CLINICAL EXPERIENTIAL LEARNING WEBINAR
Transcript

Ann Tyler
Welcome to the Next Steps Summer Webinar series, my name is Ann Tyler and I am the Chair of the ASHA Ad Hoc Committee to Plan Next Steps to Redesign Entry-Level Education for SLPs, which is hosting this webinar series.

We will be recording the first part of this webinar which consists of a presentation about the Growth of the Professoriate and Faculty Sufficiency, so that others can view it asynchronously. The Next Steps website where you registered for this webinar will host all of the Next Step webinar recordings within a couple of days after the live webinar event has taken place. The QR code on this slide will take you to the Next Steps website on www.asha.org.

We will not be enabling the chat function during the presentation, but because the primary reason for the webinar series is to gather widespread input from stakeholders, we are of course **very** interested in your perspective. So, we have reserved more than half of each webinar to convene breakout groups, which will be recorded. We have also prepared surveys, so that those attending the live webinar events and also those who access the webinar recordings at a later point in time, can share their perspectives with the committee.

During the breakouts, you will be joined by a few other attendees to discuss questions related to this webinar's topic. Each breakout group discussion will be recorded in Zoom and transcribed. Committee members will then have access to the transcript and qualitative analysis will be conducted. The breakout group recordings will not be made public and committee members will not have access to the recordings or any personally identifying information. Only group data will be reported.

There is also an email address for each webinar topic to which you can send comments and questions at any time. Those email addresses can also be found on the "Next Steps" webpage on www.asha.org. Again the QR code shown here takes you to the Next Steps webpage.

Along with those listed on this slide, I was appointed to the Ad Hoc Committee on Next Steps to Redesign Entry-Level Education for SLPs in the Summer of 2021. We have worked together during this past year to identify the most important topics related to SLP education for which widespread stakeholder input is needed.

Members of this ad hoc committee were chosen to represent different employment settings and functions as well as to ensure Bi-Directional communication between the ad hoc committee and the Council for Academic Accreditation, the Council for

Clinical Certification, the National Students Speech Language Hearing Association, the Council for Academic Programs in Communication Sciences and Disorders, the Specialty Certification Boards in SLP and from SIG 10 (Issues in Higher Education) and SIG 11 (Administration and Supervision).

The ad hoc committees charge from the ASHA Board of Directors, was to advance discussion and planning to redesign entry-level education for speech-language pathologists and formulate recommendations for the ASHA Board of Directors about how comprehensive input might be obtained from a large group of stakeholders to advance entry-level education for SLPs.

We were also charged with gathering perspectives and synthesizing information about what data, dissemination efforts, and actions are needed to make recommendations and propose a plan for advancing us SLP education, what alternative models of education and changes to the current educational model should be considered, as well as how should stakeholders be engaged to obtain comprehensive input from their larger communities.

The ad hoc committee has given a great deal of attention to the questions of what competencies are needed for entry-level practice, how should they be acquired and measured, which aspects of the current model are serving the profession and public adequately and which are not, and lastly, are there changes to the current model that would address any gaps or unmet needs that have been identified.

The ad hoc committee was not charged with considering what the entry-level degree designator should be. The ad hoc committee is **not** examining, or even discussing, the degree designator for the entry-level degree in speech language pathology (i.e., Master's Degree vs Clinical Doctorate). It's not on the Agenda! It's not in the Charge!

Instead, the ad hoc committee on Next Steps has been highly focused on determining what is needed to adequately prepare SLPs to enter the profession. And how to address some of our longstanding problems such as insufficient faculty growth and capacity, the need to increase student diversity, and how we can continue to prepare students across the full scope of practice and across a wide variety of practice settings to provide services to individuals across the lifespan with an educational model that was developed more than 60 years ago.

