confidentiality, etc.)
- 12.6 Ability to provide current information regarding professional standards (PSB, ESB, licensure, teacher certification, etc.).
- 12.7 Ability to communicate information regarding fees, billing procedures, and third-party reimbursement.
- 12.8 Ability to demonstrate familiarity with professional issues.
- 12.9 Ability to demonstrate continued professional growth.
- 13.0 Task: Demonstrating research skills in the clinical or supervisory processes.
Competencies required:
 - 13.1 Ability to read, interpret, and apply clinical and supervisory research.
 - 13.2 Ability to formulate clinical or supervisory research questions.
 - 13.3 Ability to investigate clinical or supervisory research questions.
 - 13.4 Ability to support and refute clinical or supervisory research findings.
 - 13.5 Ability to report results of clinical or supervisory research and disseminate as appropriate (e.g., in-service, conferences, publications).

The special skills and competencies for effective clinical supervision may be acquired through special training which may include, but is not limited to, the following:

1. Specific curricular offerings from graduate programs; examples include doctoral programs emphasizing supervision, other postgraduate preparation, and specified graduate courses.
2. Continuing educational experiences specific to the supervisory process (e.g., conferences, workshops, self-study).
3. Research-directed activities that provide insight in the supervisory process.

The major goal of training in supervision is mastery of the “Competencies for Effective Clinical Supervision.” Since competence in clinical services and work experience sufficient to provide a broad clinical perspective are considered essential to achieving competence in supervision, it is apparent that most preparation in supervision will occur following the preservice level. Even so, positive effects of preservice introduction to supervision preparation have been described by both Anderson (1981) and Rassi (1983). Hence, the presentation of basic material about the supervisory process may enhance students' performance as supervisees, as well as provide them with a framework for later study.

The steadily increasing numbers of publications concerning supervision and the supervisory process indicate that basic information concerning supervision now is becoming more accessible in print to all speech-language pathologists and audiologists, regardless of geographical location and personal circumstances. In addition, conferences, workshops, and convention presentations concerning supervision in communication disorders are more widely available than ever before, and both coursework and supervisory practicum experiences are emerging in college and university educational programs. Further, although preparation in the supervisory process specific to communication disorders should be the major

content, the commonality in principles of supervision across the teaching, counseling, social work, business, and health care professions suggests additional resources for those who desire to increase their supervisory knowledge and skills.

To meet the needs of persons who wish to prepare themselves as clinical supervisors, additional coursework, continuing education opportunities, and other programs in the supervisory process should be developed both within and outside graduate education programs. As noted in an earlier report on the status of supervision (ASHA, 1978), supervisors themselves expressed a strong desire for training in supervision. Further, systematic study and investigation of the supervisory process is seen as necessary to expansion of the data base from which increased knowledge about supervision and the supervisory process will emerge.

The "Tasks of Supervision" and "Competencies for Effective Clinical Supervision" are intended to serve as the basis for content and outcome in preparation of supervisors. The tasks and competencies will be particularly useful to supervisors for self-study and self-evaluation, as well as to the consumers of supervisory activity, that is, supervisees and employers.

A repeated concern by the ASHA membership is that implementation of any suggestions for qualifications of supervisors will lead to additional standards or credentialing. At this time, preparation in supervision is a viable area of specialized study. The competencies for effective supervision can be achieved and implemented by supervisors and employers.

Summary

Clinical supervision in speech-language pathology and audiology is a distinct area of expertise and practice. This paper defines the area of supervision, outlines the special tasks of which it is comprised, and describes the competencies for each task. The competencies are developed by special preparation, which may take at least three avenues of implementation. Additional coursework, continuing education opportunities and other programs in the supervisory process should be developed both within and outside of graduate education programs. At this time, preparation in supervision is a viable area for specialized study, with competence achieved and implemented by supervisors and employers.

Bibliography

- American Speech and Hearing Association. (1978). Current status of supervision of speech-language pathology and audiology [Special Report]. *Asha*, 20, 478-486.
- American Speech-Language-Hearing Association. (1980). *Standards for accreditation by the Education and Training Board*. Rockville, MD: ASHA.
- American Speech-Language-Hearing Association. (1982). *Requirements for the certificates of clinical competence* (Rev.). Rockville, MD: ASHA.
- American Speech-Language-Hearing Association. (1983). New standards for accreditation by the Professional Services Board. *Asha*, 25(6), 51-58.
- Anderson, J. (Ed.). (1980, July). *Proceedings, Conference on Training in the Supervisory Process in Speech-Language Pathology and Audiology*. Indiana University, Bloomington.
- Anderson, J. (1981). A training program in clinical supervision. *Asha*, 23, 77-82.
- Culatta, R., & Helmick, J. (1980). Clinical supervision: The state of the art—Part I. *Asha*, 22, 985-993.
- Culatta, R., & Helmick, J. (1981). Clinical supervision: The state of the art—Part II. *Asha*, 23, 21-31.

Laney, M. (1982). Research and evaluation in the public schools. *Language, Speech, and Hearing Services in the Schools, 13*, 53–60.

Rassi, J. (1983, September). *Supervision in audiology*. Seminar presented at Hahnemann University, Philadelphia.

ASHA PRACTICE PORTAL
PROFESSIONAL ISSUES
CLINICAL EDUCATION AND SUPERVISION

September 2016

Overview

The scope of this Practice Portal page is the clinical education and supervision of graduate students in audiology and speech-language pathology in university and off-site settings.

Many of the principles included in this page also apply to the mentoring and supervision of speech-language pathology clinical fellows and professionals transitioning to a new area of practice, as well as to the supervision of support personnel.

For information related to mentoring clinical fellows, see [Issues in Ethics: Responsibilities of Individuals Who Mentor Clinical Fellows in Speech-Language Pathology](#) (ASHA, 2013a). For information specific to support personnel, see [audiology assistants](#), [speech-language pathology assistants](#), and [speech-language pathology assistant scope of practice](#) (ASHA, 2013b).

Definition of Terms

The terms *clinical supervisor* and *clinical supervision* are often used in reference to the training and education of student clinicians, recognizing that supervision is part of the training and education process. *Supervision* can be broadly defined as overseeing and directing the work of others. However, clinical supervisors do more than oversee the work of the student clinician. They teach specific skills, clarify concepts, assist with critical thinking, conduct performance evaluations, mentor, advise, and model professional behavior (Council of Academic Programs in Communication Sciences and Disorders [CAPCSD], 2013).

Many professionals involved in the supervisory process suggest that the terms *clinical educator* and *clinical instructor* more accurately reflect what the clinical supervisor does (CAPCSD, 2013). The term *clinical educator* is used here to refer to individuals involved in the clinical training, education, and supervision of audiology and speech-language pathology graduate students at all levels of training.

Key Issues

- [Preparation for the Clinical Educator](#)
- [Goals of Clinical Education](#)
- [Competency-Based Education](#)
- [Anderson's Continuum of Supervision](#)
- [Components of The Clinical Education Process](#)
- [Teaching Methods In Clinical Education](#)
- [Other Methods Used In Clinical Education](#)
- [Assessment of the Student Clinician's Knowledge and Skills](#)

- Effective Remediation
- Special Considerations
- Working With Academic Programs
- Ethics
- Legal/Regulatory Requirements
- Telesupervision
- Interprofessional Education and Interprofessional Practice

Preparation for the Clinical Educator

According to the ASHA Ad Hoc Committee on Supervision's *Final Report on Knowledge, Skills and Training Consideration for Individuals Serving as Supervisors* (ASHA, 2013c):

A prevailing philosophy suggests that competency in clinical service delivery translates into effective clinical supervision. However, leaders in education have long argued that this is a flawed assumption and that effective supervision requires a unique set of knowledge and skills.

The Ad Hoc Committee acknowledges that supervision is a distinct area of practice and, as in other distinct areas, individuals must receive training to gain competence before engaging in the activity. Education in the supervisory process should begin early, with—as a minimum—an introduction to the subject as part of the graduate curriculum and more extensive training readily available to practicing and aspiring supervisors. Effective education for supervision should focus on unique aspects of knowledge and specialized skills for the supervisory process and should not be limited to regulatory aspects (e.g., observation time, clock hours) of the process. (pp. 3–4)

CAPCSD also recognizes that clinical supervision is a distinct area of expertise and practice, and that clinical supervisors of student clinicians need to have the requisite knowledge and skills (CAPCSD, 2013). As such, clinical education requires training to ensure that individuals gain the necessary competence (ASHA, 2013c). ASHA and other stakeholders agree that appropriate training programs need to be developed.

Knowledge and Skills For Clinical Educators

In their final report to the ASHA Board of Directors, the Ad Hoc Committee on Supervision (ASHA, 2013c) outlined the knowledge and skills required of individuals engaging in clinical training.

Overarching Knowledge and Skills

- Knowledge of clinical education and the supervisory process, including teaching techniques, adult learning styles, and collaborative models of supervision
- Skill in relationship development, including the creation of an environment that fosters learning
- Ability to communicate, including the ability to define expectations and engage in difficult conversations

- Ability to collaboratively establish and implement goals, give objective feedback, and adjust clinical education style when necessary
- Ability to analyze and evaluate the student clinician's performance, including gathering data, identifying areas for improvement, assisting with self-reflections, and determining if goals are being achieved
- Skill in modeling and nurturing clinical decision making, including (a) using information to support clinical decisions and solve problems and (b) responding appropriately to ethical dilemmas
- Skill in fostering professional growth and development
- Skill in making performance decisions, including the ability to create and implement plans for improvement and to assess the student's response to these plans
- Ability to adhere to the principles of evidence-based practice and conveying research information to student clinicians

Knowledge and Skills Specific to Student Training in the University Clinic or Off-site Setting

- Ability to connect academic knowledge and clinical application
- Ability to sequence the student's knowledge and skill development

Knowledge and Skills Specific to the Clinical Educator Working With Students in the Culminating Externship in Audiology

- Ability to provide a multifaceted experience across the scope of the profession
- Ability to serve as a liaison between the facility, student, and university
- Skill in guiding the student in reflective practice
- Skill in facilitating the development of workplace navigation skill (e.g., being part of a team and adhering to policies and procedures)

For more detailed information about the knowledge and skills needed by clinical educators, see the [Final Report on Knowledge, Skills and Training Consideration for Individuals Serving as Supervisors](#) (ASHA, 2013c) and CAPCSD'S white paper titled [Preparation of Speech-Language Pathology Clinical Educators](#) (CAPCSD, 2013). See also the American Academy of Audiology's [Clinical Education Guidelines for Audiology Externships](#) (American Academy of Audiology, n.d.)

Training

Both ASHA (2013c) and CAPCSD (2013) suggest the need for systematic approaches to the training and preparation of clinical educators, and both organizations outline the following issues related to the development of training:

- Development of, and options for, the delivery of educational products
- Use of a team of individuals skilled in clinical education as trainers and product developers
- Identification of potential consumers for the training

- Development of outcomes and incentives for those who engage in clinical education training

Training modules and resources are currently under development; this Practice Portal page will reference these modules and resources when they are available.

Goals of Clinical Education

Effective supervision ensures that new clinicians are well prepared and that individuals with communication disorders receive quality services (ASHA, 2013a).

Clinical educators integrate theoretical, evidence-based knowledge with clinical practice to help student clinicians

- acquire fundamental knowledge about normal and disordered communication;
- develop critical thinking and clinical decision-making skills;
- acquire an understanding of clinical practices and methodology and the ability to implement them;
- develop the ability to analyze research and apply evidence to clinical practice;
- become competent in using equipment and technology necessary for diagnosing and treating communication disorders;
- become competent in analyzing assessment and treatment behaviors to evaluate the effectiveness of clinical practices;
- become competent in charting and monitoring patient records;
- develop professional communication skills—both verbal and written;
- develop professional behaviors, including the ability to work with individuals and their families;
- develop skills necessary to function appropriately on an interprofessional team; and
- become competent in medical coding and billing.

Competency-Based Education

Competency-based education focuses on student learning. It is a system of instruction, assessment, grading, and reporting based on students' ability to demonstrate expected learning of knowledge and skills as they progress through their education. The goal of competency-based education is to ensure that students acquire the knowledge and skills they need to be successful in school, in their careers, and in their adult lives (Hidden Curriculum, 2014).

Competency-based approaches to clinical education and assessment of student learning focus more on the knowledge, skills, and competencies that a student demonstrates than on a record of clinical hours obtained. This Practice Portal page is consistent with a competency-based approach to clinical education. See Frank et al. (2007) for a discussion of a competency-based approach in clinical (medical) education.

Anderson's Continuum of Supervision

Anderson's (1988) *Continuum of Supervision* is a conceptual model of supervision often referred to in the communication sciences and disorders (CSD) literature. The model

describes supervision as a continuum of stages (evaluation-feedback, transitional, and self-supervision) that allows a student to move from interdependence to independence. These stages are not time-bound; the student may be at any point along the continuum, based on his or her knowledge and skills, as well as situational variables.

The continuum comprises changes over time in the amount and type of involvement of both supervisor (clinical educator) and student clinician—as the amount of direct supervision (e.g., direct instruction; modeling or demonstration) decreases, the amount of student participation increases (e.g., the student directs by proposing clinical decisions).

Supervisory styles are adjusted in response to the needs of the student, expectations and philosophies of the supervisor and supervisee, and specifics of the situation (e.g., task difficulty; familiarity with the task or procedure; client needs and preferences; setting).

Anderson (1988) emphasizes five components of the supervisory process to facilitate movement of the student along the continuum:

- **Understanding the supervisory process** — discussing the process, understanding respective roles, and sharing expectations and objectives
- **Planning** — joint planning for the clinical process (client and clinician) and the supervisory process (supervisee and supervisor)
- **Observing** — collecting and recording objective data by both supervisor and supervisee
- **Analyzing** — examining and interpreting data in relation to changes in clinician and client
- **Integrating** — integrating content from all components at various points throughout the experience

By actively participating in all aspects of the clinical process—including data collection, problem solving, and strategy development—the student ultimately develops the ability to use the strategies needed to function independently (Dowling, 2001).

Applications and research relevant to these components are discussed in McCrea and Brasseur's (2003) update of Anderson's seminal work.

Components of The Clinical Education Process

The Supervisory Relationship

Success in facilitating clinical and professional development ultimately rests on the relationship between clinical educator and student clinician and on the ability of the clinical educator to communicate effectively with the student clinician.

Effective interpersonal communication requires

- knowledge of and ability to implement the basic principles of effective interpersonal communication;

- appreciation for the importance of listening and the ability to use behaviors that facilitate effective listening (e.g., silent listening, questioning, paraphrasing, empathizing, and supporting);
- knowledge of key principles of conflict resolution and the ability to use conflict resolution strategies appropriately (e.g., active listening, openness to discussion, and allowing for open-ended discussion);
- understanding different learning styles and having the ability to work effectively with each style within the supervisory relationship; and
- understanding different communication styles (e.g., cultural/linguistic, generational, gender) and having the ability to address potential challenges to successful communication related to these differences.

