

Responding to Market-Driven Changes Impacting the Future Demand for Graduates in Speech-Language Pathology and Audiology

Debra Busacco
ASHA Director of Academic Affairs

Arlene A. Pietranton
ASHA Associate Director for
Speech-Language Pathology

I. Workplace Realities Facing Audiologists and Speech-Language Pathologists

The 1990's have been a decade of unprecedented changes in access to and funding of clinical services. The preceding past several decades witnessed steady growth in the demand for clinical services, including those of audiologists and speech-language pathologists. This growth was the result of a variety of factors, including changing population demographics, increased awareness of communication and related disorders and their impact, and expanding scopes of practice for our professions. It was also the result of a prevalent public policy theme – “funded mandates” and the dominant reimbursement methodology – “fee-for-service”. Funded mandates and fee-for-service reimbursement served individuals with communication and related disorders well as it helped to assure that they had access to funded/covered services. However, that framework also contributed to the rapid escalation of education and health care costs. In the health care arena, for example, in 1960 the annual health care expenditures in the United States consumed 5.3% of our Gross National Product (GNP). By 1994 it had escalated to a point of consuming 16% of the GNP, with a prediction that health care costs, left untouched, would consume 100% of the United States' GNP by the year 2050¹.

This stark financial reality has unleashed a backlash of cost containment methodologies and a clear movement away from funded mandates and fee-for-service as demonstrated by such recent occurrences as:

- X the phenomenal growth of managed care - according to the Peat Marwick consulting firm, more than 85% of Americans were covered by managed care in 1998 vs. 30% in 1988
- X the proposed easing of criteria for qualified personnel waivers and the introduction of language to recognize the use of paraprofessionals and support personnel in the 1997 re-authorization of the Individuals with Disability Education Act (IDEA)
- X the morass of complicated, overlapping, and potentially devastating Medicare reimbursement limitations on rehabilitation benefits that were introduced as part of the Balanced Budget Act (BBA) of 1997

The clinical service delivery workplace is more complicated and challenging than ever before due to a diverse array of factors/trends such as:

¹Banja, JD: Ethics, outcomes, and reimbursement. REHAB Management 1994; 7(1): 61-65, 136.

Schools

- X IDEA has resulted in an increased demand for services and increased caseload complexity. Today's school clinicians' caseloads are characterized by complicated disorders such as language, learning disabilities, voice, fluency, TBI, ADD/ADHD, pediatric dysphagia, autism, and medically fragile students. Service delivery models have also changed, placing greater emphasis on inclusive practices, collaboration, and consultation.
- X The Goals 2000: Educate America Act has placed increased emphasis on intervention goals that are coordinated with students' curriculum needs and that can be demonstrated to make a difference in students' levels of academic success.
- X The current political climate is increasingly shifting education policy control/decision-making from the federal to the state level.
- X Economic trends affecting schools include:
 - X the federal government's continued failure to fully fund IDEA (per its commitment when IDEA was first enacted), resulting in an ongoing economic burden to the states that have been mandated through IDEA to provide certain services, without the benefit of federal funding to cover the services.
 - X a steadily aging population resulting in an erosion of the tax base and local financial support for education.
 - X increased use of alternative funding sources such as Medicaid for services provided in school settings.

These factors have led to higher caseloads, personnel shortages, use of less/un-qualified providers, waivers of personnel standards, and creation of other personnel categories (e.g., support personnel/aides) in school settings.

Health Care

The Balanced Budget Act (BBA) of 1997² created a variety of complicated, interwoven changes in Medicare reimbursement of rehabilitation services, including speech-language pathology and audiology services:

- X **Prospective Payment System (PPS)** - Establishes a single payment to cover a patient's care, including rehabilitation services (much like the DRG system, which was introduced in hospitals in the 1980's). PPS applies to Medicare Part A³ benefits. Based on assessment, a patient is

²For more detailed information regarding the Medicare reimbursement changes created by the BBA and their impact on speech-language pathology and audiology services, check the Governmental Affairs pages on the ASHA Web site (www.asha.org) or call ASHA at 301-897-5700, ext. 4387.