There was a previous ad hoc committee on Graduate Education in Speech Language Pathology that convened in 2018 that focused on the question of *"Which aspects of our current entry-level educational model are serving the profession and the public well, versus falling short, to adequately prepare SLPs across practice settings?"*

In addition to identifying areas that are serving the profession and the public well and not so well, the previous ad hoc committee also gathered stakeholder input on the question of *whether there are changes to the current model of entry-level education that would address gaps or unmet needs?* Their report can be found at the URL shown here or from the QR code on this slide.

Based on the results obtained from many surveys and focus groups, the previous ad hoc committee concluded that there are aspects of the current educational model that most respondents identified as challenging. These included that students are not consistently prepared even across the Big 9, nor sufficiently prepared to enter practice across common work settings for SLPs. That there is insufficient students and faculty diversity, that most undergraduate majors cannot go on in the field yet clinical shortages are severe, that there is a significant scarcity of outplacements and supervisors and that there is a scarcity of SLPs specializing in important clinical areas.

Additional concerns reported by the previous ad hoc committee included trying to fit the full scope of practice across the lifespan into 2-year master's program, that the current model lacks a competency-based education framework to guide preparation and self-evaluation of one's readiness for specific areas of practice, that access to graduate education is limited due to the predominance of our "full time residency" model, that there is an over-reliance on volunteers for supervision, that there is unequal training across SLP programs, and there is a lack of sufficient faculty to teach all topic areas.

Here are some reflections from Ad Hoc Committee Next Step Members when asked, "What Dissatisfies You About the Way Things Are Now?" One Member said, "I'm concerned about the difficulty that both academic and clinical faculty have in achieving graduate student competency across our ever-expanding scope of practice. While I believe we are successful at teaching foundational clinical skills that apply to all populations across the lifespan and across our scope of practice, we are not successful at achieving competency across the Big 9, particularly in the area of implementing evidence-based practice."

Another Member said, “I am dissatisfied with the wide-but-shallow preparation that sends clinicians out into the field without a clearly charted path for how to deepen the areas in which that clinician actually ends up working in.”

Another said, “Many graduate classes provide an overview of several methodologies and viewpoints in different areas that often results in limited knowledge of each methodology and a lack of expertise to apply in daily practice.” And finally, “Our ever-expanding scope of practice is making graduate education and pre professional preparation in 5-6 semesters very challenging, I often ponder this thought. Has our perception of “entry-level” changed due to this expansion of scope of practice? If so, how have programs adapted? Has the role of the clinical fellowship changed in response? Could it? Should it?”

There are many critical needs that are not being met, gaps, and significant challenges. These include that there is a dire need to increase the number of SLPs, Student and Faculty Diversity, Student readiness for work in diverse practice settings & with diverse populations as well as Pathways to deepen knowledge across the full Scope of Practice.

There is also a need for expanded opportunities to varied clinical experiences, to further develop critical & analytical thinking, to improve oral & written communication, to grow research literacy & adoption of evidence-based practices and lastly to instill cultural humility, professionalism, empathy, and more.

We also need to develop a competency-based educational framework with pathways to learn, assess and recognize or signal specific competencies as well as new pedagogies and curricular goals to prepare students for the future of work. These are just some of the goals and which the ad hoc committee on Next Steps had been focusing. With your help, we hope to advance consideration about how these goals can be met.

Because the scope of these issues is vast and complicated, we decided to divide the problem space up into six (6) areas and formed a “working group” on each topic. These six (6) topics can be seen here.

The goal of the Next Steps webinar series is to communicate what ASHA is working on and to solicit input from stakeholders about their perceptions and to gather ideas about how entry-level education for SLPs can be improved and lifelong learning advanced. Webinar attendees are also invited to participate in a breakout group discussion, which will be recorded, and then the transcripts will be qualitatively analyzed. All survey responses and breakout discussions on the following seven (7) topics will be considered, analyzed, and incorporated into the final report.

In summary, there are many aspects of the current educational model in speech language pathology that could be improved. The Ad Hoc Committee on Next Steps to Redesign Entry Level Education for SLPs has taken a deep dive into the topics listed here and prepared a presentation for each webinar that summarizes the challenges and opportunities in each of these areas. Each webinar starts with the portion of the presentation you just heard, and then transitions into the areas listed here so that stakeholder input can be gathered in a focused manner. Stakeholder input is being collected in three ways for each webinar.