When clinical educators adopt an effective communication style, student clinicians are more willing to participate in conferences, share ideas and feelings, and positively change clinical behaviors (e.g., Hagler, Casey, & DesRochers, 1989; McCready et al., 1996; Pickering, 1987).

Clinical behaviors also change in positive directions when students perceive genuineness, empathetic understanding, positive regard, and concreteness on the part of the clinical educator (Ghitter, 1987 [building on the research of Caracciolo, 1976; Caracciolo, Rigrodsky, & Morrison, 1978a, 1978b; McCrea, 1980; and Pickering, 1979, 1984]).

Promoting And Enhancing Critical Thinking

Critical thinking allows the clinician to access knowledge about the field, determine how that knowledge can be applied in clinical situations, evaluate outcomes, modify his or her thinking, and make appropriate clinical adjustments.

"Educational and professional success require developing one's thinking skills and nurturing one's consistent internal motivation to use those skills" (Facione, 2000, p. 81). The clinical educator must not only teach critical thinking skills but also nurture the *disposition* toward clinical thinking (Gavett & Peapers, 2007). One way to accomplish these objectives is by asking questions that activate the student's knowledge and promote analysis, synthesis, and evaluation of the situation.

Questions can

- provide a model for how practicing clinicians reason;
- provide a structure for student clinicians to connect theory and practice; and
- challenge student clinicians to apply their thinking beyond the specific client or situation (Gavett & Peapers, 2006, 2007; King, 1995).

Feedback

Feedback is an informed (data-based), nonevaluative, objective appraisal of the student clinician's performance intended to improve his or her clinical skills (Ende, 1983). It is given to confirm or reinforce behavior, correct behavior, and promote improvement in

future performance (Barnum, Guyer, Levy, & Graham, 2009; Ende, 1983; Nottingham & Henning, 2014a).

Common types of feedback (Dowling, 2001) include

- **objective data** — nonjudgmental data collected, analyzed and shared with the student clinician
- **narratives** — written descriptions of specific behaviors during a session, along with the clinical educator's impressions (e.g. field notes; Anderson, 1998)
- **rating scales** — ratings on a specified number of clinical skills; although criteria for judgment are sometimes provided, rating scales are subjective by nature and need to be paired with objective data to support the ratings

Giving Feedback

Factors that can influence the effectiveness of feedback include

- timing (immediate or delayed);
- frequency (more or less often);
- tone (positive, negative, or balanced);
- form (spoken or nonspoken); and
- specificity (more or less detailed/specific).

Each feedback exchange can include different combinations of these components; thus, each exchange is unique (Nottingham & Henning, 2014a, 2014b).

Ende (1983) offers the following guidelines for giving feedback:

- Undertake feedback so that the clinical educator and student clinician are working as allies with common goals.
- Ensure that feedback is well-timed and expected—feedback that comes unexpectedly, especially when it is negative, is almost always met with an emotional reaction.
- Base feedback on firsthand data, and phrase it in descriptive, nonevaluative language.
- Focus on specific performances, not generalizations.
- Address decisions and actions of the student clinician, not assumed intentions or interpretations.
- When offering subjective data, label it as such—use "I" statements that focus on the specific behavior and that allow the student to interpret (e.g., "I saw that you reversed the right and left earphones when fitting the headset.").

Receiving Feedback

Factors that can affect how receptive a student clinician is to feedback include

- whether or not the student agrees with the clinical educator;
- the particular learning situation (e.g., if new skills are being learned);

- personalities of the clinical educator and student clinician that can set the tone for their interactions; and
- the timing of feedback (e.g., in the presence of a client/patient or in private).

See Nottingham and Henning (2014b) for a discussion of student preferences with regard to feedback.

Seeking Feedback

Feedback-seeking behavior is a conscious effort to determine the correctness and adequacy of one's own behavior for the purpose of attaining a goal (Ashford & Cummings, 1983). Research suggests that feedback-seeking behavior can facilitate an individual's adaptation, learning, and performance (Crommelinck & Anseel, 2013).

Not all individuals seek feedback, possibly because of differences in the perceived value and costs associated with feedback seeking (Ashford, Blatt, & Vande Walle, 2003). However, given the potential benefits, encouraging feedback seeking is an important educational strategy (Crommelinck & Anseel, 2013; Bose & Gijssels, 2013).

Mentoring in Clinical Education

Mentoring is the relationship between two people in which one person is dedicated to the personal and professional growth of the other (Robertson, 1992). In clinical education, mentoring focuses on building skills, influencing attitudes, and cultivating aspirations. Mentors model, advise, tutor, and instill a professional identity in the student clinician.

Some aspects of mentoring are involved in all supervisory relationships and, to varying degrees, at all stages of clinical education, depending on the supervisor's style and the student clinician's experience and skill level. Mentoring is less likely to be addressed when performance growth is the focus (i.e., "direct-active" style of supervision) and is more likely to be addressed in later stages of learning, when "collaborative" or "consultative" styles of supervision are used. Mentoring is most appropriate in the advanced transitional stage and the self-supervision stage of the continuum (Anderson, 1988).

The Influence of Power in Supervision

The clinical educator holds the power of grading, signing off on clinical hours, and conducting performance evaluations. Awareness and understanding of the influence of power can help avoid intimidation and a reluctance by the student clinician to participate actively in the supervisory relationship.

Cultural or linguistic background may influence a student's response to the power dynamic and may result in behaviors that can be interpreted as inappropriate (Coleman, 2000). Seek advice regarding effective strategies for culturally appropriate interactions.

Evaluating The Student Clinician And The Clinical Educator

"The goals of the supervisory process are the professional growth and development of [both] the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients" (Anderson, 1988, p. 12).

To that end, the clinical education process incorporates self-assessment on the part of the student clinician *and* the clinical educator. Self-assessment enhances professional growth and development and provides an opportunity for each person to identify goals and determine whether these goals are being met.

The clinical education process also incorporates *reciprocal evaluations*—this encompasses the clinical educator's evaluation of the student clinician and the student clinician's evaluation of the clinical educator. Reciprocal evaluations are critical to the process and help both individuals improve their skills.

Teaching Methods In Clinical Education

Deliberate Practice

Deliberate practice is a highly structured activity directed at improving performance on a particular task or set of tasks (Ericsson, Krampe, & Tesch-Römer, 1993). It incorporates immediate, specific, and informative feedback, problem-solving and evaluation, and opportunities for repeated performance to improve and refine skills.

Training that utilizes deliberate practice can facilitate acquisition and maintenance of expert performance in a wide variety of fields (e.g., De Bruin, Smits, Rikers, & Schmidt, 2008; Krampe & Ericsson, 1996; Unger, Keith, Hilling, Gielnik, & Frese, 2009), including acquisition of clinical skills (Duvivier et al., 2011; Ericsson, 2004).

Duvivier et al. (2011) identified a number of study habits related to deliberate practice in the behavior of clinical (medical) students at various stages of skill development:

- Tendency to organize work in a structured way
- Increased concentration and attention span
- Tendency to practice
- Tendency to self-regulate learning

As students progressed through the curriculum, their use of these study habits increased, particularly in the areas of planning and organization of work.

Deliberate practice can facilitate acquisition of a broad range of clinical skills in audiology and speech-language pathology, including administering tests and interpreting results; conducting oral motor exams; using technology and equipment; and completing audiologic assessments.

Reflective Practice

Reflective practice involves critical self-analysis, self-evaluation, problem solving, and the ability to modify one's behavior. It is an important tool in practice-based professional learning where clinical skills are acquired through experience rather than from formal classroom teaching.

- **Reflection-on-action** is the process of reflecting on what has been done. It allows the individual to reflect on a prior experience, evaluate how he or she contributed to the outcome, and determine what to do when a similar situation arises (Schön, 1983).

Tools that provide opportunities to reflect on performance include self-evaluation checklists, journals, diaries, portfolios, reviews of video recorded sessions, and clinical educator observations and evaluations.

- **Reflection-in-action** is the process of "thinking on your feet" that allows an individual to make changes in his or her behavior while engaged in a task. It requires critical, in-the-moment evaluation and the ability to identify what is not going well or what needs to be changed and to modify behaviors accordingly (Schön, 1983).

Examples include modifying task instructions or cuing strategies during a therapy session or deciding to forego otoacoustic emissions testing in favor of multifrequency tympanometry to investigate possible causes of a conductive hearing loss.

For more information about reflective practice in clinical education, see Aronson (2011); Geller and Foley (2009); Mann, Gordon, and MacLeod (2009); and Ng (2012).

Supervision, Questioning And Feedback (SQF) Model Of Clinical Teaching

The *Supervision, Questioning and Feedback (SQF) model of clinical teaching* integrates supervision, questioning and feedback into clinical learning experiences. It is designed to help the student clinician become an autonomous clinician with sound clinical reasoning (Barnum et al., 2009).

The SQF model incorporates

- **supervision** (S) that changes in response to the needs of the learner and the situation;
- **strategic questioning** (Q) to facilitate development of clinical reasoning skills by providing a model for thinking; and
- meaningful **feedback** (F) to help shape learning and skill development.

Strategic questioning consists of consciously adapting the timing, order, and phrasing of questions to help the student process information at increasingly more complex levels. In order of complexity, questions require recall of facts; comparison, analysis, synthesis, and application of knowledge; and the ability to evaluate information, formulate plans, infer meaning, and defend decisions (Barnum 2008).

Three types of **feedback** can be utilized—*confirming* lets students know when knowledge and skills are being applied correctly; *corrective* lets them know when these skills are not on target; and *guiding* reinforces and advances current levels of knowledge and skills (Barnum & Guyer, 2015).

Specific **questioning** and **feedback** techniques depend on the clinical situation—the student clinician, the task he or she is trying to complete, the urgency with which the task must be completed, and the consequences for the patient/student/client and for the student clinician (Barnum & Guyer, 2015).

Cognitive Apprenticeship Instructional Model

Cognitive apprenticeship was introduced by Collins, Brown, and Newman (1989) as an instructional model for situated learning, in which students learn to apply skills by performing tasks and solving problems in a variety of authentic contexts.

The cognitive apprenticeship model applies the following teaching methods to promote situated learning:

- **modeling** — demonstrating tasks and explaining internal (cognitive) processes (e.g., decision making)
- **coaching** — observing students as they perform tasks and providing feedback, hints, models, and reminders
- **scaffolding** — tailoring support to students' current level of knowledge and gradually removing support as they become more competent
- **articulation** — encouraging students to verbally express their knowledge, reasoning, or problem solving
- **reflection** — encouraging students to reflect on their own skills and problem-solving abilities as compared with their cognitive model of expertise
- **exploration** — setting general goals for students and encouraging them to formulate and pursue personal goals of interest

Using these methods, the clinical educator makes tacit elements of expert practice explicit so that students gain a deeper understanding of the cognitive processes underlying clinical decision making (Dennen & Burner, 2008).

Other Methods Used In Clinical Education

Simulation

Simulation is a method that replaces or amplifies real client/patient experiences with scenarios designed to replicate real health encounters (Passiment, Sacks, & Huang, 2011). Simulation affords an opportunity to build knowledge and experience by rehearsing in a safe environment (e.g., clinical skills lab), where potential harm to the client/patient is minimized.

The *standardized patient (SP)* is a well-accepted and frequently used simulation tool. The SP is a layperson hired and trained to portray an actual patient within a clinical setting. He or she presents with faculty-defined patient history and physical symptoms and provides a consistent, controlled clinical experience for teaching and assessment purposes. Academic programs in CSD are beginning to employ SPs for clinical education purposes (e.g., Zraick & Allen, 2002; Zraick, Allen, & Johnson, 2003). Other simulation tools include computer avatars and lifelike mannequins (Zraick, n.d.).

Grand Rounds

Grand rounds are formal meetings at which cases are presented to student clinicians, clinical educators, and other medical and allied health professionals, followed by a discussion of each case. Students may review current literature to provide support for test protocols, test interpretation, and treatment options. Grand rounds originated as part of medical residency training but can be used in any clinical education setting to enhance clinical reasoning and decision-making skills.

Problem-based and Case-Based Learning Scenarios

Problem-based learning scenarios are experiences in which groups of students—with guidance from an instructor—learn through solving an open-ended problem by identifying what they know, what they need to know, and where they can access the necessary information to solve the problem.

Case-based learning scenarios are similar but use discussion of case studies and real-life scenarios to help students put their learning into practice in a clinical setting. Students work collaboratively to examine, analyze, and discuss problems related to the case.

Assessment of the Student Clinician's Knowledge and Skills

Assessment is an essential component of any clinical education process. It involves

- defining expected knowledge and skills;
- developing learning goals;
- setting criteria for demonstrating learning;
- gathering and analyzing data regarding performance or verification of clinical outcomes;
- providing feedback; and
- documenting feedback and remediation opportunities.

Setting objectives is fundamental to subsequent evaluation; progress can be measured adequately only if clear objectives have been established and if behaviors relating to those objectives have been quantified (McCrea & Brasseur, 2003).

It is critical that the clinical educator and the student clinician be jointly involved in the evaluation process (Anderson, 1988; McCrea & Brasseur, 2003). Expectations for performance and evaluation tools need to be clarified at the beginning of the supervisory experience (Brasseur, 1989).

Types of Assessment

A variety of assessment mechanisms and techniques are used to evaluate progress in acquiring the necessary knowledge and skills. Assessments are conducted on an ongoing basis throughout training and at the conclusion of a defined instructional period.

Formative Assessment

Formative assessment is ongoing measurement and feedback yielding critical information for monitoring acquisition of knowledge and skill *during the learning process* for the purpose of improving learning.

Formative assessment in clinical education evaluates the individual's critical thinking, decision-making, and problem-solving skills; it typically includes oral and written components as well as demonstrations of clinical proficiency in actual or simulated settings.

Examples of Formative Assessment

- **Observation** – observing the student clinician during sessions and providing feedback (written or verbal) regarding mastery of a skill (e.g., branching to a less difficult task during the session or selecting an appropriate masking level during audiologic testing).
- **Questioning** – engaging the student clinician with questions that encourage open dialogue, critical thinking, problem solving, and exploration of new information.
- **Learning logs** – asking students to reflect on a session or learning experience by summarizing the experience, noting what they learned, posing questions that they still have, evaluating their clinical skills, and providing insight and suggestions for continued performance improvement. Learning logs allow the clinical educator to monitor student progress and provide feedback and concrete suggestions on ways to improve.
- **Proficiency exams** – evaluating student performance on a particular skill (e.g., pure-tone testing) to determine skill level at various points throughout training. Exam performance can help determine the need for additional practice and/or remediation.

Summative Assessment

Summative assessment is the comprehensive evaluation of learning outcomes at the conclusion of a defined instructional period (e.g., end of semester, academic year, or program of study).