³Part A Medicare Benefits were created (in 1968) to help pay for hospital expenses. Part A covers the first 90 days of a hospital stay, the first 100 days in a skilled nursing facility

assigned to a level of care with a specified number of minutes designated for rehabilitation services per week. PPS goes into effect at different times between July 1998 and October 2000, depending on the setting.

- X **\$1500 Annual Cap** - Effective January 1, 1999, Medicare beneficiaries have a cumulative annual cap of \$1500 on their Part B⁴ benefits. Due to a technicality in the way coverage for speech-language pathology was added into Medicare law in the early 1970s, speech-language pathology and physical therapy share a single \$1500 cap. Occupational Therapy has a separate \$1500 cap.
- X **Salary Equivalency** - an interim cost containment methodology in effect until PPS is totally phased in. In order to set limits on the rates associated with contractual clinical services, salary equivalency establishes guidelines for the purchase of clinical services, including speech-language pathology, based on the *time* the clinical provider is on the premises (as opposed to the number of visits or procedures provided while there). The rates are adjusted for travel, supervision, equipment, supplies, overtime, assistants, administrative duties and geographic location. The rates are based on certain national salary figures the Health Care Financing Administration (HCFA) weighed in order to determine the “salary (hourly) equivalencies”.
- X **Fee Schedule** - uses a payment scale (the Resource-Based Relative Value Scale [RBRVS]) in which a relative value unit (RVU) is associated with each procedure versus the previous reimbursement methodology within which charges, established by providers were subjected to a determination as to whether or not they were “reasonable and customary”. The Medicare fee schedule applies to Part B services and was implemented in hospital outpatient rehab programs in January 1998, SNFs in July 1998, and in comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and home health agencies in January 1999.

The \$1500 cap and PPS are coverage limitations on a per-patient basis that are likely to result in:

- X fewer sessions per patient (which has implications for clinical intervention models)
- X out-of-pocket costs to patients/family members
- X increased emphasis on clinical efficiency
- X increased competition among rehab disciplines for limited dollars/coverage

(SNF), and the first 100 home health visits following a hospital or SNF stay. Social security beneficiaries have Medicare Part A coverage at no additional cost.

⁴Part B Medicare Benefits are intended to pay for medical expenses such as doctors visits. They cover outpatient services, such as speech-language pathology and audiology services, and inpatient services that are rendered after a patient has exhausted their Part A days/visits. Medicare Part B benefits are optional and require the payment of a monthly premium by the Social Security beneficiary.

In contrast, salary equivalency and the Medicare fee schedule are payment limitations on a per-session/visit/procedure, which are likely to result in:

- X decreased reimbursement per visit/session/procedure
- X increased emphasis on clinical efficiency
- X increased emphasis on “billable” (vs. “non-billable”) clinical time in order to meet revenue requirements

Health Care Marketplace Issues - (a.k.a. Managed Care)

Managed care has enjoyed a phenomenal rate of growth over the past decade (according to the Peat Marwick consulting firm; in 1998, more than 85% of Americans were covered by managed care vs. 30% in 1988). With its bottom line focus on profits, managed care is more interested in “buying your outcomes” than “paying for your services”. In order to survive in such an environment, clinical providers need to be able to prove the value of their services in measurable, meaningful, and preferably cost-savings terms.

II. What Makes for a Successful and Valued Employee in Today’s Clinical Environment?

Given current clinical workplace realities, today’s clinical practitioners clearly need particular skills in order to function successfully - and to be viewed as highly valued contributors in their clinical workplace:

- X clinical practitioners are expected to enter the clinical work setting with sufficient clinical knowledge and skills to “hit the ground running” as there is little tolerance in the clinical workplace for any “inefficiency” (real or perceived) associated with an individual’s “learning curve”
- X individuals who are independent, productive, and capable of demonstrating effective leadership in a continuously changing clinical environment are highly valued
- X the facile use of efficacy and treatment outcomes data as objective proof of the benefits of one’s clinical services is essential in order to effectively advocate for one’s patients and profession
- X clinical practitioners who are determined to thrive and not merely survive in the clinical arena need to demonstrate workplace success skills that enable them to “take the lead” in a highly challenging and increasingly competitive clinical workplace so they are recognized as among *the* key players and decision-makers in their clinical workplace:

time management (i.e., the highly efficient management of clinical *minutes*),

negotiation (e.g., which discipline gets which part of the \$1500 cap, the PPS minutes??)