First, for those attending the live webinar events, the **breakout room discussions will be recorded**, transcribed, and then qualitatively analyzed with no personally identifying information shared. Secondly, a survey has been prepared for each webinar. If you attend a live webinar, then the QR code will be provided to access the survey immediately following the event.

If you watch this webinar asynchronously, the survey link will be made available on the Next Steps web page on www.asha.org where all of the ”Next Steps” information can be found. You can see a QR code for the Next Steps webpage displayed here. Third and lastly, there is an email address listed under each webinar topic on this slide, and they can also be found on the Next Steps webpage. You are invited to email your ideas, concerns, or ask questions at any time.

We hope that you will participate or watch these webinars asynchronously. Most importantly, please share your perspectives and ideas on these topics with the committee. Thank You.

Barbara Zucker
Good Evening everyone. We are now going to focus on tonight’s topic. Clinical Experiential Learning. I would like to recognize our Working Group members shown here that assisted in developing this webinar.

A major challenge in our current Clinical Experiential Learning model is that there is large variability in how clinical hours are obtained. Further, the accumulation of hours does not assure that students are prepared to enter practice across the full scope of practice, across the lifespan, and in different practice settings.

As a refresher, here are some highlights of our current clinical educational model: We have a 400-Hour direct contact clock hour requirement; 75 clinical clock hours accumulated during an undergraduate program may be applied towards that requirement. The remainder of the required clock hours must be obtained at the graduate level. Graduate programs use different models of clinical experiences to help students satisfy clock hour accumulation, as well as required external placements. Some programs provide students with both on-campus and off-campus clinical experiences, while others rely more heavily on off-campus placements to provide these experiences. Data from the recent 2020 CSD Education Survey show

that an average of 115 clock hours per student are accumulated in on-campus clinical experiences. The greater proportion of clock hour accumulation, however, occurs off-campus, with an average of 321 hours per student being accumulated there, and typically in two different settings. Following completion of the master's degree, graduates must complete a Clinical Fellowship.

When we think about what is needed to adequately prepare SLPs to enter the profession, we can consider how we build competency in the clock hour model. The accumulation of hours may not be enough to ensure competency. The previous Ad Hoc Committee on Graduate Education in SLP received feedback that there is a need for longer and more varied clinical experiences. There is also reported need for an increased focus on working towards independence and critical thinking in clinical decision making.

Throughout the **Clinical Experiential Pathway**, there is a need for more robust clinical experiences and competencies across populations, settings, and the lifespan with a goal of greater consistency across programs.

This is especially the case due to our **Expanding Scope of Practice**. Within that scope we have Professional Practice Competencies of advocacy and outreach, supervision, education, research, and administration and leadership. And these transcend all the Domains of SLP Service Delivery which extend to our Big 9 categories of communicative and swallowing disorders. Service delivery domains involved patient centered activities such as collaboration, counseling, prevention and wellness, screening, assessment, treatment, modalities, technology and instrumentation for populations and systems. Finally, we have competencies sought by employers and viewed as desirable in workforce ready candidates. These include professional responsibility, communication skills, problem solving, cultural humility/cultural competence, and Interprofessional practice.

Further, as our scope of SLP practice has expanded, we have witnessed reports of Lack of Competency and Concerns of Encroachment in certain areas. Those areas most often cited include: Swallowing and feeding, AAC, autism, cognitive communication impairments, and developmental language disorders.

As our workgroup explore these challenges, we sought creative opportunities that reflect our value for the autonomy of programs to make decisions for themselves, as there is not a “one size fits all” solution. We also recognize that many programs may already be implementing suggestions we provide here. We offer the opportunities in this and the next two slides, advocating for greater consistency across programs, whenever that may be possible.