Summative assessment in clinical education yields critical information for determining an individual's acquisition of knowledge and achievement of clinical skills, including the ability to integrate academic knowledge with clinical practice.

Summative assessments can serve as gateway measures prior to embarking on a more advanced clinical process stage. They often result in a score or grade that is incorporated into the individual's overall performance.

Examples of Summative Assessment

- **Gateway clinical exams** administered as benchmarks before more complex clinical procedures (or placements) are permitted.
- **Examination of practical skills** (e.g., demonstration of skills in use of technology; demonstrating diagnostic skills using simulated patients).
- **End-of-semester final exams or evaluations.**

- **End-of-program comprehensive written and oral exams.**
- **Culminating demonstrations of learning**, such as
 - *oral presentations* (e.g., case presentations);
 - *capstone projects* (e.g., case studies, surveys, and outcomes-based research) in which theory and knowledge are applied to a real-world setting; and
 - *portfolios of work* (e.g., case reviews, treatment plans, reports, and academic papers) demonstrating evidence of academic and clinical achievements.
- **Standardized tests** (e.g., Praxis® exams).

Pitfalls To Avoid When Assessing Student Performance

It is important for the clinical educator to avoid the following common pitfalls when assessing student performance.

- **Halo Effect** — cognitive bias in which an observer's *overall* (positive or negative) impression of a person influences the evaluation of specific traits (Thorndike, 1920).
- **Central Tendency** — tendency to rate all individuals (or all performances of a particular individual) around the midpoint of the scale; this bias results in a failure to differentiate between individuals or between the skills of a particular individual (Heery & Noon, 2008).
- **Similar-to-Me Effect** — tendency for an individual to give a higher rating to someone who is similar, in some way, to the rater himself or herself (e.g., similar attitudes or demographics; Sears & Rowe, 2003).
- **Judgmental Bias** — tendency (usually subconscious) to judge someone based on factors (e.g., racial, gender, or political bias) unrelated to his or her performance (Kerr, MacCoun, & Kramer, 1996).
- **Leniency/Strictness Error** — error that results when consistently easy or strict criteria are applied in rating an individual, regardless of his or her performance (Lunenburg, 2012).

Clinical educators can use one or more of the following strategies to avoid these pitfalls and ensure objectivity, fairness, and accuracy when assessing student performance:

- Establish clear educational plans and objective goals.
- Set expectations with the student.
- Rate each expected behavior independently.
- Consider specific data to support performance judgments.
- Use full performance rating levels to accurately indicate strengths and areas for improvement.
- Separate oneself from the evaluation—recognize that someone can be different but still perform effectively.
- Conduct in-house reliability training to ensure that all clinical educators use rating systems in a similar manner.

Effective Remediation

Difficult Conversations

Difficult conversations frequently pertain to the student's clinical performance but may also be related to other behaviors such as keeping commitments, being punctual, or demonstrating professionalism. These conversations often involve differing perspectives, opposing opinions, strong emotions, and potentially high-stakes outcomes (Patterson, Grenny, McMillan, & Switzler, 2012; Whitelaw, 2012).

One approach for initiating and resolving difficult conversations is the *learning conversation*. It involves

- learning the story of the participants without assigning blame;
- inviting participants to express their views and feelings; and
- creating a partnership for problem-solving ([Harvard Negotiation Project](#), n.d.; Stone, Patton, & Heen, 2010).

The learning conversation requires willingness on the part of the clinical educator to put aside his or her views and listen to the student, with the goal of understanding and acknowledging the student's perspective. This nonjudgmental listening can provide a safe emotional environment and facilitate the problem-solving process (Luterman, 2006).

Performance Improvement Plan

A *performance improvement plan*—also referred to a *remediation plan*—is a formal process used to help the student clinician improve performance or modify behavior. The need for remediation can stem from performance on clinical examinations that identifies the student's areas of need.

As part of the process, the clinical educator and student clinician identify specific performance and/or behavioral concerns and develop a written plan of action to address these concerns. The following specific steps in developing and implementing performance improvement plans are adapted from the Society for Human Resource Management (2013).

Steps In Developing And Implementing A Performance Improvement Plan

I. Document areas of performance and/or behavior in need of improvement by

- providing objective and specific documentation;
- documenting performance and behavior regularly throughout the term; and
- providing examples for clarification.

II. Develop action plan for improvement that includes

- specific and measurable objectives;
- a timeline for completion of objectives;

- additional resources that might be needed; and
- a statement of consequences if objectives are not successfully met.

III. Meet with student clinician to review plan. Be sure to

- clearly explain areas in need of improvement and the plan of action;
- provide the student with an opportunity to give his or her feedback and modify the plan if needed; and
- sign the plan.

IV. Gather data

- Data specific to each objective are gathered by both student and clinical educator.
- Student maintains log of performance-related self-evaluations.

V. Meet regularly with the student clinician (e.g., weekly, biweekly) to

- provide opportunities for student to seek guidance or ask for clarification of expectations;
- discuss and document progress toward achieving objectives; and
- modify objectives and/or timeline if needed.

VI. Conclude plan when student clinician

- meets all objectives and continues/progresses in his or her training or
- fails to meet objectives, at which time agreed-upon consequences are implemented.

Special Considerations

Students With Disabilities

The rights of students with disabilities are protected by the Americans With Disabilities Act (ADA; 1990) and Section 504 of the Rehabilitation Act of 1973. The ADA and Section 504 of the Rehabilitation Act of 1973 define *individuals with disabilities* as

- persons with a physical or mental impairment that substantially limits one or more major life activities;
- persons who have a history or record of such an impairment; or
- persons who are perceived by others as having such an impairment.

Major life activities include caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning.

The Americans With Disabilities Act (ADA)

The ADA (1990) is comprehensive civil rights legislation that prohibits discrimination and guarantees that people with disabilities have the same opportunities as everyone

else to participate in mainstream American life. This includes the opportunity to participate in higher education. Title II of the ADA covers state-funded schools such as universities, community colleges, and vocational schools. Title III of the ADA covers private colleges and vocational schools.

Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 (hereafter, "the Rehabilitation Act") protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any federal department or agency and include many institutions of higher learning, hospitals, nursing homes, mental health centers, and human service programs.

Section 504 of the Rehabilitation Act covers any school that receives federal dollars, regardless of whether it is private or public. A recipient of federal financial assistance may not, on the basis of disability,

- deny qualified individuals the opportunity to participate in or benefit from federally funded programs, services, or other benefits;
- deny access to programs, services, benefits, or opportunities to participate as a result of physical barriers; or
- deny employment opportunities, including hiring, promotion, training, and fringe benefits, for which they are otherwise entitled or qualified (U.S. Department of Education, 1980).

To be protected by Section 504, a student must be a qualified individual with a disability. In addition to meeting the above definition of *individuals with disabilities*—and for purposes of receiving services, education, or training—the term *qualified* means that the student meets essential eligibility requirements, with or without use of a reasonable accommodation.

Discriminatory Conduct

Examples of discriminatory conduct by a college or university include

- denying a qualified individual with a disability admission because of her or his disability;
- excluding a qualified student with a disability from any course, course of study, or other part of its education program or activity because of her or his disability; and
- counseling a qualified student with a disability toward more restrictive career objectives than other students (U.S. Department of Education, 1980).

Reasonable Accommodations

Institutions are required by law to provide *reasonable accommodations*. Specifically, they are required to make reasonable modifications in their practices, policies, and procedures and to provide auxiliary aids and services for individuals with disabilities—unless doing so would (a) fundamentally alter the nature of the goods, services,

facilities, privileges, advantages, and accommodations that they offer or (b) result in an undue financial or administrative burden on the institution.

Colleges and universities are not required to provide personal attendants, individually prescribed devices, readers for personal use or study, or other devices or services of a personal nature, such as tutoring and typing.

A reasonable accommodation for a student with a disability may include appropriate academic adjustments (e.g., modifications to academic requirements) that are necessary to ensure equal educational opportunity.

Examples include

- arranging for priority registration;
- reducing an individual's courseload;
- substituting a course;
- providing notetakers, recording devices, and/or sign language interpreters;
- allowing extended time for taking tests and completing clinic-related tasks (e.g., documentation and preparation);
- equipping school computers with screen-reading, voice recognition, or other adaptive software or hardware;
- modifying the environment to facilitate use of clinical equipment; and
- ensuring wheelchair access to clinical environments (e.g., for both examiner and patient side of sound suites).

The college or university is not required to lower or substantially modify essential requirements. For example, although the college or university may modify elements of the clinical practicum to meet the student's disability-related needs, it is not required to change the substantive requirements of the clinical experience in ways that can potentially interfere with quality of client care.

All students are held to the same standards and expectations. The presence of a disability may help explain how the student performs but does not excuse inadequate performance. All students deserve equal access to realistic performance assessment.

See [Jarrow \(2012\)](#) for a discussion of students with disabilities and information about maintaining essential requirements for all students.

Bilingual Student Clinicians

On occasion, a bilingual student clinician shares the language of the client/patient and/or family. When the clinical educator does not also share the language, a unique set of knowledge and skills is needed to understand, monitor, and evaluate the work of the bilingual student clinician. When this situation arises, it is important to consider the following:

- There may be a relationship between the student clinician and the client/patient stemming from a shared cultural and linguistic background, and this relationship is not an attempt to be exclusionary.

- Bilingual student clinicians who are in the process of being trained as professional service providers are not automatically considered bilingual service providers. Bilingual service providers must have adequate linguistic skills and must be appropriately trained to provide services to the individual with limited English proficiency (see [bilingual service delivery](#) and [collaborating with interpreters, transliterators, and translators](#)).
- The student clinician may be able to serve as an interpreter, transliterator, or translator, but additional consideration is necessary before this additional role is given (see [collaborating with interpreters, transliterators, and translators](#)).
- Although the student clinician may be able to serve appropriately in multiple roles, it must be recognized that the roles of bilingual service provider, interpreter, transliterator, and translator are unique, with each serving a different function and requiring a different set of knowledge and skills (see [collaborating with interpreters, transliterators, and translators](#)).
- The clinical educator and student clinician have a responsibility to collaborate in planning the session, selecting culturally relevant materials, and appropriately administering the services.

Student Clinicians Who Use Non-Standard American English Dialects or Accented Speech

Accents are defined as English pronunciation that is not the result of pathology and that is perceived to be different from the listener's—whether the English was learned as a first, second, or other language. Accents include aspects of speech sound production, prosody, rate, and fluency (Celce-Murcia, Brinton, & Goodwin, 1996), all of which can affect intelligibility. A *dialect* is any variety of a language that is shared by a group of speakers (Wolfram, 1991).

All individuals speak with an accent and/or dialect, whether it is regional or influenced by another native language. Variation is the norm, and no single standard can be appropriately applied in every clinical interaction. Audiologists and speech-language pathologists (SLPs) manage cases across linguistic variation as a matter of routine.

Student clinicians who speak with accents and/or dialects can effectively provide speech, language, and audiological services as long as they have

- the expected level of knowledge in normal and disordered communication;
- the expected level of diagnostic and clinical case management skills, and when necessary; and
- the ability to model the target (e.g., phoneme, grammatical feature, or other aspect of speech and language) that characterizes the particular problem of the client/patient (ASHA, 1998)—modeling can be provided in a variety of ways, given current technology (e.g., computer applications, software, audio and video recordings).

Universities impose the same requirements on all student clinicians and consider the potential means by which students can successfully provide clinical services with the

varied tools and resources now available. According to ASHA (1998), "the nonacceptance of individuals into higher education programs or into the professions solely on the basis of the presence of an accent or dialect is discriminatory" (p. 1).

When there are concerns about the impact of a student clinician's accent on the delivery of clinical services, the following strategies (ASHA, 2011) are offered to increase the likelihood of success:

- Provide early support, including opportunities for students to raise concerns.
- Offer an accent modification/intelligibility enhancement plan.
- Avoid communicating inferiority (e.g., by offering accent modification/intelligibility enhancement by a fellow student or allowing fellow students to observe the session).
- Be respectful of what the student brings to the profession (e.g., an understanding of culturally and linguistically diverse issues germane to the CSD discipline).
- Focus on the client's/patient's perception of accent—what matters is whether he or she can understand and learn from a student clinician with an accent.
- Address client/patient concerns—a client/patient or family member may indicate concerns about working with a student clinician who has an accent.
- Choose external placement sites with care (e.g., choose outside placements with clinical educators who are aware of and sensitive to the influence of cultural and linguistic diversity in the professions).
- Acquisition of self-awareness by students is key (e.g., being aware of a student's accent and its clinical impact and having resources to rely upon in various situations).
- Seek outside support and guidance—assess the support given to students with accents through exit interviews; ask for suggestions on improving the approach for future students.

Cultural Influences On Clinical Education

Both the service provider and the client/patient bring a unique combination of cultural variables to the clinical interaction, including ability, age, sex, beliefs, ethnicity, experience, gender, gender identity, linguistic background, national origin, race, religion, sexual orientation, and socioeconomic status.

Just as audiologists and SLPs are required to consider each client's/patient's or caregiver's cultural and linguistic characteristics and values in order to provide the most effective services (ASHA, 2004), the clinical educator also considers those of the student clinician (Herd & Moore, 2012). Clinical educators and student clinicians demonstrate **cultural competence** as they relate to each other and to the diverse populations they serve (ASHA, 2013d).

Culturally competent clinical educators successfully perform the following tasks:

- Discuss differences in cultures and the effect of differences on the relationship between clinical educator and student clinicians (Gardner, 2002).

- Discuss the unique influence of an individual's cultural and linguistic background that may necessitate adjustments in clinical approaches and interactions (e.g., interview style, assessment tools, and therapeutic techniques, feedback mechanisms, and critical evaluations).
- Gain an understanding of cultural norms and linguistic profiles—for example, what may appear to be an "unnecessary" amount of time "wasted" before beginning the session may actually reflect an awareness of the value of introductory talk in building rapport and showing respect before beginning the formal task.
- Give thoughtful attention to issues related to who speaks which language(s) (e.g., clinical educator, student clinician, client/patient, or family member). Such thoughtful attention provides opportunities for a collaborative relationship between student clinician and clinical educator (Muñoz, Watson, Yarbrough, & Flahive, 2011).
- Engage in discussions about expectations of performance and provide clear statements of evaluation criteria, including the influence of each person's cultural background.

Generational Differences

Generational differences can present unique challenges in clinical education. Four distinct generations (traditionalists, baby boomers, generation Xers, and millennials) are currently working together in potentially stressful, competitive environments (Lancaster & Stillman, 2002). Each generation is defined by people, places, events, and symbols that profoundly influence expectations and values.

