ASHA
Speech-Language Pathology
Dedicated to Advancing the Profession of Speech-Language Pathology

SLP HEALTH CARE 2025 SURVEY

Survey Summary Report: Number and Type of Responses

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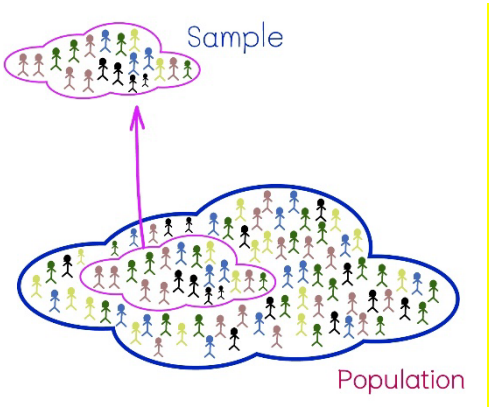
Sampling and Response Rates

The American Speech-Language-Hearing Association (ASHA) used probability (nonreplacement) sampling via a stratified systematic technique to select a sample of 15,000 ASHA-certified speech-language pathologists (SLPs) for the *2025 SLP Health Care Survey.* We stratified the sample by facility type. Small groups, such as SLPs who work in pediatric hospitals, were oversampled in order to include sufficient numbers from these groups in the sample. Within each facility type, one third were randomly assigned to receive postal surveys, and two-thirds received SurveyMonkey (SM) surveys. We weighted the data to reflect their proportion by facility in the Association. The survey was fielded in the spring of 2025.



We obtained a response rate of 18.6% (2,693 completed surveys from a net sample of 14,496 eligible SLPs). This percentage is unweighted.

We weighted data for all tables in the report. The “All Facility Types” column throughout the report reflects results for respondents from the six facility types as well as for the 75 respondents who were employed in “other” types of health care facilities and, for some questions, includes the 10 respondents who did not answer the question about their primary employment facility. Therefore, the “All Facility Types” column may not be the sum of the *n*s in the other six columns. We did not present data for table cells with fewer than 25 respondents, and we excluded administrators and supervisors for questions where we limited responses to clinical service providers.

Appendix A contains a list of facilities; Appendix B, a list of regions of the country; Appendix C, a description of statistical terms; and Appendix D, a list of open-ended responses.

Workplace

1. Do you currently have funded, unfilled positions for SLPs at your facility? (Percentages)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Positions	Facility Type						
	All Facility Types (*n* = 2,668)	**General Medical/VA/ LTAC Hospital (*n* = 406)**	**Home Health/ Client's Home (*n* = 415)**	**Outpatient Clinic/Office (*n* = 1,063)**	**Pediatric Hospital (*n* = 101)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* = 433)**
Yes	44.8	46.8	44.3	45.5	57.4	48.2	36.3
No	55.2	53.2	55.7	54.5	42.6	51.8	63.7
Not currently employed (SKIP to Thank you at the end of the survey.)	**Removed from analyses**						
		Statistical significance: $\chi^2(5) = 20.9$, ***p* < .001,** Cramer's $V = .090$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

2. Based on your own observations and experiences, rate the current job market for SLPs in your type of employment facility and in your geographic area. (Percentages)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Observations	Facility Type						
	All Facility Types (*n* = 2,659)	**General Medical/VA/ LTAC Hospital (*n* = 405)**	**Home Health/ Client's Home (*n* = 416)**	**Outpatient Clinic/Office (*n* = 1,059)**	**Pediatric Hospital (*n* = 100)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* = 428)**
More job openings than job seekers	55.5	39.8	68.5	56.8	42.0	42.1	61.0
Job openings and job seekers in balance	24.2	26.4	20.9	23.8	28.0	29.3	23.6
Fewer job openings than job seekers	20.4	33.8	10.6	19.4	30.0	28.7	15.4
		Statistical significance: $\chi^2(10) = 118$, ***p* < .000,** Cramer's $V = .151$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Employment and Earnings

3. Do you work directly for the facility you serve (i.e., in-house provider) or for a contract company that assigns your location? (Percentages)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time, part time, or per diem