The clinical experiential pathway could begin with encouraging undergraduate clinical experiences through both face-to-face and alternative modalities, such as simulation. If guided observation hours were required to represent the breadth of communication disorders, then students would begin to develop competency with different populations across the lifespan. Alternative pedagogical models can also be used to bridge classroom to clinical learning. Case-based and problem-based learning strategies, help to strengthen critical thinking skills. And finally, if competency-based education is advanced, standardized performance criteria for clinical skills could be adopted.

In thinking about clinical experiential learning within the context of broader programmatic opportunities and constraints, we recognize that academic and clinical curricular are interdependent; therefore, both components should be considered when program modifications are developed.

Program changes should support sufficient clinical learning and competency, while maintaining a generalist degree. It is also important that we embrace lifelong learning through shared expectations for continued professional development and competency. To achieve this, we must provide opportunities for advanced training and specialization in the professions, for example, clinical skills, program administration, and supervision. Professional training received in the workplace, for example, in advocacy or leadership, could also be recognized.

Finally, a specific suggestion to address the need for more robust clinical experiences and competencies across populations and settings is the recommendation that programs provide a minimum of two high-quality externship experiences, beyond on-campus or initial clinical experiences, that provides students with increased independence and competency in both pediatric and adult assessment as well as intervention. As programs implement these externships, they must determine the length of placements and coordinate them with other required clinical experiences to promote competency and use of best practices.

Another challenge within our current clinical learning model is that there is large variability in the rigor and quality of clinical placements, in clinical educator expertise and expectations and, in some areas, an insufficient number of placements.

With respect to the latter, **Insufficiency of Clinical Placements,** in a supplemental question to the CSD 2019-20 Education Survey, faculty and extern coordinators in more than three-quarters of master's programs expressed some or a lot of concern about finding clinical placements for experience across the full range of populations and lifespan. They further indicated that placements are a limiter on enrollment – programs are unable to increase the size of cohorts due to insufficient numbers of clinical placements.

Some of the factors affecting the Variability of Externship Supervision and quality of clinical placements are high variability in the supervision practices of clinical educators, different program models and expectations for clinical educators and limited resources and incentive to recruit orient and retain clinical educators.

Our workgroup identified a variety of **Opportunities** related to increasing the rigor and quality of clinical placements across populations and the lifespan. These are presented in this and the next two slides. We begin with suggestions relating to increasing the clinical educator workforce and consistency of preparation. Consistency in the rigor and quality of clinical education that should align with the priorities and resources available to a given college/university. Requesting for our professional organization to encourage all certified members to engage in continuing professional development for clinical education and providing them with resources and recognition is one path to elevating the importance of this role. Lastly, this may inspire clinicians to contribute to the professions, the goal of increasing the number of professionals who participate in clinical education could be advanced by incentivizing clinical education through short term availability of free hours of CE units, it may also be advantageous to establish a clinical educator mentoring program, for example as a path in the step mentor program.

We also suggest that there are **Opportunities** to increase consistency in the rigor and quality of clinical placements through SLP programs' onboarding of clinical educators; many of these practices are implemented already in some programs.

Programs can require their clinical educators to implement best practices in setting expectations, communicating feedback, evaluating, and teaching students to use evidence-based practice through mechanisms such as providing a resource manual that details, how to foster clinical reasoning communication techniques, etc., as well as by providing an orientation that includes use of templates and evaluation tools to facilitate consistency in both on-campus and off-campus clinical supervision. And lastly, by supporting exchange of knowledge and experiences between clinical educators and program faculty.

Finally, there are **Opportunities** to foster communication between programs and the clinical sites at which students are placed and to elevate the value of educating graduate student and clinicians. Programs should be encouraged to have active involvement in the placement of students at extern sites, including selection and continued monitoring throughout the placement. We also need to help employers understand the importance of having their SLP clinicians educate graduate students through investing in clinical education.

Advocacy efforts that describe the benefits of taking graduate students and the value of clinical education can be developed with the unique focus by the type of setting and lastly employers could incentivize the role of clinical education through establishing an annual award for an employee who fulfills this role.

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