Different expectations and values between and among generations can result in misinterpretations and misunderstandings between clinical educator and student clinician in a clinical setting. McCready (2007) describes a number of ways to bridge the generation gap and facilitate improved communication, including

- increasing knowledge and understanding of potential generational differences, including defining events and values;
- avoiding the assumption that all members of a particular generation have a "collective personality;"
- developing an appreciation of potential strengths of each generation (e.g., technological experience and expertise);
- talking about generational differences in orientation meetings, in-service presentations, study groups, and the like;
- sharing generational stories; and
- having discussions with colleagues and student clinicians about generational characteristics that might lead to misunderstandings.

Working With Academic Programs

Student clinicians typically gain practical experience in the field by "interning" at one or more external practicum sites (e.g., schools, rehabilitation centers, skilled nursing facilities, private practices, hospitals). Academic programs work together with external practicum sites to help provide these experiences.

Clinical Affiliation Agreements

The *clinical affiliation agreement* is a formal contract between an academic institution (college or university) and an external practicum site. Most academic programs require a clinical affiliation agreement before sending students to external practicum sites.

The clinical affiliation agreement identifies the responsibilities and liabilities of each party and ensures an appropriate learning experience for the student clinician. Agreements typically include the responsibilities listed in the boxed information below:

Mutual responsibilities of the academic institution and practicum site

- Determine the length of time that the agreement will be in effect and options for renewal
- Agree on terms for appropriate discipline or dismissal of a student clinician
- Provide reasonable accommodations to student clinicians with disabilities so that they can perform essential job functions and acquire the necessary clinical knowledge and skills

Responsibilities of the academic institution

- Select qualified student clinicians
- Advise student clinicians of their rights and responsibilities under the agreement
- Require student clinicians to comply with the site's health status requirements and provide appropriate documentation
- Ensure that student clinicians have the necessary professional liability insurance
- Educate student clinicians regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Provide the practicum site with expected learning objectives for the student clinician and necessary evaluation forms

Responsibilities of the practicum site

- Provide student clinicians and academic institution with the rules and policies of the practicum site
- Provide student clinicians with the necessary experiences to attain learning objectives
- Maintain student records and protect the confidentiality of these records as dictated by the Family Educational Rights and Privacy Act (FERPA, 1973)
- Gather data regarding clinical performance
- Evaluate performance and provide feedback to the student clinician and academic institution
- Provide the student clinician with any necessary credentialing information (e.g., requirements for provisional licensure from the state)

Administrative Tasks Prior To Student Clinician Placement

The practicum site needs to complete a number of tasks prior to student clinician placement, including those listed below:

- Obtain any necessary approvals from the facility for serving as a clinical educator and placement site.
- Determine if the university offers or requires clinical educators to have taken university or professional development courses on clinical supervision or specific clinical topics.
- Review the agreement that the facility has established with the university.
- Contact human resources staff members at the facility regarding requirements and orientation processes, including
 - procuring required ID badges;
 - ensuring that student background checks, if required, are complete;
 - ensuring that students complete required facility orientations; and
 - ensuring that immunization requirements have been met.
- Confirm dates for student clinician practicum.
- Schedule periodic "check-in" meetings with the university clinic director.
- Facilitate site visits by university clinical faculty over the course of the student clinician's placement.
- Confirm grade submission policies and procedures.

Stipends

There is no official ASHA policy regarding payment of students for clinical practicum. However, because it is acceptable to charge for supervised services provided by students, it follows that it is acceptable to pay students in practicum settings. See [*Issues in Ethics: Ethical Issues Related to Clinical Services Provided by Audiology and Speech-Language Pathology Students*](#) (ASHA, 2013e) for more details.

Students work with their academic program and practicum site to determine whether a stipend is available and/or appropriate. Important considerations include

- the academic program's policy on student stipends;
- compliance with state licensing or other regulatory agency policy; and
- the potential impact of the stipend on the student's financial aid package.

Even if a student is being paid a stipend, he or she requires the appropriate level of supervision and teaching necessary for training. Make clients, patients, and families aware that services are being rendered by a student clinician under the supervision of a credentialed and/or licensed practitioner.

Clinical Educator Compensation

It is not uncommon for clinicians serving as external practicum site clinical educators to be offered incentives or compensation for the additional work involved in being a clinical educator. ASHA does not have a policy on payment of externship clinical educators. Some academic institutions may offer compensation in the form of a stipend or in-kind

services (e.g., continuing education opportunities) or, for example, a "thank you" lunch at the end of the semester.

In some cases, the employer (practicum site) might offer compensation or incentives to the employee for working with student clinicians. For example, when practical, the employee may be given a temporarily reduced caseload while working with a student clinician.

If the audiologist or SLP receives payment from the university for serving as an externship clinical educator, he or she will need to disclose this to the employer. As the direct beneficiary of this payment, the individual will also need to declare the income when filing his or her personal income taxes.

Ethics

Clinical educators who are members of ASHA are expected to abide by the [Code of Ethics](#) (ASHA, 2010r) and have the unique opportunity to reinforce and model the importance of the Code of Ethics to their student clinicians.

There are also a number of Issues in Ethics Statements published by ASHA's Board of Ethics that provide guidance in addressing some of the challenges inherent in clinical education. See [Ethical Issues Related to Clinical Services Provided by Audiology and Speech-Language Pathology Students](#) (ASHA, 2013e) and [Issues in Ethics: Supervision of Student Clinicians](#) (ASHA, 2010) for more details.

Clinical educators and mentors working with speech-language pathology clinical fellows can also review [Issues in Ethics: Responsibilities of Individuals Who Mentor Clinical Fellows in Speech-Language Pathology](#) (2013a) for guidance.

Legal/Regulatory Requirements

Certification Standards

The standards for certification for audiology and speech-language pathology are established by audiologists and SLPs, respectively, who are members of ASHA's Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC). It is important for clinical educators to be familiar with the Standards and Implementation Procedures for the [Certificate of Clinical Competence in Audiology](#) (CCC-A) and the [Certificate of Clinical Competence in Speech-Language Pathology](#) (CCC-SLP) when working with students interested in seeking ASHA certification.

Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA)

To embark on a career as an ASHA-certified audiologist or SLP, students must complete the necessary entry-level graduate degree from a program accredited by the [Council on Academic Accreditation in Audiology and Speech-Language Pathology](#) (CAA; ASHA, 2014).

Medicare Coverage Of Students And Clinical Fellows

Clinical educators must comply with Medicare guidelines related to coverage of student and clinical fellowship services. ASHA has compiled information about these regulations in the following sources:

- [Medicare Coverage of Students: Audiology](#)
- [Medicare Coverage of Students & Clinical Fellows: Speech-Language Pathology](#)

Medicaid Coverage

Audiology and speech-language pathology are recognized as covered services under the Medicaid program. The federal government establishes broad guidelines, and each state then administers its own program. Review and approval is conducted by the federal Centers for Medicare & Medicaid Services (CMS).

Medicaid coverage of services provided "under the direction of" a qualified professional varies by state. See [Medicaid Coverage of Speech-Language Pathologists and Audiologists](#) for professional and state-specific information.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a law designed to improve the efficiency and effectiveness of the nation's health care system and health care operations. HIPAA

- protects health insurance coverage when someone loses or changes his or her job;
- addresses issues such as pre-existing conditions;
- includes provisions for the privacy and security of health information;
- specifies electronic standards for the transmission of health information; and
- requires unique identifiers for providers.

See the [Health Insurance Portability and Accountability Act \(1996\)](#) for additional information and resources.

Student Clinicians and HIPAA

HIPAA regulations apply to all [covered entities](#). These include health care operations or systems "conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers."

Student clinicians providing services in such health care settings will need to learn about HIPAA regulations and should be introduced to the facility's HIPAA policies and procedures. Facilities may require that student clinicians receive HIPAA training as part of their orientation. Just as any employee in the facility, student clinicians are expected to abide by HIPAA's Privacy Rule which applies to all forms of protected health information (PHI) whether oral, paper, or electronic.

Family Educational Rights and Privacy Act (FERPA)

[FERPA](#) (1973) protects the privacy of student education records and applies to all schools that receive funds under an applicable program of the U.S. Department of

Education. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 years or attends an institution beyond the high school level.

Student Clinicians and FERPA

Rights of students receiving services in the practicum setting. In education practicum settings (i.e., schools), student clinicians under the supervision of a qualified professional may generally be considered a "school official" with a "legitimate educational interest" and, as such, may have access to an individual's education records under this legislation. FERPA requires that schools specify the criteria for determining which parties are school officials and what the school considers to be a legitimate educational interest. Student clinicians should be made aware of their responsibilities under FERPA not to disclose personally identifiable information from education records unless authorized to do so, either with parental consent or under one of the conditions in FERPA permitting disclosure without consent. For more information, see [FERPA General Guidance for Students](#).

Rights of the student clinician. The education records of student clinicians are also protected under FERPA; the student clinician has the right to access his or her own education records, seek to have those records amended, control the disclosure of personally identifiable information from the records, and file a complaint with the school or department if he or she feels that these rights have been violated.

Although there are some exceptions, the university generally may not disclose personal identifiable information from the student clinician's educational records without the student's written consent. One exception is when the information is of legitimate educational interest. A clinical practicum site might be allowed access to a student clinician's personal identifiable information and must protect the confidentiality of this information, along with any other educational records generated during the practicum experience (e.g., performance evaluations and grades). For more information, see [FERPA General Guidance for Students](#).

Telesupervision

Telesupervision of student clinicians occurs when a qualified professional observes, from a distance, the delivery of services by the student and provides feedback or assistance as needed. Telesupervision offers the potential to expand students' access to clinical placements and to reduce travel and scheduling conflicts for clinical educators. Although telesupervision and telepractice are related due to their use of technology, ASHA's definition of *telepractice* does not include supervision.

See [ASHA's resource on telepractice](#) for information on technology, security, licensure, and other tips.

Regulations and Laws

The use of telesupervision as an alternative to in-person supervision may depend on the policies, regulations, and/or laws of various stakeholders such as universities,

clinical settings, ASHA, state licensure boards, and state and federal laws and regulations.

Increasingly, state licensure laws include a definition of *telepractice* and regulations related to it, which may or may not include guidance regarding telesupervision. States may vary in terms of whether they specifically address the issue of supervising students from a distance.

Ethical Responsibilities

The clinical educator has an ethical responsibility for the welfare of the individual receiving clinical services and must determine if telesupervision is an appropriate means to supervise a particular student clinician in view of the type of setting, client population, and level of independence of the individual delivering the service.

When implementing telesupervision practice and policies, consider the security of the telesupervision transmission in light of relevant state and federal laws such as HIPAA and FERPA. Policies about safety, liability, and whether a certified and/or licensed professional needs to be on site are also important and relevant considerations.

Knowledge and Skills

Like telepractice, delivering supervision services from a distance requires additional knowledge and skills for issues such as managing technology, complying with licensure and security requirements, providing feedback, and so forth. Training may be necessary for clinical educators regarding how to provide telesupervision so that quality and effectiveness of the supervision is equivalent to in-person supervision.

Tips And Considerations For Telesupervision

ASHA offers several guidelines for the implementation of telesupervision:

- Conduct a trial prior to the scheduled observation to identify and resolve technical and logistical issues (e.g., connectivity location of the microphone and camera).
- Always have an alternate means for the telesupervisor and clinician to communicate in case there is a problem with connectivity or equipment.
- The telesupervisor shares his or her web camera when being introduced to the client/student/patient at the beginning of the session but may stop sharing the web camera after introductions in order to minimize distractions.
- Providing the background case information as well as an outline for the test plan/lesson plan in advance helps to plan camera/microphone placement so that the telesupervisor can have an optimal view of the client/student/patient and materials.
- If online feedback or instructions are being provided during the session, the telesupervisee can receive communications via an earpiece to avoid distracting the client/student/patient.

Interprofessional Education and Interprofessional Practice

According to the World Health Organization (WHO; 2010), "Interprofessional education (IPE) occurs when two or more professions learn about, from, and with each other to enable effective collaboration and improve . . . outcomes" (p. 7). IPE is an essential first step in preparing professionals to work collaboratively in response to client/student/patient needs.

Interprofessional practice (IPP) allows workers from a variety of professional backgrounds to work together with clients/students/patients, families, caregivers, and communities to provide the highest quality and most comprehensive services possible (WHO, 2010).

Interprofessional education and collaborative practice align with national efforts toward a more interprofessional and collaborative service delivery model that centers on the individual and family with the aim of educating populations, improving health and safety, and enhancing the overall cost effectiveness of educational and health care services.

Clinical educators have the opportunity to engage in IPE/IPP and can reinforce best practices in this area. ASHA has compiled a number of [interprofessional education/interprofessional practice \(IPE/IPP\) resources](#). Clinical educators and CF mentors may want to familiarize themselves with [Core Competencies for Interprofessional Collaborative Practice](#), a report published by an expert panel of the Interprofessional Education Collaborative (IPEC, 2011), as well as ASHA's [Interprofessional Education \(IPE\): Final Report, Ad Hoc Committee on Interprofessional Education](#) (ASHA, 2013f).

References

American Academy of Audiology. (n.d.). *Clinical education guidelines for audiology externships*. Available from <http://www.audiology.org/publications-resources/document-library/clinical-education-guidelines-audiology-externships>

American Speech-Language-Hearing Association. (1991). *Students and professionals who speak English with accents and nonstandard dialects: Issues and recommendations* [Position Statement]. Available from <http://www.asha.org/policy/PS1998-00117/>

American Speech-Language-Hearing Association. (2004). *Knowledge and skills needed by speech-language pathologists and audiologists to provide culturally and linguistically appropriate services*. [Knowledge and Skills Document]. Available from <http://www.asha.org/policy/KS2004-00215/>

American Speech-Language-Hearing Association. (2010a). *Code of ethics* [Ethics Document]. Available from <http://www.asha.org/Code-of-Ethics/>

American Speech-Language-Hearing Association. (2010b). *Issues in ethics: Supervision of student clinicians* [Issues in Ethics Statement]. Available from <http://www.asha.org/Practice/ethics/Supervision-of-Student-Clinicians/>

American Speech-Language-Hearing Association. (2011). *The clinical education of students with accents* [Professional Issues Statement]. Available from <http://www.asha.org/policy/PI2011-00324/>

American Speech-Language-Hearing Association. (2013a). *Issues in ethics: Responsibilities of individuals who mentor clinical fellows in speech-language pathology* [Issues in Ethics Statement]. Available from <http://www.asha.org/Practice/ethics/Responsibilities-of-Individuals-Who-Mentor-Clinical-Fellows-in-Speech-Language-Pathology/>

American Speech-Language-Hearing Association. (2013b). *Speech-language pathology assistant scope of practice* [Scope of practice document]. Available from <http://www.asha.org/policy/SP2013-00337>

American Speech-Language-Hearing Association. (2013c). *Knowledge, skills and training considerations for individuals serving as supervisors* [Final report, Ad Hoc Committee on Supervision]. Available from <http://www.asha.org/uploadedFiles/Supervisors-Knowledge-Skills-Report.pdf> [PDF]

American Speech-Language-Hearing Association. (2013d). *Issues in ethics: Cultural and linguistic competence* [Issues in Ethics Statement]. Available from <http://www.asha.org/Practice/ethics/Cultural-and-Linguistic-Competence/>

American Speech-Language-Hearing Association. (2013e). *Issues in ethics: Ethical issues related to clinical services provided by audiology and speech-language pathology students* [Issues in Ethics Statement]. Available from <http://www.asha.org/Practice/ethics/Ethical-Issues-Related-to-Clinical-Services-Provided-by-Audiology-and-Speech-Language-Pathology-Students/>

American Speech-Language-Hearing Association. (2013f). *Interprofessional education: Final report, Ad Hoc Committee on Interprofessional Education*. Available from <http://www.asha.org/uploadedFiles/Report-Ad-Hoc-Committee-on-Interprofessional-Education.pdf>

American Speech-Language-Hearing Association. (2014). *Council on Academic Accreditation in Audiology and Speech-Language Pathology Handbook. Section III. Standards for accreditation of graduate education programs in audiology and speech-language pathology*. Retrieved from www.asha.org/Academic/accreditation/Accreditation-Handbook/

Americans With Disabilities Act of 1990, 42 U.S.C. § 126 (1990).