conflict management/resolution (with clinical colleagues, patients/family members, case managers)

organizing/planning/priority setting/process management (in order to organize your caseload/practice and to provide effective clinical leadership across disciplines)

interpersonal and organizational savvy (how to most effectively navigate workplace/institutional/education or health care system)

circumstances on behalf of your patients and discipline)
entrepreneurialism - in an environment where reimbursement dollars are shrinking, those individuals who have an “entrepreneurial orientation” and can identify and/or create new approaches or new work opportunities may “have the edge”

III. The Traditional Model of Clinical Preparation

The majority of students in Communication Sciences and Disorders begin clinical practicum experience during their first year of study in their masters degree program. A small number of students entering graduate school may have completed an undergraduate clinical practicum, but for the majority of graduate students their first clinical practicum will occur in graduate school. This is especially true for audiology students who typically enter graduate school with minimal or no clinical exposure to diagnostic audiology testing or aural rehabilitation.

The traditional model of clinical preparation used by many academic programs is largely driven by the ASHA certification requirements. These certification requirements stipulate a minimum number of practicum sites a student must complete in graduate school, as well as a specified number of hours in clinical areas that each student must obtain. The traditional model of clinical education allows a student to begin clinical practicum upon the completion of 25 hours of observation of therapy and/or diagnostic testing. The majority of graduate programs in speech-language pathology and audiology require that students complete their initial clinical practicum in the university speech-language-hearing clinic. During this initial clinical practicum faculty and/or university clinical supervisors provide direct supervision to each student. As part of this intensive learning experience speech-language pathology and audiology students are evaluated throughout the semester and provided with a significant amount of feedback regarding their clinical performance. Upon successful completion of the university-based clinical practicum, each student is placed in a clinical externship. The underlying assumption of the traditional model of clinical education is that given successful performance in the university clinic, a student is prepared to meet the clinical demands required by most externship sites.

The university speech-language-hearing clinical practicum provides a supportive learning environment for students; however, its current structure may not provide the breadth of clinical experiences students need to acquire in order to compete in today’s rapidly changing work environment. Today’s graduating students in speech-language pathology and audiology need to excel in both clinical knowledge and leadership skills. It is imperative that each academic program and university clinic evaluate on a regular basis the types of clinical experiences that students obtain in the university-based clinical practicum to determine whether speech-language pathology and audiology students are prepared to enter today’s competitive work force.

There are advantages and disadvantages associated with the traditional university-based clinical practicum. Some of the advantages associated with university-based clinical practicum include:

- supportive, nurturing environment for students
- clinical education is a priority
- direct supervision is provided with on-going constructive feedback for students
- efforts are made to integrate academic coursework and clinical experience
- time is provided for planning and implementation of diagnostic testing and treatment sessions
- unique clinical experiences can be obtained (e.g., family/client support groups, aural rehabilitation groups)
- fees are usually on a sliding fee scale; clients are usually not denied treatment because of their inability to pay, with the exception of dispensing hearing aids

The disadvantages associated with university-based clinical practicum include:

- client diversity may be limited (i.e., specific populations and disorders may not be available)
- procedures used in the university clinic may not reflect those used in the workplace
- documentation/paperwork required in university clinics is often more extensive in comparison to most clinical settings
- client assignment may be based on students' needs rather than client needs
- university schedule may be a deciding factor regarding duration of treatment
- students may obtain limited exposure to team management and client advocacy
- university supervisors may or may not have the full-depth and breadth of current clinical workplace realities
- clinical decision-making and time management may not reflect the current demands of third-party payers (i.e., length of treatment, duration of treatment, purpose for the audiological evaluation and tests that may be performed)

University-based speech-language-hearing clinics provide beginning students with a supportive initial practicum experience. In most university clinics every effort is made by clinical supervisors and faculty to help students develop strong clinical skills that are based on solid theoretical knowledge. One question that academic programs must ask themselves is whether their university clinical practicum is preparing students with the necessary balance of technical knowledge and workplace success skills required to meet the high demands of today's clinical work environment? If the answer is no then academic programs may need to modify their university clinical practicum to provide students with more "real-world" clinical experiences so that speech-language pathology and audiology students can meet the rigorous demands necessary to succeed in today's clinical work settings.