Status	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
	n = 2,657	*n* = 408	*n* = 419	*n* = 1,050	*n* = 102	*n* = 163	*n* = 431
In-house provider	74.5	91.4	57.3	79.2	96.1	93.3	54.5
Contract provider	16.3	5.6	26.7	8.0	0.0	4.9	43.4
Not applicable	9.2	2.9	16.0	12.8	3.9	1.8	2.1
		Statistical significance: $\chi^2(10) = 492.6$, ***p* < .000,** Cramer's *V* = .309 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Recoded, deleting "Not applicable"							
	n = 2,412	*n* = 396	*n* = 352	*n* = 916	*n* = 98	*n* = 160	*n* = 422
In-house provider	82.0	94.2	68.2	90.8	100.0	95.0	55.7
Contract provider	18.0	5.8	31.8	9.2	0.0	5.0	44.3
		Statistical significance: $\chi^2(5) = 377.0$, ***p* < .000,** Cramer's *V* = .401 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

4. Which ONE of the following best describes your employment status? (Percentages)
   Analyses limited to respondents who met the following criterion:
   - ❖ CCC-SLP

Status	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* = 407)**	**Home Health/ Client's Home (*n* = 423)**	**Outpatient Clinic/Office (*n* = 1,066)**	**Pediatric Hospital (*n* = 103)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* = 434)**
Employed full time	69.6	64.4	57.9	74.1	78.6	71.3	73.3
Employed part time	19.9	17.9	28.4	22.9	15.5	11.0	9.7
Employed per diem / as needed	10.6	17.7	13.7	3.0	5.8	17.7	17.1
		Statistical significance: $\chi^2(10) = 176.5$, ***p* < .000,** Cramer's $V = .184$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

5. Identify whether any of your current work includes the employment arrangements listed below.

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Arrangement	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Early Intervention							
	n = 2,208	*n* = 356	*n* = 362	*n* = 846	*n* = 85	*n* =129	*n* = 360
Yes	35.5	6.2	58.8	56.6	34.1	3.9	2.5
No	64.5	93.8	41.2	43.4	65.9	96.1	97.5
		Statistical significance: $\chi^2(5) = 612.9$, ***p* < .000,** Cramer's *V* = .535 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Private Practice							
	n = 2,202	*n* = 354	*n* = 351	*n* = 856	*n* = 81	*n* = 129	*n* = 361
Yes	31.5	4.0	40.7	57.7	7.4	2.3	2.8
No	68.5	96.0	59.3	42.3	92.6	97.7	97.2
		Statistical significance: $\chi^2(5) = 622.5$, ***p* < .000,** Cramer's *V* = .540 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 5 continues on next page.)

5. (cont'd) Identify whether any of your current work includes the employment arrangements listed below.
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Arrangement	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Telepractice							
	n = 2,193	*n* = 354	*n* = 343	*n* = 848	*n* = 86	*n* = 129	*n* = 364
Yes	36.7	12.4	41.7	58.7	39.5	5.4	13.2
No	63.3	87.6	58.3	41.3	60.5	94.6	86.8
		Statistical significance: $\chi^2(5) = 412.9$, ***p* < .000,** Cramer's $V = .441$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

6. Select the ONE type of facility that best describes where you work most of the time. *Note that for the purposes of this question, private practice, early intervention, and telepractice are **not** "types of facilities." (Multiple responses will be excluded.)*

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time, part time, or per diem

Facility Type	**Unweighted (*n* = 2,675)**	**Weighted (*n* = 2,674)**
General medical, Veterans Affairs (VA), or long-term acute care (LTAC) hospital	18.3	15.3
Home health agency or client's home	15.0	15.8
Outpatient clinic or office	28.9	39.8
Pediatric hospital	8.3	3.8
Rehabilitation hospital	9.4	6.1
Skilled nursing facility (SNF)	17.3	16.2
Other; specify:	2.8	2.9
Recoded, deleting "Other"	**Unweighted (*n* = 2,602)**	**Weighted (*n* = 2,597)**
General medical, Veterans Affairs (VA), or long-term acute care (LTAC) hospital	18.8	15.7
Home health agency or client's home	15.4	16.3
Outpatient clinic or office	29.7	41.1
Pediatric hospital	8.5	3.9
Rehabilitation hospital	9.7	6.3
Skilled nursing facility (SNF)	17.8	16.7

Note. Although asked to select only one facility, 53 unweighted and 56 weighted respondents identified multiple facilities as *other.* They are included in this table as part of *other*, and they are included throughout the report in the *All Facility Types* column. See Appendix A for a list of facilities in each group and Appendix D for specified *other* facilities.