Anderson, J. (1988). *The supervisory process in speech-language pathology and audiology*. Boston, MA: College-Hill.

Anderson, N. (1998). Providing feedback to preservice teachers of reading in field settings. *Reading Research and Instruction*, 37, 123–136.

Aronson, L. (2011). Twelve tips for teaching reflection at all levels of medical education. *Medical Teacher*, 33, 200–205.

Ashford, S. J., & Cummings, L. L. (1983). Feedback as an individual resource: Personal strategies of creating information. *Organizational Behavior and Human Performance*, 32, 370–398.

- Ashford, S. J., Blatt, R., & Vande Walle, D. (2003). Reflections on the looking glass: A review of research on feedback-seeking behavior in organizations. *Journal of Management*, 29, 773–799.
- Barnum, M. G. (2008). Questioning skills demonstrated by approved clinical instructors during clinical field experiences. *Journal of Athletic Training*, 43, 284–292.
- Barnum, G. M., & Guyer, M. S. (2015, April). *The SQF model of clinical supervision*. Paper presented at the Annual Conference of the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD), Newport Beach, CA.
- Barnum, G. M., Guyer, M. S., Levy, L. S., & Graham, C. (2009). The supervision, questioning, and feedback model of clinical teaching: A practical approach. In T. G. Wiedner (Ed.), *The athletic trainer's pocket guide to clinical teaching* (pp. 85–99). Thorofare, NJ: SLACK.
- Bose, M. M., & Gijsselaers, W. H. (2013). Why supervisors should promote feedback-seeking behaviour in medical residency. *Medical Teacher*, 35(11), e1573–e1583.
- Brasseur, J. (1989). The supervisory process: A continuum perspective. *Language, Speech, and Hearing Services in Schools*, 20, 274–295.
- Caracciolo, G. (1976). *Perceptions by speech pathology student-clinicians and supervisors of interpersonal conditions and professional growth during the supervisory contract* (Doctoral dissertation, Columbia University Teachers College). *Dissertation Abstracts International*, 37, 4411B.
- Caracciolo, G. L., Rigrodsky, S., & Morrison, E. B. (1978a). Perceived interpersonal conditions and professional growth of master's level speech-language pathology students during the supervisory process. *ASHA*, 20, 467–477.
- Caracciolo, G. L., Rigrodsky, S., & Morrison, E. B. (1978b). A Rogerian orientation to the speech-language pathology supervisory relationship. *ASHA*, 20, 286–290.
- Celce-Murcia, M., Brinton, D. M., & Goodwin, J. M. (1996). *Teaching pronunciation: A reference for teachers of English to speakers of other languages*. Cambridge, England: Cambridge University Press.
- Coleman, T. J. (2000). *Clinical management of communication disorders in culturally diverse children*. Needham Heights, MA: Allyn & Bacon.
- Collins, A., Brown, J. S., & Newman, S. E. (1989). Cognitive apprenticeship: Teaching the crafts of reading, writing, and mathematics. In L. B. Resnick (Ed.), *Knowing, learning, and instruction: Essays in honor of Robert Glaser* (pp. 453–494). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Council of Academic Programs in Communication Sciences and Disorders. (2013). *White paper: Preparation of speech-language pathology clinical educators*. Retrieved from <http://scotthall.dotster.com/capcsd/wp-content/uploads/2014/10/Preparation-of-Clinical-Educators-White-Paper.pdf>

- Crommelinck, M., & Anseel, F. (2013). Understanding and encouraging feedback-seeking behaviour: A literature review. *Medical Education*, 47, 232–241.
- De Bruin, A. B., Smits, N., Rikers, R. M., & Schmidt, H. G. (2008). Deliberate practice predicts performance over time in adolescent chess players and drop-outs: A linear mixed models analysis. *British Journal of Psychology*, 99, 473–497.
- Dennen, V. P., & Burner, K. J. (2008). The cognitive apprenticeship model in educational practice. In J. M. Spector, M. D. Merrill, J. van Merriënboer, & M. P. Driscoll (Eds.), *Handbook of research on educational communications and technology* (pp. 425–439). New York, NY: Lawrence Erlbaum Associates.
- Dowling, S. (2001). *Supervision: Strategies for successful outcomes and productivity*. Needham Heights, MA: Allyn & Bacon.
- Duvivier, R. J., van Dalen, J., Muijtjens, A. M., Moolaert, V. R., van der Vleuten, C. P., & Scherpbier, A. J. (2011). The role of deliberate practice in the acquisition of clinical skills [Open Access article]. *BMC Medical Education*, 11(1), 101. Retrieved from <http://www.biomedcentral.com/1472-6920/11/101>
- Ende, J. (1983). Feedback in clinical medical education. *Journal of the American Medical Association*, 250, 777–781.
- Ericsson, K. A. (2004). Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains. *Academic Medicine*, 79(10), S70–S81.
- Ericsson, K. A., Krampe, R. T., & Tesch-Römer, C. (1993). The role of deliberate practice in the acquisition of expert performance. *Psychological Review*, 100, 363–406.
- Facione, P. A. (2000). The disposition toward critical thinking: Its character, measurement, and relationship to critical thinking skill. *Informal Logic*, 20(1), 61–84.
- Family Educational Rights and Privacy Act of 1973. 20 U.S.C. § 1232g (1973).
- Frank, J. R., Snell, L. S., Cate, O. T., Holmboe, E. S., Carraccio, C., Swing, S. R., . . . Harris, K. A. (2010). Competency-based medical education: Theory to practice. *Medical Teacher*, 32, 638–645.
- Gardner, R. (2002). Cross cultural perspectives in supervision. *Western Journal of Black Studies*, 26, 98–106.
- Gavett, E., & Peapers, R. (2006, November). *Developing critical thinking in student clinicians: The role of questions*. Paper presented at the Annual Convention of the American Speech-Language Hearing Association, Miami Beach, FL.
- Gavett, E., & Peapers, R. (2007). Critical thinking: The role of questions. *Perspectives on Issues in Higher Education*, 10, 3–5.
- Geller, E., & Foley, G. (2009). Broadening the "ports of entry" for speech-language pathologists: A relational and reflective model for clinical supervision. *American Journal of Speech-Language Pathology*, 18, 22–41.

Ghitter, R. (1987). Relationship of interpersonal and background variables to supervisee clinical effectiveness. In S. Farmer (Ed.), *Proceedings of a National Conference on Supervision—Clinical supervision: A coming of age* (pp. 49–56). Jekyll Island, GA: Council of University Supervisors of Practicum in Speech-Language Pathology and Audiology.

Hagler, P., Casey, P., & DesRochers, C. (1989). Effects of feedback on facilitative conditions offered by supervisors during conferencing. In D. Shapiro (Ed.), *Proceedings of the 1989 National Conference on Supervision: Supervision Innovations* (pp. 155–158). Sonoma, CA: Council of Supervisors in Speech-Language Pathology and Audiology.

Harvard Negotiation Project. (n.d.). Program on negotiation: Harvard Law School. Retrieved from http://www.pon.harvard.edu/category/research_projects/harvard-negotiation-project/

Health Insurance Portability and Accountability Act of 1996. Pub. L. No. 104-191, 110 Stat. 1938 (1996).

Heery, E., & Noon, M. (2008). *A dictionary of human resource management*. New York, NY: Oxford University Press.

Herd, C., & Moore, R. (2012). Multicultural issues: Supervision and multicultural issues: Supervisors and supervisees. *Perspectives on Administration and Supervision*, 22, 33–39.

Hidden Curriculum. (2014, August 26). In S. Abbott (Ed.), *The glossary of education reform*. Retrieved from <http://edglossary.org/hidden-curriculum>

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, DC: Author. Retrieved from <http://www.aacn.nche.edu/education-resources/ipcreport.pdf>

Jarrow, J. (2012, February). Students with disabilities in classroom and clinic: Business as usual. *Access Academics and Research*. Retrieved from <http://www.asha.org/Academic/questions/Students-With-Disabilities-in-Classroom-and-Clinic--Business-as-Usual/>

Kerr, N. L., MacCoun, R. J., & Kramer, G. P. (1996). Bias in judgment: Comparing individuals and groups. *Psychological Review*, 103, 687–719.

King, A. (1995). Designing the instructional process to enhance critical thinking across the curriculum. *Teaching of Psychology*, 22(1), 1–17.

Krampe, R. T., & Ericsson, K. A. (1996). Maintaining excellence: Deliberate practice and elite performance in young and older pianists. *Journal of Experimental Psychology: General*, 125, 331–359.

Lancaster, L. C., & Stillman, D. (2002). *When generations collide: Who they are, why they clash, how to solve the generational puzzle at work*. New York, NY: Harper Business.

- Lunenburg, F. C. (2012). Performance appraisal: Methods and rating errors. *International Journal of Scholarly Academic Intellectual Diversity*, 14(1), 1–9.
- Luterman, D. (2006, March 21). The counseling relationship. *The ASHA Leader*.
- Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Science Education*, 14, 595–621.
- McCrea, E. (1980). *Supervisee ability to self-explore and four facilitative dimensions of supervisor behavior in individual conferences in speech-language pathology* (Doctoral dissertation, Indiana University, 1980). *Dissertation Abstracts International*, 41, 2134B. (University Microfilms No. 80-29, 239)
- McCrea, E. S., & Brasseur, J. A. (2003). *The supervisory process in speech-language pathology and audiology*. Boston, MA: Allyn & Bacon.
- McCready, V. (2007). Generational differences: Do they make a difference in supervisory and administrative relationships? *Perspectives on Administration and Supervision*, 17, 6–9.
- McCready, V., Roberts, J. E., Bengala, D., Harris, H., Kingsley, G., & Krikorian, C. (1996). A comparison of conflict tactics in the supervisory process. *Journal of Speech, Language, and Hearing Research*, 39, 191–199.
- Muñoz, M. L., Watson, J. B., Yarbrough, L., & Flahive, L. K. (2011, April 26). Monolingual supervision of bilingual student clinicians: Challenges and opportunities. *The ASHA Leader*.
- Ng, S. L., & Jennings, M. B. (Eds.). (2012). Lessons from reflective learning in theory, research, and practice. *Seminars in Hearing*, 33(2), 115–212. doi:10.1055/s-002-23256
- Nottingham, S., & Henning, J. (2014a). Feedback in clinical education, Part I: Characteristics of feedback provided by approved clinical instructors. *Journal of Athletic Training*, 49(1), 49–57.
- Nottingham, S., & Henning, J. (2014b). Feedback in clinical education, Part II: Approved clinical instructor and student perceptions of and influences on feedback. *Journal of Athletic Training*, 49(1), 58–67.
- Passiment, M., Sacks, H., & Huang, G. (2011). *Medical simulation in medical education: Results of an AAMC survey*. Washington DC: Association of American Medical Colleges.
- Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2012). *Crucial conversations: Tools for talking when stakes are high*. New York, NY: McGraw-Hill.
- Pickering, M. (1979). *Interpersonal communication in speech-language pathology clinical practicum: A descriptive humanistic perspective* (Doctoral dissertation, Boston University School of Education, 1979). *Dissertation Abstracts International*, 40, 2140B. (University Microfilms No. 79-23, 892)

Pickering, M. (1984). Interpersonal communication in speech-language pathology supervisory conferences: A qualitative study. *Journal of Speech and Hearing Disorders*, 49, 189–195.

Pickering, M. (1987). Interpersonal communication and the supervisory process: A search for Ariadne's thread. In M. Cargo & J. Pickering (Eds.), *Supervision in human communication disorders: Perspectives on a process* (pp. 203–225). San Diego, CA: College-Hill Press.

Rehabilitation Act of 1973, Section 504. Pub. L. No. 93-112, 87 Stat. 394 (Sept. 26, 1973), codified at 29 U.S.C. § 701.

Robertson, S. C. (1992). *Find a mentor or be one*. Bethesda, MD: American Occupational Therapy Association.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York, NY: Basic Books.

Sears, G. J., & Rowe, P. M. (2003). A personality-based similar-to-me effect in the employment interview: Conscientiousness, affect- versus competence-mediated interpretations, and the role of job relevance. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, 35(1), 13–24.

Society for Human Resource Management. (2013). How to establish a performance improvement plan. Retrieved from <http://www.shrm.org/templatestools/howtoguides/pages/performanceimprovementplan.aspx>

Stone, D., Patton, B., & Heen, S. (2010). *Difficult conversations: How to discuss what matters most*. New York, NY: Penguin.

Thorndike, E. L. (1920). The constant error in psychological ratings. *Journal of Applied Psychology*, 4, 25–29.

Unger, J. M., Keith, N., Hilling, C., Gielnik, M. M., & Frese, M. (2009). Deliberate practice among South African small business owners: Relationships with education, cognitive ability, knowledge, and success. *Journal of Occupational and Organizational Psychology*, 82(1), 21–44.

U.S. Department of Education. (1980). (34 C.F.R. 100.3 [b]; 34 C.F.R. 100.3 [b]; 34 C.F.R. 100.3 [c]). Available from <https://www2.ed.gov/policy/rights/reg/ocr/edlite-34cfr100.html>

U.S. Department of Education. (1980). (34 C.F.R. 104.42 [a]; 34 C.F.R. 104.43 [c]; 34 C.F.R. 104.47 [b]). Available from <https://www2.ed.gov/policy/rights/reg/ocr/edlite-34cfr104.html>

Whitelaw, G. M. (2012). Administration: Leadership challenges: Difficult conversations. *Perspectives on Administration and Supervision*, 22, 40–44. doi:10.1044/aas22.1.40

Wolfram, W. (1991). *Dialects and American English*. Englewood Cliffs, NJ: Prentice Hall.