IV. Developing Workplace Success Skills

Until fairly recently, human performance management theory held that certain skills/attributes were "subjective" and not measurable in the workplace. Performance reviews focused on elements such as "job knowledge", "productivity", "time & attendance". However, as the information age continues to further infuse our professional (and personal) lives, our work patterns and habits have changed dramatically, and so have the skills that "count" in the workplace. In many environments, job knowledge is no longer a meaningful variable - it has been replaced by the ability to access, analyze and effectively use information. Productivity has fallen by the wayside in favor of skills such as the setting and achieving of goals that advance the vision of the organization in a meaningful way. Time and attendance are less relevant in work environments that are increasingly dominated by flextime and flexplace schemes. Today

performance reviews are likely to include 360 degree feedback⁵ and include workplace success skills such as (taken from ASHA's performance management system):

- X **Accepts responsibility:** assumes obligations readily; dependable; accountable for own behavior; sets appropriate priorities to accomplish planned projects on time; internal and external customers can rely on performance.
- X **Is collaborative, supportive, and trusting:** cooperates; works easily with others and as part of a team; involves others; readily accepts joint decision making; displays confidence in others; serves as a resource for others; reinforces the ideas of others; supports risk-taking; does not attribute blame to others.
- X **Is committed to achieving the organization's objectives:** works to incorporate desired organizational characteristics; understands and promotes the organization's mission; persists with extra effort to attain objectives.
- X **Is flexible, responsive:** recognizes and reacts effectively to crises and unplanned events; adapts quickly to changing situations; meets deadlines or communicates when deadlines must be changed.
- X **Shares information readily:** provides information necessary for others to do their job; does so frequently and consistently; obtains and then passes on information to appropriate individuals; identifies and discusses key topics; keeps people abreast of current issues; asks questions to ensure understanding.
- X **Resolves conflict:** willing to initiate and/or participate in a conflict-resolution process; deals with differing opinions openly; reacts to resolve conflict; provides feedback; gathers facts, considers alternatives, and balances all considerations to reach an effective solution.
- X **Shares credit, provides recognition:** acknowledges the accomplishments of others informally and formally as appropriate; makes people feel that what they do has meaning and significance in regard to the organization's success; expresses appreciation to team members regularly for good performance/behavior.
- X **Shows initiative, is innovative:** improves existing processes and/or endorses new methods; originates new ideas and ways of doing things; challenges the system to get new ideas adopted; is creative; takes risks; acts independently without being urged; recognizes good ideas and supports them.
- X **Uses good judgment in applying policies and procedures:** works effectively with the organization's policies and procedures to get the job done and to protect organization's the long-term health; works to change obsolete or inappropriate rules.

⁵Feedback from a number of workplace colleagues, including one's manager, peers, and direct reports

- X **Values diversity of thought and culture:** treats everyone with respect; appreciates and welcomes different work, communication, and personal styles; recognizes and acknowledges contributions made by all members of the staff; maintains open relationships.

Individuals who have coaching or supervisory responsibilities are likely to also be evaluated in the following areas:

- **Delegates responsibility:** shares responsibilities; involves team members in setting performance goals and objectives; sets expectations on the basis of mutually agreed-upon goals; supports others to take on added responsibility and accountability; encourages others to monitor their own efforts.
- **Provides ongoing constructive feedback:** communicates consistently in an effective manner; confirms that objectives are understood and ensures that any areas of uncertainty are clarified; provides frequent and accurate performance feedback to team members; ensures regularly scheduled reviews of progress toward goals; recognizes achievement.
- **Motivates, mentors, and develops others:** serves as a resource for all team members; exemplifies and teaches the organization's values to others; encourages; listens; provides training necessary to do the job; supports individuals to reach their full potential; ensures that staff members' strengths are recognized and used; inspires team members.
- **Identifies and resolves performance issues:** assists staff in setting appropriate priorities to accomplish goals; takes appropriate action to resolve/mitigate problems relating to team performance or group process and duties; addresses unsatisfactory performance, and puts in place a reasonable action plan.

