

## BRINGING THE UNIVERSITY CLINIC INTO THE REAL WORLD

Betsy P. Vinson, MMSc  
University of Florida

### Introductory Remarks

When I was asked to address the issue of bringing the university clinic into the real world, two questions immediately popped into my head: "How important is it to do so?" and secondly, "Do we really want to?" The mission and driving forces of the real world and the university clinic are quite different:

Real world's mission is client service and it is driven by finances and politics.

The mission and driving forces of university clinics are education and research.

However, a survey done by ASHA in 1997 revealed the following:

1. Fifty-three clinical activities and 85 knowledge areas were judged to be important for Speech-Language Pathologists, and the majority of these activities and knowledge areas were not being learned in the appropriate place.
2. Ninety five percent of educators believed these were being learned in the appropriate setting. The percentage of practitioners, CFY supervisors, and clinic directors ranged from 20%-28% when asked the same question.
3. The survey also concluded that entry-level clinicians need to:
  - a. Know how to navigate the reimbursement systems
  - b. Understand the complexities of managed care systems
  - c. Understand relevant and recent legislation
  - d. Advocate for services using efficacy and outcomes data
  - e. Be skilled problem-solvers, and
  - f. Be able to self-supervise
4. In addition to being technically competent, Speech-Language Pathologists need to have an arsenal full of entrepreneurial skills. That is to say, they need to be able to organize and manage a business. The skills include:

- a. Maintaining awareness of societal trends,
- b. Discerning how these trends may affect the profession,
- c. Responding to any perceived future changes by developing new skills and capabilities, and
- d. Being able to identify and create new approaches to accomplish goals.

These skills are critical regardless of whether the student is in a school-based setting or a medically based setting. Kathleen discussed the demands of the schools as a work place, and Janet discussed the demands of the medical sites, so I will not say much about that other than to talk briefly about our interaction with each type of site.

### **Types of Sites**

#### **School-Based Sites**

Our public school supervisors have identified the following as “real world” knowledge that comes with experience in the public schools:

- a. Working with groups (which is difficult in our clinic because parents typically expect private therapy when they are paying for the service),
- b. education law,
- c. writing of IEPs and IFSPs,
- d. working with paraprofessionals,
- e. service delivery models, and
- f. inservices.

We work very closely with our public schools by providing outreach programs to assist the public school clinicians. The main way we do this is to help with the hearing and speech screenings every fall. Our clinicians are typically assigned to a screening team that is organized by the school district with each team screening at 3-4 different schools. In preparation for being in the schools, we discuss education law including P. L. 94-142, P. L. 99-457, and

IDEA. Case law such as *Diana vs the Board of Education* and the Ann Arbor case are also presented. Supervisors are encouraged to have the student present an in-service for the teachers, and to have the students experience various service delivery systems.

### **Medical Sites**

One of the biggest transitions involved in the medical setting is going from clinic reports to chart notes. We have started modifying our clinic reports to more closely approximate the length and content of our clinic reports in order to help the students make this transition. Other curricular emphases include knowing what Medicaid and Medicare entail with regard to specific requirements and mandates, and understanding the differences between HMOs, PPOs, and so forth. We also discuss ADA legislation, Social Security legislation, Title XIII of the U.S. Public Health Service Act.

### **Collaboration**

Regardless of what type of setting the student is in, it is critical that there be collaboration between the university and the sites. To accomplish the facilitation of real world knowledge, collaboration is essential. Generally speaking, there needs to be collaboration between the university and any professional setting, including schools and medical sites.

**The University and the Professional Setting.** At Temple University, the university has established a Supervisory Advisory Committee with representatives from several clinical settings and one faculty member. The supervisors have input into the graduate curriculum, and the university has input in the design of the practica experiences. Some universities make their supervisors adjunct professors who provide mini-seminars and lectures in the graduate classes. We also provide a continuing education by sponsoring symposia and workshops free of charge for our supervisors.

**The University and the Schools.** Placement decisions should be a joint effort, with the supervisor and placement coordinator discussing the needs of the supervisor as well as the needs of the student to determine the best match-up for the practicum.

**The University and Medical Sites.** Most of our medical sites require that the students interview prior to being placed in a practicum or internship. The site supervisor then informs the placement coordinator as to which students have been selected and with what supervisors they will be working. This decision is made in part by the clock hour needs of the students, as well as the needs and supervision style of the supervisor. In addition, medical site supervisors who have their PhD are assigned as adjunct professors in our department, and teach courses such as the Medical Practicum, Dysphagia, and Cleft Palate.