World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. Geneva, Switzerland: Author. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HP_N_10.3_eng.pdf?ua=1

Zraick, R. I. (n.d.). The use of standardized patients in communication sciences and disorders. Rockville, MD: American Speech-Language-Hearing Association. Retrieved from <http://www.asha.org/Academic/questions/Use-of-Standardized-Patients-in-CSD/>

Zraick, R. I., & Allen, R. M. (2002). Using standardized patients to train and test speech-language pathology students. The innovative professor in communication disorders. *Perspectives on Issues in Higher Education*, 1, 17–19.

Zraick, R. I., Allen, R. M., & Johnson, S. B. (2003). The use of standardized patients to teach and test interpersonal and communication skills with students in speech-language pathology. *Advances in Health Sciences Education*, 8, 237–248.



AMERICAN
SPEECH-LANGUAGE-
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Supervision of Student Clinicians

Board of Ethics

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About This Document

This Issues in Ethics statement is a revision of *Supervision of Student Clinicians* (2003). The Board of Ethics reviews Issues in Ethics statements periodically to ensure that they meet the needs of the professions and are consistent with ASHA policies.

Issues in Ethics Statements: Definition

From time to time, the Board of Ethics determines that members and certificate holders can benefit from additional analysis and instruction concerning a specific issue of ethical conduct. Issues in Ethics statements are intended to heighten sensitivity and increase awareness. They are illustrative of the Code of Ethics and intended to promote thoughtful consideration of ethical issues. They may assist members and certificate holders in engaging in self-guided ethical decision-making. These statements do not absolutely prohibit or require specified activity. The facts and circumstances surrounding a matter of concern will determine whether the activity is ethical.

Introduction

This Issues in Ethics statement is presented for the guidance of American Speech-Language-Hearing Association (ASHA) members and certificate holders in matters relating to supervision of students engaged in the provision of clinical services during practicum experiences. ASHA members and certificate holders are employed in a variety of work settings and are required by their employers, by their states, and by governmental agencies, as well as by ASHA, to comply with prescribed personnel standards related to certification and licensure. Although the specific standards of these groups can and do differ, under the Code of Ethics, members and certificate holders delivering or supervising clinical services must hold ASHA certification in the area of their clinical or supervisory work regardless of the work setting, state, or jurisdiction in which they are employed. Further, ASHA-certified individuals engaged in supervision of student clinicians are bound to honor their responsibility to hold paramount the welfare of persons they serve professionally and to ensure that services are provided competently by students under their supervision.

Discussion

The Board of Ethics cites and interprets the following sections of the Code of Ethics (2010) that pertain to the supervision of student clinicians:

- **Principle of Ethics I:** Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities and they shall treat animals involved in research in a humane manner.
- **Principle of Ethics I, Rule A:** Individuals shall provide all services competently.
- **Principle of Ethics I, Rule D:** Individuals shall not misrepresent the credentials of assistants, technicians, support personnel, students, Clinical Fellows, or any others under their supervision, and they shall inform those they serve professionally of the name and professional credentials of persons providing services.
- **Principle of Ethics I, Rule G:** Individuals who hold the Certificates of Clinical Competence may delegate tasks related to provision of clinical services that require the unique skills, knowledge, and judgment that are within the scope

of their profession to students only if those services are appropriately supervised. The responsibility for client welfare remains with the certified individual.

- **Principle of Ethics II, Rule A:** Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.
- **Principle of Ethics II, Rule B:** Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training, and experience.
- **Principle of Ethics IV, Rule B:** Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.

ASHA-certified individuals who supervise students cannot delegate the responsibility for clinical decision making and management to the student. The legal and ethical responsibility for persons served remains with the certified individual. However, the student can, as part of the educational process, make client management recommendations and decisions pending review and approval by the supervisor. Further, the supervisor must inform the client or client's family of the qualifications and credentials of the student supervisee involved in the provision of clinical services.

All supervised clinical activities provided by the student must fall within the scope of practice for the specific profession to count toward the student's certification. The supervisor must achieve and maintain competency in supervisory practice as well as in the disability areas for which supervision is provided. The amount of supervision provided by the ASHA-certified supervisor must be commensurate with the student's knowledge, experience, and competence to ensure that the welfare of the client is protected. The supervisor must also ensure that the student supervisee maintains confidentiality of client information and documents client records in an accurate and timely manner.

Discrepancies may exist among state requirements for supervision required for teacher certification in speech-language pathology and audiology, state licensure in the professions of speech-language pathology and/or audiology, and ASHA certification standards. In states where credential requirements or state licensure requirements differ from ASHA certification standards, supervised clinical experiences (including student practica for teacher licensing) will count toward or may be applied toward ASHA certification (CCC) requirements only if those practicum hours have been supervised by ASHA-certified personnel.

Guidance

ASHA-certified individuals who supervise students should possess or seek training in supervisory practice and provide supervision only in practice areas for which they possess the appropriate knowledge and skills. The supervisor must oversee the clinical activities and make or approve all clinical decisions to ensure that the welfare of the client is protected. The supervisor should inform the client or the client's family about the supervisory relationship and the qualifications of the student supervisee.

The supervisor must provide no less than the level of supervision that is outlined in the current certification standards and increase supervision if needed based on the student's knowledge, experience, and competence. The supervisor should document the amount of direct and indirect supervision provided, and design and implement procedures that will protect client confidentiality for services provided by students under supervision.

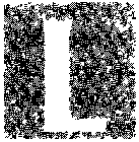
ASHA members and certificate holders engaged in the preparation, placement, and supervision of student clinicians must make reasonable efforts to ensure that direct practicum supervision is provided by professionals holding the appropriate CCC. They must inform students who engage in student practica for teacher licensing, or other clinical practica under a non-ASHA-certified supervisor that these experiences cannot be applied to ASHA certification. ASHA-certified personnel cannot sign for clinical practicum experiences that were actually supervised by non-ASHA-certified individuals. It is unethical for certificate holders to approve or sign for clinical hours for which they did not provide supervision.

RESEARCH TO PRACTICE

Defining, Developing, and Maintaining Clinical Expertise

Alan C. Kamhi

University of Memphis, TN



Last year, I wrote about the need for a theory of clinical expertise in speech-language pathology (Kamhi, 1994). In the changing health care market, considerable energies are being expended now on ways to measure and document the efficacy of our treatment methods. Much has been written concerning the particular knowledge, technical skills, interpersonal skills, and attitudes that contribute to clinical expertise (see, for example, Cornett & Chabon, 1988; American Speech-Language-Hearing Association's Speech-Language Pathology Skills Inventory [ASHA, 1994a], and the rich body of supervision literature). There is relatively little information, however, concerning the actual impact some of these factors have on treatment outcomes. To address these gaps in our clinical research, I suggested that clinicians and clinician characteristics need to become the focus of our studies (Kamhi, 1994).

During the past couple of years, I have conducted a series of studies involving over 100 speech-language pathologists with varying levels of clinical experience. In this article, I will summarize some of the major findings from several of these studies, present a working model of clinical expertise, offer some speculative comments concerning the development and maintenance of clinical expertise, and discuss some of the problems with research in this area.

SUMMARY OF CLINICAL EXPERTISE RESEARCH

How do experienced clinicians view clinical expertise? In order to answer this question, 12 clinicians with 8-25 years of clinical experience ($M = 17$ years) were asked to discuss the factors they thought were important for providing effective therapy. The clinicians were drawn from a variety of clinical settings, including a university clinic, public and

private schools, and a home-based private practice. The interviews, which ranged from 30-60 minutes, were transcribed verbatim. The factors mentioned by the clinicians clustered into four categories: knowledge, technical skills, interpersonal skills/attitudes, and a category I have labeled "clinical philosophies," for lack of a better term. The specific factors clinicians mentioned appear in the Appendix.

Knowledge-based factors were not mentioned as much as the other three factors. When questioned about why they did not mention knowledge-based factors, clinicians indicated that an adequate knowledge base was assumed. The various clinical philosophies mentioned by the clinicians seemed fairly inclusive, though one could surely add to the list. For example, Naremore, Densmore, and Harman (1995) concluded a recent book on language intervention with school-age children with their four-part philosophy: question, think, strive for the ideal, and welcome the challenges.

In a related study, 26 graduate students and 46 practicing clinicians were asked to rate the importance of IO technical/procedural and IO interpersonal/attitudinal aspects of therapy and answer a few questions in writing about their ratings. The 46 practicing clinicians had been working for an average of 7 years (range 1-20 years). The majority worked in schools (33%), but all settings were represented (e.g., hospitals, rehabilitation facilities, home health, etc.). After completing the written portion of the study, clinicians were given the opportunity to talk about their written responses in follow-up interviews. Specific questions concerning the importance of the technical and interpersonal/attitudinal aspects of therapy were used to facilitate discussion. Technical aspects included objectives, therapy activities, materials, speech-language models, and behavioral management. Interpersonal/attitudinal aspects included adaptability, enthusiasm, confidence, interest, and innovativeness.

The data indicated that all clinicians, regardless of experience, rated interpersonal/attitudinal factors as significantly more important than technical aspects of therapy. Importantly, the average ratings were well above 4

on a 5-point scale for both aspects of therapy. The technical aspects of therapy that received the highest ratings were objectives and speech-language models. Interestingly, these aspects of therapy depend heavily on an adequate knowledge base. The attitudes that received the highest ratings were interest and adaptability. In the follow-up interviews, clinicians generally said that technical and interpersonal/attitudinal aspects of therapy were equally important. However, when one aspect of therapy was judged to be more important, it was almost always the interpersonal/attitudinal aspects. For example, a typical response was that one has to have the right attitudes in order for procedures to be effective.

A Model of Clinical Expertise

Figure 1 presents a working model of clinical expertise that is based on the factors clinicians believe are important for the provision of effective treatment. The examples of the three components listed on the figure are not meant to be inclusive. Over 100 clinicians were asked to comment on the model. The addition of the self-monitoring component and problem solving was based on suggestions on earlier versions of the model. A few clinicians felt that problem-solving skills were distinct from procedural skills and should be a separate box. Most clinicians, however, thought that there was enough overlap between the two to justify combining them. Clinicians were not concerned with the potential difficulty of distinguishing between knowledge and procedural/problem-solving skills. That is, they had no difficulty distinguishing the knowledge a clinician has of assessment and treatment procedures from the skills involved in implementing these procedures. Many clinicians appreciated the simplicity of the model and felt that any factor they thought was important for providing effective treatment could be placed in one of the four components of the model.

The Development of Clinical Expertise

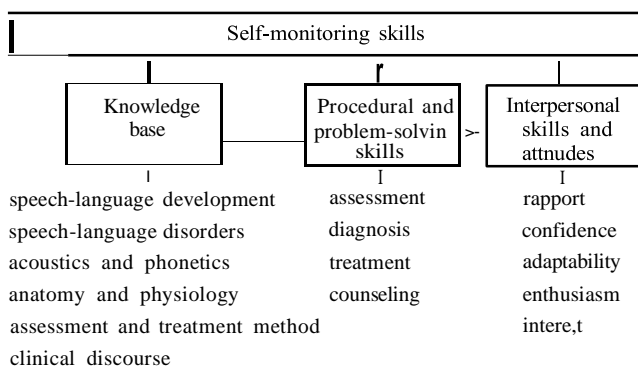
In order to get a sense of how experienced clinicians view the development of clinical expertise, the 12 experienced clinicians who helped me to define clinical expertise were asked to talk about how they have changed during

their professional careers. Clinicians talked a lot about their comfort level and confidence in their abilities to effect change. Several clinicians noted that they had a greater knowledge base right out of school. One clinician talked about how she was more tied to the knowledge base and techniques when she first began working. Now she takes the time to listen to clients and tries to get to know them. A couple of clinicians said they have become more "seat of the pants" as they have gotten older. One of the clinicians mentioned that he makes decisions more quickly and accurately now. Many of the clinicians noted the increasing importance of interpersonal skills as they have matured as clinicians. Clinicians also noted a change to more functional and pragmatic objectives. One clinician said that she is not "so hung up on speech and language" as she was in the past; her main goals now focus on interpersonal and interactive skills and on treating the whole person.

Based on these interviews, I would like to offer some speculative thoughts on the development of clinical expertise. The development of clinical expertise seems to be characterized by the attainment of a certain comfort level with one's knowledge base, technical/problem-solving skills, and interpersonal skills/attitudes. In novice clinicians, there is a distinct division between these three components because novices are expending considerable efforts acquiring the requisite knowledge base at the same time they are learning technical skills. Their interpersonal skills and attitudes also may be inconsistent with some of the clinician models they are asked to emulate. With experience, novice clinicians become more confident with their ability to effect change. They become comfortable expressing their knowledge of the field, their technical skills become well honed, and they gradually develop their own clinical style/approach that reflects a unique combination of knowledge, technical/problem-solving skills, and interpersonal abilities and attitudes.

The experienced clinicians who were interviewed in these studies spoke often about learning to focus on the whole client rather than the part of the client that involves speech-language behavior. The view of clinical expertise that I am suggesting here also has to do with a whole and its parts. In this case, the whole is the clinician as a person. The part of the person that is the clinician consists of the three main components of clinical expertise discussed previously: knowledge base, procedural/problem-solving skills, and interpersonal skills/attitudes. Students do not view themselves as clinicians because they are first learning the knowledge and skills that define clinical expertise. Stated somewhat differently, in novice clinicians, there is a clear division between the student as a clinician (clinical self) and the student as a person (personal self). With experience, the knowledge, skills, and attitudes that define clinical competence gradually become an integral part of the person. The development of clinical expertise thus may be viewed as a gradual integration of clinical attributes with the attributes that define the person. The integration continues until the clinical self becomes fully merged with the personal self. The integration of the clinical self with the personal self is one reason experienced clinicians are so comfortable and confident.

Figure 1. Components of clinical expertise.



There is some support for this conceptualization of the developing clinician in the literature. DeJoy's (1991) recent article on overcoming fragmentation through the client-clinician relationship concludes with a section on the self as instrument. He cites a book by Combs, Avila, and Purkey (1971) on helping relationships, in which they stated that

Effective operation in the helping professions is a question of the use of the helper's self, the peculiar way in which he (sic) is able to combine his knowledge and understanding with his own unique ways of putting it into operation to be helpful to others. (DeJoy, 1991, p. 24)

DeJoy went on to write:

As professional helpers we may have to pull together not only our fragmented approaches to clients but also our fragmented selves.... Individuals may feel compelled to do something or be someone very special, when engaged in the role of professional helper. In fact, our clients may be best served when we interact in a manner consistent with our own self-concepts and perceptions of what makes good sense. (p. 24)

Of course what makes sense to one clinician may not make sense to another. There is, however, some consensus in the field that intervention should be functionally oriented, emphasizing meaningful communication with different partners in different social situations (e.g., Owens, 1995). For the novice clinician, it is as if barriers exist between clinical procedures and real life (i.e., functional, meaningful communication). The novice clinician typically treats the communication problem in the person rather than the person who happens to have a communication problem.