7. Although you may perform more than one job function, select the ONE position that best describes how you spend most of your time. *Only one response can be accepted.* (Percentages)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Position	Facility Type						
	All Facility Types (*n* = 2,677)	**General Medical/VA/ LTAC Hospital (*n* = 408)**	**Home Health/ Client's Home (*n* = 424)**	**Outpatient Clinic/Office (*n* = 1,062)**	**Pediatric Hospital (*n* = 101)**	**Rehab Hospital (*n* = 163)**	**Skilled Nursing Facility (*n* = 432)**
Primarily clinical service provider (e.g., SLP).	86.3	88.7	89.9	85.3	87.1	80.4	85.2
Primarily administrative or supervisory, but I do see some patients.	10.2	7.8	7.5	11.7	8.9	12.3	11.6
Exclusively administrative or supervisory.	3.5	3.4	2.6	3.0	4.0	7.4	3.2
		Statistical significance: $\chi^2(10) = 19.7$, ***p* = .032,** Cramer's $V = .062$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

8. How are you paid in your main job? *Only one response allowed.* (Percentages)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Basis	Facility Type						
	All Facility Types (*n* = 2,671)	**General Medical/VA/ LTAC Hospital (*n* = 406)**	**Home Health/ Client's Home (*n* = 419)**	**Outpatient Clinic/Office (*n* = 1,062)**	**Pediatric Hospital (*n* = 101)**	**Rehab Hospital (*n* = 163)**	**Skilled Nursing Facility (*n* = 432)**
Primarily annual salary	37.2	39.7	25.8	45.0	60.4	50.9	18.1
Primarily per hour (SKIP to Q. 10.)	45.4	59.6	24.3	32.6	39.6	47.2	81.5
Primarily per visit (SKIP to Q. 12.)	15.0	0.5	47.0	18.1	0.0	0.6	0.0
Other; specify: (SKIP to Q. 13.)	2.4	0.2	2.9	4.3	0.0	1.2	0.5
		Statistical significance: $\chi^2(15) = 803.3$, ***p* < .000,** Cramer's $V = .322$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Note. See Appendix B for specified *other* salary bases.

9. If you are paid an annual salary, including bonuses, what is your gross annual income before deductions for your main job?

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time
- Paid primarily an annual salary
- Annual salary of at least $1

Annual Income	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
25th percentile	Data in this table are being withheld until 90 days following the close of data collection to ensure compliance with federal regulations on price fixing. Return after August 19, 2025, to view the data in this table.						
50th percentile **(Median)**							
75th percentile							
Mean							
Standard deviation							
Mode							

10. If you are paid on an hourly basis, what is the hourly rate you receive at your primary job?

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Paid primarily per hour
- ❖ Hourly wage of at least $1

Hourly rate	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Employed Full Time							
	Data in this table are being withheld until 90 days following the close of data collection to ensure compliance with federal regulations on price fixing. Return after August 19, 2025, to view the data in this table.						
25th percentile							
50th percentile **(Median)**							
75th percentile							
Mean							
Standard deviation							
Mode							

(Question 10 continues on next page.)

10. (cont'd) If you are paid on an hourly basis, what is the hourly rate you receive at your primary job?

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Paid primarily per hour
- Hourly wage of at least $1

Hourly rate	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Employed Part Time							
25th percentile	Data in this table are being withheld until 90 days following the close of data collection to ensure compliance with federal regulations on price fixing. Return after August 19, 2025, to view the data in this table.						
50th percentile **(Median)**							
75th percentile							
Mean							
Standard deviation							
Mode							

11. On average, how many hours do you work per week for the hourly rate you entered in Q. 10? (Responses in hours and minutes)

    Analyses limited to respondents who met the following criteria:

    - ❖ CCC-SLP
    - ❖ Paid primarily per hour
    - ❖ Hourly wage of at least $1

Hours	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
25th percentile	Data in this table are being withheld until 90 days following the close of data collection to ensure compliance with federal regulations on price fixing. Return after August 19, 2025, to view the data in this table.						
50th percentile **(Median)**							
75th percentile							
Mean							
Standard deviation							
Mode							

12. If you are paid per visit, indicate your average per-visit rate.

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Paid primarily per home visit
- ❖ Per-visit rate of at least $1

Per-visit wage	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
25th percentile	Data in this table are being withheld until 90 days following the close of data collection to ensure compliance with federal regulations on price fixing. Return after August 19, 2025, to view the data in this table.						
50th percentile **(Median)**							
75th percentile							
Mean							
Standard deviation							
Mode							

13. Have you worked "off-the-clock" (i.e., unpaid) since January 2024? (Percentages)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Paid per hour or per visit
- ❖ Primarily clinical service provider

Off-the-Clock Work	Facility Type						
	All Facility Types (*n* = 1,517)	**General Medical/VA/ LTAC Hospital (*n* = 238)**	**Home Health/ Client's Home (*n* = 280)**	**Outpatient Clinic/Office (*n* = 498)**	**Pediatric Hospital (*n* = 37)**	**Rehab Hospital (*n* = 75)**	**Skilled Nursing Facility (*n* = 333)**
No—rarely or never	48.4	66.0	31.4	38.2	54.1	62.7	59.8
Yes—typically a few times a month	19.2	19.3	16.8	21.7	24.3	17.3	18.0
Yes—typically a few times a week	15.2	10.5	18.9	19.1	16.2	10.7	10.8
Yes—typically daily	17.2	4.2	32.9	21.1	5.4	9.3	11.4
		Statistical significance: $\chi^2(15) = 153.7$, ***p* < .000,** Cramer's $V = .187$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

14. Does your employer have a defined clinical ladder or career advancement structure for SLPs? (Percentages)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ SurveyMonkey/electronic survey version only

Response	Facility Type						
	All Facility Types (*n* = 1,264)	**General Medical/VA/ LTAC Hospital (*n* = 196)**	**Home Health/ Client's Home (*n* = 189)**	**Outpatient Clinic/Office (*n* = 499)**	**Pediatric Hospital (*n* = 51)**	**Rehab Hospital (*n* = 81)**	**Skilled Nursing Facility (*n* = 230)**
Yes	25.7	33.2	10.1	29.3	56.9	53.1	9.1
No (SKIP to Q. 16.)	62.9	63.3	71.4	56.7	39.2	45.7	82.6
Not applicable (SKIP to Q. 16.)	11.4	3.6	18.5	14.0	3.9	1.2	8.3
		Statistical significance: $\chi^2(10) = 154.3$, ***p* < .000,** Cramer's $V = .249$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

15. What are the components of your clinical ladder/advancement structure? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ SurveyMonkey/electronic survey version only

Component	Facility Type						
	All Facility Types (*n* = 1,286)	**General Medical/VA/ LTAC Hospital (*n* = 408)**	**Home Health/ Client's Home (*n* = 422)**	**Outpatient Clinic/Office (*n* ≥ 1,063)**	**Pediatric Hospital (*n* ≥ 101)**	**Rehab Hospital (*n* ≥ 162)**	**Skilled Nursing Facility (*n* ≥ 432)**
Structured leadership roles (e.g., supervision, committee work)	20.3	12.7	3.8	11.2	19.8	23.9	3.5
		Statistical significance: $\chi^2(5) = 89.0$, ***p* < .000,** Cramer's *V* = .185 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Performance evaluations	17.5	10.3	2.8	10.0	23.5	17.8	3.0
		Statistical significance: $\chi^2(5) = 84.4$**, *p* < .000,** Cramer's *V* = .180 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Years of experience	16.2	10.5	2.8	9.1	23.5	14.7	2.1
		Statistical significance: $\chi^2(5) = 84.0$, ***p* < .000,** Cramer's *V* = .180 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Advanced training resulting in certification	14.5	8.8	1.2	7.9	18.6	20.4	1.9
		Statistical significance: $\chi^2(5) = 106.5$, ***p* < .000,** Cramer's *V* = .203 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 15 continues on next page.)