**To Facilitate Collaboration.** I make a site visit each semester, and contact the clinician by phone 2-3 times per semester. In the site visits, I observe the student in action and the supervisory style of the clinician. I also discuss with the supervisor what knowledge or skills the student needs prior to being placed at that site, then I incorporate this into our professional issues curriculum. Other means of facilitation collaboration are to provide supervision courses for off-site supervisors, have off-site supervisors teach a course or guest lecture, have supervisors serve on an advisory board, and, as I have already mentioned, provide continuing education for the supervisors.

So, what have supervisors determined to be necessary for the students to understand and participate in the “real world”? That will be the focus of my remaining time tonight. Standards IV-E and III offer some specifics that are related to clinical education, and I will discuss two of the activities we incorporate into our curriculum to facilitate the “culturization” process.

### **ASHA's New Standard IV-E and III**

The new standard IV-E states the following: 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: Evaluation, Intervention, and Interaction and Personal Qualities. Janet and Kathleen have addressed some issues specific to evaluation and intervention. I am going to discuss the implementation of this standard (along with Standard III) which states that the clinician must demonstrate the listed skills with “appropriate independence, consistency, accuracy, and application of background knowledge.” The clinician should also know how to complete administrative and clinical functions needed for professional practice.

The implementation of Standards III and IV-E stresses the need for academic coursework, clinical teaching, and independent projects. One way we do this is through our applied clinics.

### **Applied Clinics**

**Purpose.** Our applied clinics were developed as a mechanism through which the students can learn to mesh the academic, clinical, and research aspects of a disorder so that they have an extensive integrated knowledge base.

**Organization.** We are working toward the assignment of one PhD and one MA level supervisor per clinic, and four to eight students per clinic. Each clinic includes evaluations and therapy, and a one-hour discussion/lecture segment. The applied clinics also serve as a reservoir of potential research clients for the faculty.

**Benefits.** Students learn teamwork; students develop case presentation skills; students gain an understanding of clinical research; and faculty get credit

for supervision, which they did not get prior to the development of the applied clinics as courses.

**Problems.** Having enough students to man all the clinics and Absorbing clients when the course isn't offered.

I believe that, through our applied clinics, we can accomplish what Dr. Jette said yesterday in his remark that we need to “integrate individual clinical expertise with the best available clinical evidence from systematic research.” Finally, our applied clinics offer a spiral form of learning using an analytic approach as Dr. Lubinski advocated in his talk.

### **Two-Year Professional Issues Curriculum**

Another way we are bringing the real world into the university clinic is through the implementation of a two-year professional issues curriculum. This curriculum consists of the ASHA Code of Ethics, Interpersonal Skills, Supervision, Professional Liability, Clinical Decision Making, Professional Standards and Accreditation, Legislation, Client Advocacy, and Business Aspects. I would like to briefly address each of these areas of emphasis.

**ASHA Code of Ethics.** First, we discuss the Code of Ethics and the students are tested on the code. In addition to reviewing the ASHA Code of Ethics, we discuss ethical dilemmas that arise in hospitals, clinics, skilled nursing facilities, and school sites. We define ethics, morals and values and explore how the three inter-relate. Models for ethical decision-making are presented, and how these models can be implemented in the different sites is discussed. We discuss the “qualifications” for a person to be considered to have decision-making capacity, and the ethical role of the speech-language pathologist with these patients. Informed consent is addressed, and we talk about issues related to tube-feeding and the choice of a patient to forgo nutrition and hydration.

Furthermore, we include some discussion of the client-clinician relationship. This discussion leads into the interpersonal skills segment of the curriculum.

### **Interpersonal Skills**

Myers-Briggs: With regard to interpersonal skills, the first thing we do is analyze the student's information processing and sharing styles. During orientation, the students complete the Kiersey scale which is a variant of the complete Myers-Briggs test designed to determine their organizational and information processing type. Once that is done, we discuss the roles and thinking styles associated with each type, and the best job-related links based on their type.

Team: Learning to collaborate to deliver appropriate cost-effective services in a variety of settings. This includes a discussion of potential team members and what each team member can bring to the table. This is also a major focus of our applied clinics.

Time Management: Clinician needs to be able to find a balance in the amount of time needed to provide diagnostics and therapy intervention, document treatment outcomes, and bill for services through the appropriate channels. We also discuss balancing work and personal life, including recreation for stress release.

Conflict Resolution: We define conflict and its inevitability in our careers. We then teach the student to become an accomplished negotiator in order to 1) gain other's trust; 2) facilitate cooperation, and 3) focus on mutual issues and goals. We discuss conflict of interest, and transforming conflict into opportunity. Strategies for conflict resolution are presented as well.

Problem Solving: Skills related to “innovation, learning to identify an issue and view it objectively, seeing connections, and thinking globally” are discussed. The clinician needs to be creative in her problem-solving by looking at issues from new perspectives and looking broadly for connections. We discuss blocks that need to be overcome in order to be an effective problem solver.