Maintaining Clinical Expertise: A Commitment to Learning and Change

The notion that clinical expertise can be attained suggests that once one reaches a certain level of clinical competence, there is nothing more to be learned. But clinical expertise involves more than the attainment of a certain level of clinical competence; it involves a commitment to learning as well. Expert clinicians are not satisfied with the attainment of a certain level of clinical competence; they continually strive to improve the effectiveness of the services they provide. Often, change is mentioned as the key element in maintaining clinical expertise. In defining clinical expertise, a number of clinicians noted the importance of change. For example, one clinician stated that "change was essential; if you don't change, you don't grow" (see Appendix).

In the January 1995 issue of *Asha*, a special section focused on change. In the lead article, Barbara Goldberg noted that "the single most important key to success is lifelong learning" (p. 47). Although change is arguably the key element in maintaining clinical expertise, the amount of change necessary to maintain clinical expertise and the areas in which change should occur are not very clear. Goldberg reprinted some suggestions from ASHA's Long Range Strategic Planning Board. These included: (a) work to maintain and enhance skills, (b) stay abreast of advances in technology, (c) be capable of evaluating communication

needs of specific populations, and (d) be flexible; participate in cross-disciplinary service delivery.

A number of factors influence the likelihood of clinician change. These factors can be divided into those that are clinician initiated and those that are externally generated by changes in clients, settings, or administrators. Continuing education experiences are another important source of change. The likelihood of a clinician-initiated change can be viewed in terms of a cost-benefit ratio. Cost equals the amount of effort involved in making the change. The benefit is the perceived benefit of the change on client progress and clinician job satisfaction. The higher the cost, the greater the benefits need to be. Clinicians may have more difficulty initially accepting changes that result from external factors, but with time, these changes may be viewed in a more positive light. For example, changes in continuing education requirements to maintain certification generally are not well received by most practitioners.

It should be clear that it is not sufficient for a model of clinical expertise simply to acknowledge the importance of adaptability and change; we need to understand how clinicians change throughout their professional careers. It may be possible to identify a series of stages that reflect the ongoing development and refinement of clinical expertise. For example, one important stage may occur when the clinical self becomes the personal self.

An understanding of the central role change plays in clinical expertise requires knowledge of the factors that influence learning and change in adults. The education field has a rich literature in this area (cf. Evans, 1982; Evertson, 1987). In our field, Crais and her colleagues (Crais, Geissinger, & Lorch, 1992) have examined the needs and preferences of clinicians and the impact in-service experiences have on clinical practice. They provide a number of suggestions of ways to ensure that information and skills gained in in-service activities will be used in the clinical setting.

CONCERNS AND FUTURE DIRECTIONS

I think we can learn a lot about clinical expertise and clinical decision-making by making clinicians and clinician characteristics the focus of research studies. One problem with this research that needs to be recognized, however, concerns the validity of asking clinicians to define clinical expertise. Just because a clinician believes that a particular attribute (e.g., flexibility) is critical for providing effective services does not mean that such an attribute is more important than one that is not mentioned. Many clinicians failed to mention the importance of observational skills or professional commitment, but these and other factors may play a significant role in the provision of effective therapy. Although clinicians have been an untapped resource for too long, it is important to realize that some clinicians may not know what makes them effective. A related concern is that clinical experience does not ensure clinical competence. We can all think of someone who is not providing high-quality services despite many years of clinical experience. It may

not be appropriate, therefore, to assign equal weight to the comments and views of all experienced clinicians.

The ideas concerning clinical expertise expressed in this article need to be supported by future studies that address the relationship between the knowledge and skills that define clinical expertise and measures of treatment outcome. As I noted last year (Kamhi, 1994), it is not easy to operationalize qualities such as flexibility, enthusiasm, and confidence and relate these qualities to outcome measures. There are now, however, a number of ongoing efforts in our profession that are addressing the need for high-quality outcome data. For example, ASHA's Task Force on Treatment Outcome and Cost Effectiveness currently is working to organize available data on the functional outcomes of adult patients in rehabilitation settings as well as develop plans for collecting outcome data in pediatric populations and in schools (ASHA, 1994b). Our understanding of clinical expertise will not be complete until we have research that systematically evaluates the effect different attributes of clinical expertise have on the clients we serve.

REFERENCES

- American Speech-Language-Hearing Association.** (1994a). *ASHA Speech-Language Pathology Skills Inventory*. Rockville, MD: Author.
- American Speech-Language-Hearing Association.** (1994b). *ASHA Task Force on Treatment Outcome and Cost Effectiveness Report II*. Rockville, MD: Author.
- Combs, A., Avila, D., & Purkey, W.** (1971). *Helping relationships*. Boston: Allyn & Bacon.
- Cornett, B., & Chabon, S.** (1988). *The clinical practice of speech-language pathology*. Columbus, OH: Merrill.
- Crais, B., Geissinger, S., & Lorch, N.** (1992). Inservice needs and preferences of speech-language pathologists working with infants and toddlers with special needs and their families. *Infant Toddler Intervention* 2, 263-276.
- DeJoy, D.** (1991). Overcoming fragmentation through the client-clinician relationship. *National Student Speech Language Hearing Association Journal*, 18, 17-25.
- Evans, J.** (1982). Inservice training for the 1980's. *Journal of the Division for Early Childhood*, 6, 67-73.
- Evertson, C.** (1987). Creating conditions for learning: From research to practice. *Theory Into Practice*, 26, 44-49
- Goldberg, B.** (1995, January). The transformation age: The sky's the limit. *Asha*, 37, 44-50.
- Kamhi, A.** (1994). Toward a theory of clinical expertise in speech-language pathology. *Language, Speech, and Hearing Services in Schools*, 25, 115-119.
- Naremore, R., Densmore, A., & Harman, D.** (1995). *Language intervention with school-aged children*. San Diego: Singular.
- Owens, R.** (1995). *Language disorders: A functional approach to assessment and intervention* (2nd ed.). Boston: Allyn & Bacon.

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Contact author: Alan G. Kamhi, Memphis Speech and Hearing Center, 807 Jefferson Avenue, Memphis, TN 38105.

APPENDIX

Knowledge, Skills, Attitudes, and Philosophies That Characterize Clinical Expertise

Knowledge

broad range of knowledge
knowledge about the client's background/family, level of functioning, etc.
know your goals/know what you're targeting and listening for

Technical/Procedural Skills

stay tuned to client's responses
specificity of feedback
pacing/timing
speech-language models
behavioral management
materials
reinforcement
organization/structure
preparedness

Interpersonal Skills and Attitudes

flexibility, adaptability
confidence
genuine concern/interest in client, sensitive to needs
enthusiasm
sincerity, warmth
risk-taker

creative, innovative
value system-the way you present yourself
positive, accepting/nonthreatening attitude
believing in what you're doing
patience
motivation
rapport (clinician-client relationship)
humor (be able to laugh at oneself)

Clinical Philosophies

family involvement, peer interaction (normal and disordered)
child-focused activities
client should know you're in control
therapy should be fun and meaningful
whole language
change is essential; if you don't change, you don't grow
classroom inclusion activities
functional communication (therapy should mimic real life)/hands-on activities
make sure client knows what to expect
controlled naturalism, nurturing environment
relaxed atmosphere
if it works, it's OK

Defining, Developing, and Maintaining Clinical Expertise

Alan G. Kamhi

Lang Speech Hear Serv Sch 1995;26;353-356

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University

The Supervisory Process in Speech-Language Pathology: Graduate Students' Perspective

Kathryn Taylor

Georgia State University
Atlanta, GA

Disclosure: Kathryn Taylor has no financial or nonfinancial relationships related to the content of this article.

Emily White

Georgia State University
Atlanta, GA

Disclosure: Emily White has no financial or nonfinancial relationships related to the content of this article.

Rachael Kaplan

Georgia State University
Atlanta, GA

Disclosure: Rachael Kaplan has no financial or nonfinancial relationships related to the content of this article.

Colleen M. O'Rourke

Georgia State University
Atlanta, GA

Disclosure: Colleen M. O'Rourke has no financial or nonfinancial relationships related to the content of this article.

Supervision is a critical component of graduate education in communication sciences and disorders. Students spend a large amount of time with their supervisors, who guide them through clinical experiences in graduate school. Thus, students believe certain supervisor characteristics may enhance or inhibit their success as a student clinician. This study investigated the opinions of graduate students about the supervisor behaviors and attributes that create a positive supervisory experience. Twenty-three students in the graduate Communication Disorders Program at Georgia State University completed a survey regarding their thoughts and opinions on the supervisory process. The results of the study indicated that students prefer supervisors who are knowledgeable and supportive and who create a collegial atmosphere for supervisory conferences. The results further suggested that supervisors should provide timely feedback to supervisees in a written or face-to-face form. The results of this study can be used to offer advice to clinical supervisors on the types of feedback and interpersonal characteristics that can maximize the student clinician's success.

All entry-level graduate programs in communication sciences and disorders require clinical practicum experiences. Practicum is a critical component of graduate education and the quality of the experience often depends on the supervisor-supervisee relationship. The American Speech-Language-Hearing Association's (ASHA's) technical report, "Clinical Supervision in Speech-Language Pathology" (2008a), recognized the critical nature of this relationship and stressed the need for it to be a collaborative relationship between the supervisor and the supervisee. In addition, ASHA's "Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision" (2008b) designated interpersonal skills needed for effective supervision, including using effective interpersonal strategies; recognizing and accommodating differences in learning styles; identifying challenges to successful communication interactions (i.e., gender, culture, generation); understanding the value of different observation formats; implementing a supervisory style appropriate to various supervisees and clients; resolving conflict; and fostering the supervisee's independent thinking in recognizing problems and developing solutions.

Graduate clinicians, however, will have unique perspectives on what characteristics they believe a supervisor needs to be effective in facilitating the development of clinical skills. A number of researchers have examined the characteristics that students find important. Myers (1980) studied the needs of students at different levels of clinical experience. Results of the study found beginning students needed supervisor enthusiasm and interest, demonstration of therapy techniques, and theoretical bases and rationales underlying therapy more than advanced students. Affective support was necessary for all students. In 1992, Dowling examined how supervisors might support students in supervisory conferences. The author found "[supervisees] desire the opportunity to contribute their thoughts and have those ideas incorporated, respected, and responded to in a thoughtful manner" (p. 138). Atkins (2001) also looked at the interpersonal needs of students as related to the clinical supervisory experience. Positive and negative feedback, written evaluations, frequent contact, and supervisor observation were ranked as high needs. Recently, Herd, Epperly, and Cox (2011) examined the clinical supervision process and student preference for feedback delivery systems (i.e., hand written feedback from supervisors versus feedback sent via electronic format). The authors found no significant difference in student preferences for the two feedback options. Staltari, Baft-Neff, Marra, and Rentschler (2010) focused on how supervisors might assist students in developing clinical writing skills. Results of their study indicated that students perceived the feedback and edits that supervisors wrote on their clinical reports to be more beneficial than feedback via a formal checklist developed to assist in writing.

The purpose of this study was to investigate graduate student preferences related to supervisor attributes and styles of interaction during the supervisory process. Graduate students at different levels of their clinical experience were surveyed, and their responses were evaluated to determine characteristics that create a positive supervisory experience.

Methods

Participants

A total of 23 students, 22 females and 1 male, enrolled in the master's degree Communication Disorders Program at Georgia State University participated in this study. Seventeen of the subjects had at least one full-semester of clinical practicum experience (range of 1 semester to 5 semesters) and six subjects had no clinical practicum experience. Subjects' ages ranged from 22 to 44 years with the majority of participants being under the age of 25 years.

Procedure

A 14-item survey was developed (see Appendix A). The survey questions focused on the students' attitudes and opinions about supervisor characteristics and supervisory styles and most required a response using a 5-point Likert rating scale. Some questions were modeled

after ones used in previous surveys done by Broyles, McNiece, Ishee, Ross, and Lance (1999); Dobbs, McKerverey, Roti, Stewart, and Baker (2006); and Tihen (1984). The survey was placed in all communication disorders graduate students' department mailboxes and was also e-mailed to all the students (50 individuals). Twenty-three completed surveys were returned.

Results

Survey results were tallied and analyzed to determine if there were patterns or trends in the graduate students' preferences for supervisor attributes and styles of interaction.

In regards to the importance of the supervisor and supervisee having similar demographic characteristics (age, race, culture, gender), none of the subjects believed any of the demographics were important (see Figure 1). Subjects considered the supervisor's ability to provide assistance in clinical management issues as important overall, with assistance in data collection and report writing being more important than provision of time management strategies (see Figure 2).

Figure 1. Subject responses regarding the importance of being similar in age, race, culture, and gender to their supervisor