There are many available performance review "systems" which are variations on the above theme. Given the value placed on workplace success skills, it is not surprising that a wealth of professional development resources and tools have emerged. There are any number of books - including many in the self assessment/self study/self help genre, that have been written on these skills. There is a proliferation of continuing education offerings from national CE providers in the areas of conflict resolution, project management, negotiation skills, coaching, team work, communication skills, and so forth. There are also a number of electronic mailing lists (ex., <http://isca.indiana.edu/conflict>), programs (ex., the University of Texas at San Antonio Problem Solving/Conflict Resolution Program), and projects (ex., the Colorado School Mediation Project) devoted to conflict resolution skills alone!

There are professional development "systems" or approaches that are based on decades of studying workplace success skills and their successful development. For example, the *Successful Manager's Handbook: Development Suggestions for Today's Managers* which is published by Personnel Decisions International, provides specific strategies and suggestions for developing/enhancing 39 success skills organized into nine categories (administrative skills, communication skills, interpersonal skills, leadership skills, motivation skills, organizational knowledge, organizational strategy skills, self-management skills and thinking skills). In the preface to the 1996 edition to the book, its fifth printing, Personnel Decisions International, which was founded in 1967, states that they are "convinced that these

skills can be learned.... through the proper use of experiences, relationships, education, and training. These four avenues of development allow individuals to enhance their strengths and overcome their limitations”.

Another professional development system, *FYI: For Your Improvement (A Development and Coaching Guide for Learners, Supervisors, Managers, Mentors, and Feedback Givers)* grew out of studies at the Center for Creative Leadership and long-term studies at major employers such as AT&T and Sears. FYI delineates 67 workplace competencies (i.e., workplace success skills) as well as 19 career stallers & stoppers. It provides a structured framework within which to assess an individual’s skill level in these areas and includes over 5,000 tips for professional development. A few examples of *FYI*’s competencies that may be especially relevant to the clinical workplace are:

- **Conflict management** - steps up to conflicts, seeing them as opportunities; reads situations quickly; good at focused listening; can hammer out tough agreements and settle disputes equitably; can find common ground and get cooperation with minimum noise.
- **Interpersonal savvy** - relates well to all kinds of people, up, down, and sideways, inside and outside the organization; builds appropriate rapport; builds constructive and effective relationships; uses diplomacy and tact; can diffuse even high-tension situations comfortably.
- **Organizing** - can marshal resources (people, funding, material, support) to get things done; can orchestrate multiple activities at once to accomplish a goal; uses resources effectively and efficiently; arranges information and files in a useful manner.
- **Planning** - accurately scopes out length and difficulty of tasks and projects; sets objectives and goals; breaks down work into the process steps; develops schedules and task/people assignments; anticipates and adjusts for problems and roadblocks; measures performance against goals; evaluates results.
- **Political savvy** - can maneuver through complex political situations effectively and quietly; is sensitive to how people and organizations function; anticipates where the land mines are and plans his/her approach accordingly; views corporate politics as a necessary part of organizational life and works to adjust to that reality; is a maze-bright person.
- **Priority setting** - spends his/her time and the time of others on what’s important; quickly zeros in on the critical few and puts the trivial many aside; can quickly sense what will help or hinder accomplishing a goal; eliminates roadblocks; creates focus.
- **Process management** - good at figuring out the processes necessary to get things done; knows how to organize people and activities; understands how to separate and combine tasks into efficient work flow; knows what to measure and how to measure it; can see opportunities for synergy and integration where others can’t; can simplify complex processes; gets more out of fewer resources.
- **Time management** - uses his/her time effectively and efficiently; values time; concentrates his/her efforts on the more important priorities; gets more done in less time than others; can attend to a broader range of activities.