Goal Setting, Organizational Agility and Flexibility: Each semester we encourage our students to write down their learning objectives or goals for the upcoming 12 weeks. We then try to organize their in-house and offsite experiences to facilitate the achievement of these goals. We teach the students how to be flexible in achieving their goals, and to develop organizational agility. Organizational Agility is defined by ASHA as “the ability to successfully find one’s way through and organizational maze and its politics to achieve one’s goals.” We discuss how to organize information in order to set appropriate goals not only for therapy, but for one’s own professional development. We also discuss the role of the supervisor in helping to set clinical and personal goals to be achieved during the student’s tenure in a specific setting.

**Supervision.** One of the things I like to stress in this part of the curriculum is that supervision exists on a continuum, and that with each change in experience the continuum repeats itself. Specifically, there is the evaluation-feedback stage, the transitional stage when skills are emerging, and the self-evaluation stage. It is our hope that the student will progress to the self-evaluation stage in each setting she is placed. Supervisors evaluate the performance of each student, and the supervisor determines the final grade for the student. We also discuss the tasks and end-goals of supervision, as well as the components of the supervisory process. Leadership styles as they relate to supervision are presented, and the student is encouraged to link the leadership styles with their supervision needs in each site.

**Professional Liability.** Liability and malpractice are rarely an issue in university clinics, but the possibility exists, and the students need to be aware of how liability and malpractice can affect them in the university clinic as well as at their “real-world” practicum sites. We discuss ASHA’s sanctions for malpractice, and our role in identifying instances of malpractice. In addition, we discuss universal precautions and how they will be implemented in the various sites at which they are placed.

**Clinical Decision-Making.** The goal of this topic is to be sure the clinician understands care maps and critical pathways as they relate to specific disorders. The clinician should be able to make effective plans by scoping out the length and difficulty of a task, setting objectives, performing task analysis, and adjusting when roadblocks or problems appear. In this section, we also stress the role of the family in making decisions about the goals and activities of therapy to facilitate generalization and maintenance.

**Legislation Affecting Delivery of SLP Services.** I have already mentioned some of the laws we teach the students prior to their participating in an off-site clinical experience. With regard to state legislation, we primarily discuss laws and procedures related to applying for a state license, and the use of assistants. Several examples of case law are presented to familiarize the students with case law that eventually forms the foundation for much of our federal legislation. We also discuss legal protection for individuals with disabilities.

**Business Aspects.** A variety of business aspects are addressed at various points in the curriculum. Specifically, we discuss business management practices including the management of time, resources, and people. This includes a discussion of third party payments, managed care, policy and procedure manuals, negotiations, professional autonomy, marketing skills and techniques, resume preparation and interviewing skills. After hearing Theresa

Knath-Chisholm's talk yesterday, I would like to add portfolio preparation to this list.

**Client Advocacy.** We teach client advocacy by example, and our students have accompanied clients to the Social Security office and other local agencies to procure services and communication devices. They also learn about consumers' rights through this process. I plan to have one of our local legislators speak about lobbying. Regarding consumer satisfaction, we had the students develop feedback forms for our clients to complete following their visits to our clinic, and we also use ASHA's Customer Satisfaction survey.

**Professional Standards and Accreditations.** In this part of the course, we talk about the ASHA standards, and familiarize the student with JCAHO and CARF standards. However, the bulk of this information is taught in our medical speech-language pathology practicum course.

### **Summary**

In summary, I come back to my original questions: How important is it to bring the real world into the university clinic, and do we really want to? Certainly, real world issues need to be addressed, but it should not be done at the expense of true clinical education. In talking with several practicum and externship supervisors, the students adapt to the mission based on politics and economics, and feedback is often limited to after hours or walks down the hall between clients. In talking with our in-house supervisors, they schedule at least 45 minutes per week per client to provide feedback and instruction to the students. I firmly believe the reason we get such positive feedback about our students from the practicum and externship supervisors is because we spend that extra time providing instruction. Through the two-year curriculum, we can provide much of the information they need to survive in the real world as they are experiencing it through their practica experiences.

It is important that university clinics be structured in a manner that enables the students to learn about outcome measures, fiscal operations, managing diversity, and developing skills related to executive functions. To that end, I think it is important for university clinics to do outreach programs in settings where we can simultaneously have our students experience the real world while getting the benefit of the mission of education.

### **Resources**

ASHA (1999). *Responding to the changing needs of SLP and Audiology students in the 21<sup>st</sup> century*. Rockville Pike, MD: ASHA.

ASHA (2000). *Standards and implementations for the CCC in SLP*. Rockville Pike, MD: ASHA.

Vinson, B. P. (2001). *Essentials for Speech-Language Pathologists*. San Diego: Singular-Thomson Learning.

Vinson, B. P. (2001). *A two-year curriculum to address professional development*. Unpublished.