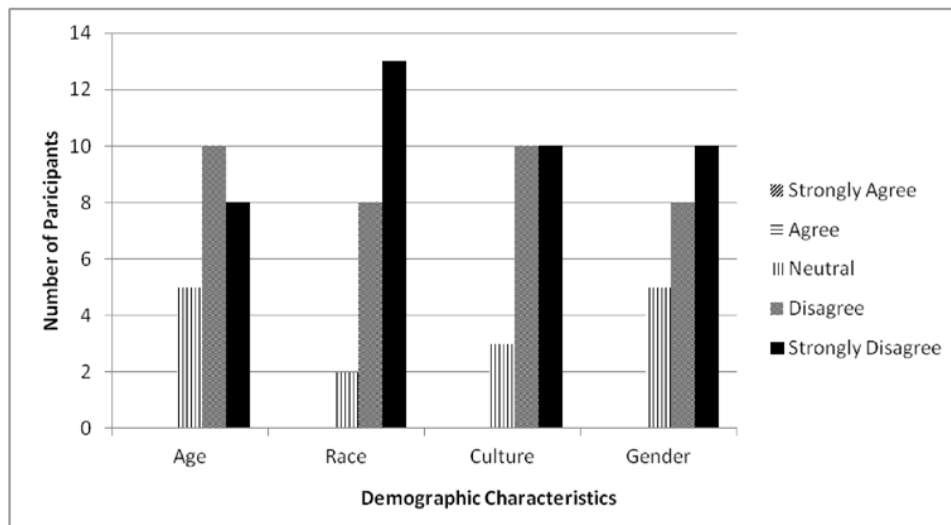
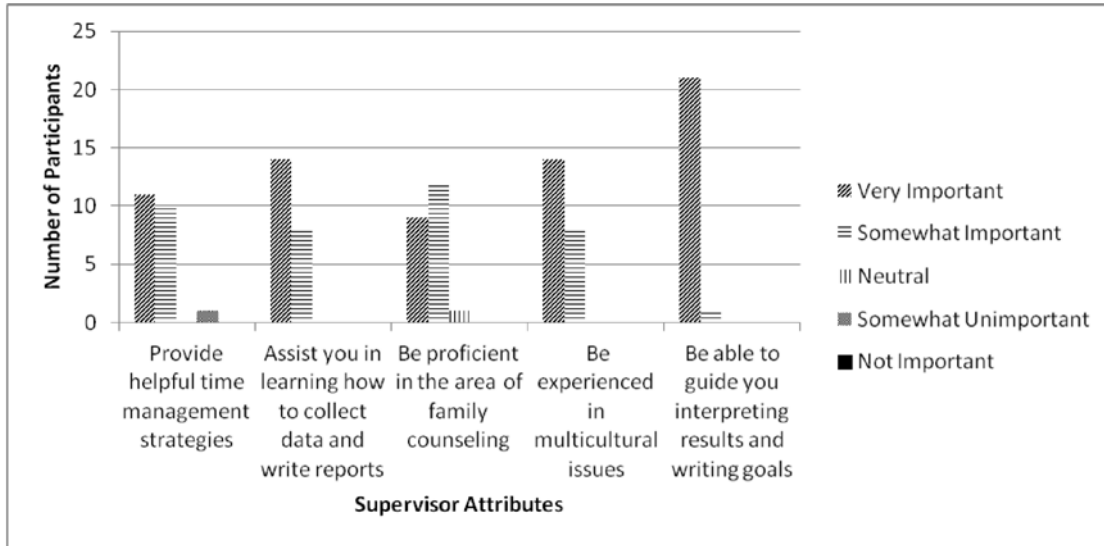
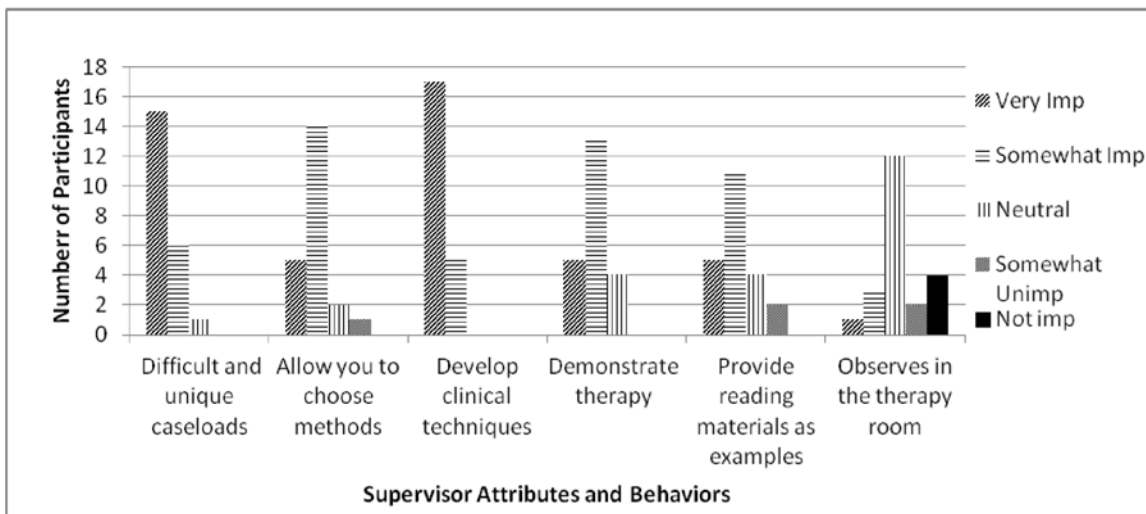


Figure 2. Subject responses regarding the importance of different supervisor attributes related to client evaluation



When considering supervisor attributes related to the evaluation of clients, all subjects ranked the supervisor’s ability to guide them in interpreting results and writing appropriate client goals as very important (see Figure 2). Those subjects not enrolled in practicum all ranked being proficient in family counseling and being experienced in multicultural issues also as very important. With regard to supervisor attributes related to the treatment of clients, highest ranked by all subjects were being experienced with difficult/unique caseloads and working with the supervisee to develop clinical techniques. Observing in the therapy room was ranked lowest by all subjects (see Figure 3).

Figure 3. Subject responses regarding the importance of different supervisor attributes and behaviors related to treatment.



Subjects were asked to rate their preferences for supervisor behaviors during face-to-face meetings with them. Most important to all subjects was that supervisors allow them to

express their opinions during those supervisory conferences, and least important to all subjects was having the supervisor test them on retention of given information (see Figure 4). More subjects not enrolled in practicum thought regularly scheduled conferences were important than those subjects who had been enrolled in practicum. When asked about the format of feedback received from supervisors, more subjects wanted written narrative and face-to-face feedback rather than electronic narrative feedback. In addition, the majority of subjects were neutral about receiving delayed feedback but believed that immediate feedback was somewhat important. Furthermore, more subjects not enrolled in practicum indicated that immediate feedback was very important than those subjects who had been enrolled in practicum. However, when subjects were asked how often they would like to receive feedback from their supervisor, those not enrolled in practicum generally wanted feedback once a week (which would not typically be considered “immediate”). Most subjects enrolled in practicum preferred feedback after each therapy session. All subjects wanted the focus of feedback to be on overall clinical performance, strengths in therapy, and ways to improve (see Figure 5).

Figure 4. Subject responses regarding the importance of different supervisor behaviors in face-to-face supervisory meetings.

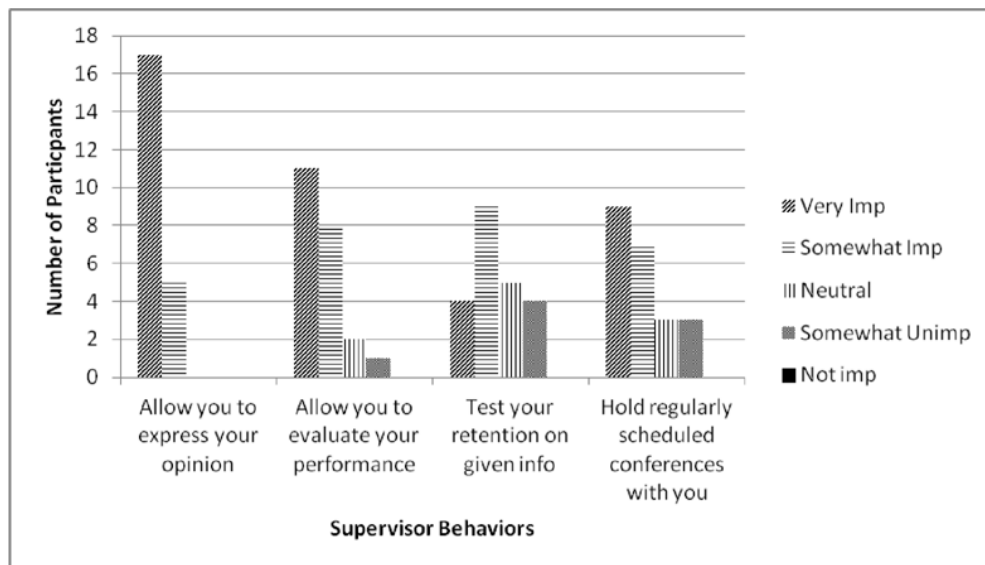
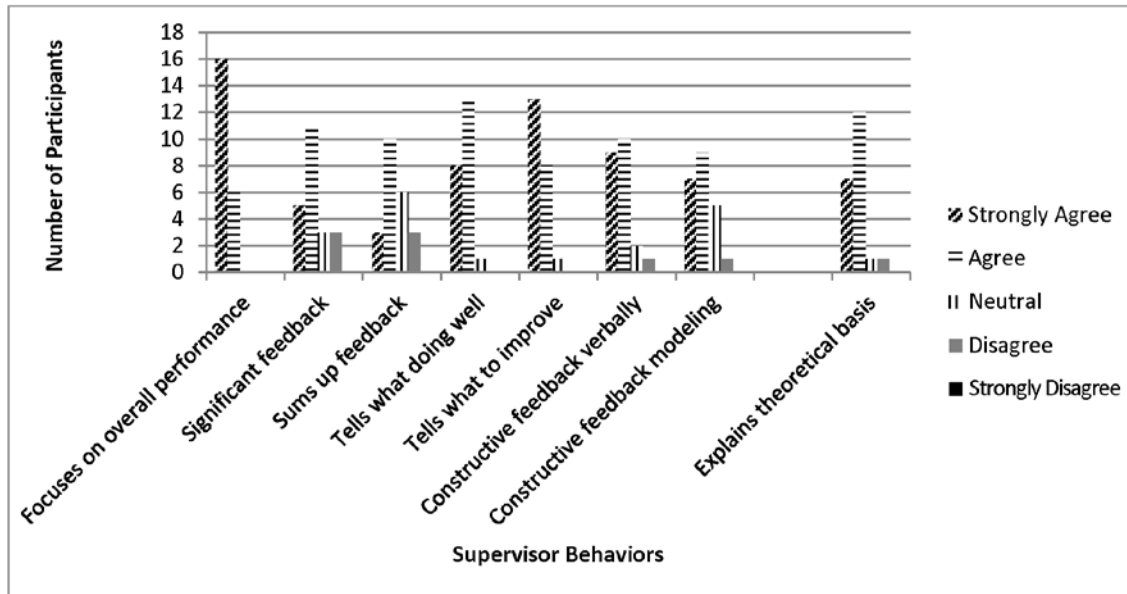


Figure 5. Subject responses regarding the preferred focus of feedback given by supervisors.



Subjects were asked to rate the importance of supervisor availability when they had a question, any time of day, and after clinic hours. All subjects wanted supervisors to be available when they had a question and were less concerned with supervisors being available to them after clinic hours.

When subjects were asked to rank 10 skills and attributes of supervisors from most important to least important, interesting similarities and differences were noted between students with clinical experience and those without. As seen in Table 1, all subjects rated *knowledgeable* and *supportive* as the two most important supervisor attributes and *patient* and *flexible* as two of the three least important attributes. While students without clinical experience considered *being enthusiastic* important for supervisors (rank of 4 out of 10), those students with clinical experience ranked *enthusiastic* as least important. The overall ranking order of the 10 skills and attributes was determined by tallying the subjects' individual rankings to obtain the highest and lowest scores.

Table 1. Ranking of supervisor skills/attributes from most important to least important by students with and without practicum experience.

	Ranking by Students With Practicum Experience	Ranking by Students Without Practicum Experience
Most Important	Knowledgeable	Knowledgeable
	Supportive	Supportive
	Realistic	Honest
	Organized	Enthusiastic
	Honest	Organized
	Timely	Timely
	Caring	Realistic
	Flexible	Flexible
Least Important	Patient	Caring
	Enthusiastic	Patient

Two survey questions focused on previous clinical experiences of students and what made those experiences either positive or negative. The most notable factors in positive clinical experiences were supervisors whose behaviors made the students feel comfortable, who welcomed explorations about client’s behavior, and who offered tactful comments about the student’s performance. When students reported negative clinical experiences, they noted that the supervisors did not encourage formulation of their own intervention with the client, did not help the student to talk freely, and did not foster a collegial relationship.

Discussion

Much of what has been found in previous studies related to the supervisory process was also demonstrated in the responses of the participants in this study. Overall results supported findings of previous research that indicated that supervisees desire an atmosphere where they are comfortable freely expressing their opinions and where supervisors are both supportive and knowledgeable. In addition, it was observed in this study that subjects not yet enrolled in clinical practicum generally rated nearly all possible supervisor behaviors and all aspects of the supervisory process as important. This may suggest that before students have begun clinical practicum, they are unable to differentiate the most important aspects of the supervisory experience.

The previous literature also discussed supervisees’ desire to be treated as colleagues. Our research supported these findings, suggesting that a collegial atmosphere is important to all students whether or not they have been enrolled in clinical practicum. As recommended in the ASHA technical report on clinical supervision (2008a), supervisors should work to establish a collegial/collaborative relationship with their supervisees. This will better prepare student clinicians to establish similar relationships with other speech-language pathologists when they enter the workforce and will prepare them to be supervisors themselves.

With regard to feedback from supervisors, the subjects in this study preferred to have it delivered face-to-face rather than electronically. This was an interesting finding given that society is moving more in the direction of electronic methods of communication. However, it was clear in this research that supervisees appreciated the conversational exchange and more personal experience that come with receiving face-to-face feedback. The results of this study also found that subjects enrolled in practicum desired supervisory feedback after each therapy

session and that it is more important to them than it is to students who have not yet enrolled in practicum.

The results of this study can be incorporated into the supervisory experience in several ways. It may be obvious that supervisors should be knowledgeable and supportive of their supervisees. However, it is essential that supervisors strive to create a collegial atmosphere for supervisory conferences during which supervisees are able to voice their opinions, express their concerns, and contribute to the overall clinical experience. Supervisors also should provide timely feedback to supervisees and explore each supervisee's preference for the form of feedback (hand written, face-to-face, or electronic). Although the results of this study provided interesting information, this study used a small sample size and included students who were enrolled in a single communication disorders program. More research needs to be done with a larger sample size from a variety of university programs to be able to further generalize these results.

References

- American Speech-Language-Hearing Association. (2008a). *Clinical supervision in speech-language pathology* [Technical Report]. Available from www.asha.org/policy.
- American Speech-Language-Hearing Association. (2008b). *Knowledge and skills needed by speech-language pathologists providing clinical supervision* [Knowledge and Skills]. Available from www.asha.org/policy.
- Atkins, P. C. (2001). Understanding student clinicians' interpersonal needs. *The Clinical Supervisor, 20*(1), 161–172.
- Broyles, S., McNiece, E., Ishee, J., Ross, S., & Lance, D. (1999, November). *Influence of selected factors on the perceived effectiveness of various supervision strategies*. Poster session presented at the Annual Convention of the American Speech-Language-Hearing Association, San Francisco, CA.
- Dobbs, A., McKervey, H., Roti, E., Stewart, R., & Baker, B. M. (2006). Supervisees' expectations of supervisor characteristics: Preclinical fellowship year versus postclinical fellowship year. *Contemporary Issues in Communication Disorders, 33*, 113–119. doi:1092-5171/06/3302-0113
- Dowling, S. (1992). *Implementing the supervisory process: Theory and practice*. Englewood Cliffs, NJ: Prentice-Hall.
- Herd, C. L., Epperly, R., & Cox, K.M. (2011). Technology: Clinical and technological innovations: Use of the Apple iPad in clinical supervision. *Perspectives on Administration and Supervision, 21*(3), 112–116. doi:10.1044/aas21.3.112.
- Myers, F. (1980). Clinician needs in the practicum setting. *SUPERvision, 4*(2), 7.
- Staltari, C. F., Baft-Neff, A., Marra, L. J., & Rentschler, G. J. (2010). Supervision: Formative feedback for clinical documentation in a university speech-language pathology program. *Perspectives on Administration and Supervision, 20*(3), 117–123. doi:10.1044/aas20.3.117
- Tihen, L. (1984). Expectations of student speech/language clinicians during their clinical practicum (Doctoral dissertation, Indiana University, 1983). *Dissertations Abstracts International, 44*, 3048B. (University Microfilms No. 84-01, 620)