Based on extensive research regarding the competencies and their development, *FYI* further categorizes the competencies into basic, advanced and executive level skills as well as easier, moderate, harder and hardest development difficulty levels. According to *FYI*, the eight above competencies can be further described as:

Competency	Skill Level	Development Difficulty Level

Conflict Management	Advanced	Hardest
Interpersonal Savvy	Advanced	Harder
Organizing	Basic	Moderate
Planning	Basic	Easier
Political Savvy	Executive	Hardest
Priority Setting	Advanced	Moderate
Process Management	Advanced	Moderate
Time Management	Basic	Easier

If workplace success skills are a key element to the value associated with an individual's and by generalization, a profession's level of contribution in the workplace, how then can our professions assure that we are addressing the development/enhancement of such skills? Some possible ways this could be integrated into our academic preparation programs include:

1. Identify a set of workplace success skills that are essential to success in clinical work settings. This could be done on a number of different scales: nationally for the professions, on a program-by program basis, or by profiling each student.
2. Revise existing feedback mechanisms regarding academic performance and practicum (both within the university clinic and at external placements) to include feedback on the selected workplace success skills.
3. Promote the development of the selected workplace success skills:
 - X develop resource "libraries" of books, electronic mailing lists, Web sites, audio and video tapes on the workplace success skills.
 - X hold brown bag discussions of clinical experiences/situations that include challenges and opportunities related to the selected workplace success skills
 - X develop a Web site for "topic of the week" discussions on the selected workplace success skills
 - X weave discussions of effective use of the selected workplace success skills into classroom instruction, clinical instruction, and caseload management discussions.
4. Instill a passion for life-long learning and ongoing personal professional development in our students.

IV. Next Steps

There are several steps that academic programs can undertake to ensure that graduates in speech-language pathology and audiology have the workplace success skills required to succeed in today's clinical environment. Some steps that university clinics may want to consider include:

- It may be advantageous from a service-delivery perspective for university speech-language-hearing clinics to operate year-round rather than on a semester or quarter basis. This is especially important if the clinic is dispensing hearing aids which involves hearing aid repair. Consumers want hearing aid repair

services to be delivered in a timely manner. The offering of year-round services also provides greater continuity of clinical services, which are imperative for the progress of clients in individual or group treatment.

- University clinics may want to become more involved with third-party service providers, including Medicare and Medicaid, private insurance companies, and HMOs. The clinic's involvement with third-party reimbursement will expose students to the limitations imposed by various insurance plans. Students will gain valuable experience in making clinical decisions based on insurance reimbursement plans. The involvement of university clinics with third-party payers will also broaden and diversify the clinic caseload.
- Student clinical practicum assessments could include an evaluation of workplace success skills in addition to academic knowledge. University supervisors and externship supervisors would need to be provided with training and feedback from academic programs on the importance of developing workplace success skills in students. This training could be conducted on a regular basis, since externship supervisors tend to change quickly in today's dynamic clinical environment.
- Faculty, university clinic supervisors, externship supervisors, and students can begin discussing ways to integrate the development of workplace success skills into the academic and clinical curricula.

Academic programs must look at the implications of distance education on the clinical preparation of students. More academic programs, especially Au.D. programs are offering distance education as part of their curriculum. Academic programs, in conjunction with ASHA's Standards Council (SC), Council on Academic Accreditation (CAA) and the Clinical Certification Board (CCB) need to develop guidelines for the clinical preparation of students in distance education programs. These guidelines should include assessment of students' competency in technical information as well as their competency in areas such as leadership, time management, organization, planning and advocacy.

There are many positive changes occurring in the preparation of undergraduate and graduate students who will enter the professions of speech-language pathology, audiology and speech, language or hearing sciences. It is a challenging time for academic programs. Students are expected to enter the workplace with more theoretical knowledge and clinical skills than in the past. These demands will increase as the technology in our professions becomes more sophisticated. Academic programs can help students succeed in today's marketplace by developing both technical competency and workplace success skills. The combination of these skills will position our graduates in speech-language pathology and audiology to assume leadership positions in a variety of clinical settings, and position our professions to be viewed as key players and decision-makers in the clinical workplace.

Reference

Banja, J .D. (1994). Ethics, outcomes, and reimbursement. REHAB Management, 7(1), 61-65, 136.

For more detailed information regarding the Medicare reimbursement changes created by the BBA and their impact on speech-language pathology and audiology services, check the Governmental Affairs pages on the ASHA Web site (www.asha.org) or call ASHA at 301-897-5700, ext. 4387.

¹Part A Medicare Benefits were created (in 1968) to help pay for hospital expenses. Part A covers the first 90 days of a hospital stay, the first 100 days in a skilled nursing facility (SNF), and the

first 100 home health visits following a hospital or SNF stay. Social security beneficiaries have Medicare Part A coverage at no additional cost.