15. (cont'd) What are the components of your clinical ladder/advancement structure? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time, part time, or per diem
- SurveyMonkey/electronic survey version only

Component	Facility Type						
	All Facility Types (*n* = 1,286)	**General Medical/VA/ LTAC Hospital (*n* = 408)**	**Home Health/ Client's Home (*n* = 422)**	**Outpatient Clinic/Office (*n* ≥ 1,063)**	**Pediatric Hospital (*n* ≥ 101)**	**Rehab Hospital (*n* ≥ 162)**	**Skilled Nursing Facility (*n* ≥ 432)**
Advanced training without additional certification	10.9	7.1	0.9	6.1	13.9	13.5	1.4
		Statistical significance: $\chi^2(5) = 68.4$, ***p* < .000,** Cramer's *V* = .163 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Publication	6.1	4.7	0.0	2.7	10.8	10.4	0.5
		Statistical significance: $\chi^2(5) = 78.6$**, *p* < .000,** Cramer's *V* = .174 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Other; specify:	3.5	2.7	0.0	2.1	2.9	4.9	0.5
		Statistical significance: $\chi^2(5) = 24.4$**, *p* < .000,** Cramer's *V* = .097 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Note. See Appendix D for a list of specified other components, by facility.

16. What are the reasons why you have received a salary or rate increase since January 2024? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)
    Analyses limited to respondents who met the following criteria:
    - ❖ CCC-SLP
    - ❖ Employed full time, part time, or per diem

Reason	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* = 408)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* = 1,066)**	**Pediatric Hospital (*n* = 102)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* ≥ 433)**
Merit-based or related to performance evaluation	34.2	40.9	23.9	36.5	61.8	51.2	20.7
		Statistical significance: $\chi^2(5) = 120.8$, ***p* < .000,** Cramer's *V* = .216 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Cost of living	25.6	39.5	19.1	26.2	34.3	36.0	12.4
		Statistical significance: $\chi^2(5) = 102.9$**, *p* < .000,** Cramer's *V* = .199 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Additional responsibilities without change of position	5.9	4.9	4.0	7.5	4.9	6.1	5.3
		Statistical significance: $\chi^2(5) = 8.7$, *p* = .121 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
Promotion within the organization	5.9	5.6	3.8	6.6	11.8	7.9	5.1
		Statistical significance: $\chi^2(5) = 12.1$**, *p* = .033,** Cramer's *V* = .068 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 16 continues on next page.)

16. (cont'd) What are the reasons why you have received a salary or rate increase since January 2024? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time, part time, or per diem

Reason	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* = 408)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* = 1,066)**	**Pediatric Hospital (*n* = 102)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* ≥ 433)**
Completion of additional certificates or credentials	4.4	3.2	2.8	5.9	4.9	4.9	3.0
		Statistical significance: $\chi^2(5) = 11.9$**, *p* = .036,** Cramer's *V* = .068 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Other; specify:	10.6	12.0	9.2	10.5	8.8	10.4	11.1
		Statistical significance: $\chi^2(5) = 2.2$, *p* = .826 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
N/A, or I did not receive an increase	36.6	22.8	52.2	34.1	11.8	18.3	53.0
		Statistical significance: $\chi^2(5) = 182.3$, ***p* < .000,** Cramer's *V* = .265 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Note. See Appendix D for a list of specified other reasons, by facility.

Professional Services: I*f you provide NO clinical services, SKIP to Q. 23.*

17. Overall, since January 2024, my caseload size at my primary place of employment . . . (Percentages)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Caseload Size	Facility Type						
	All Facility Types (*n* = 2,272)	**General Medical/VA/ LTAC Hospital (*n* = 357)**	**Home Health/ Client's Home (*n* = 373)**	**Outpatient Clinic/Office (*n* = 897)**	**Pediatric Hospital (*n* = 86)**	**Rehab Hospital (*n* = 129)**	**Skilled Nursing Facility (*n* = 362)**
Has remained the same	50.6	46.2	46.4	51.8	47.7	68.2	51.9
Has increased	41.1	49.0	38.9	41.2	50.0	29.5	35.4
Has decreased	8.4	4.8	14.7	6.9	2.3	2.3	12.7
		Statistical significance: $\chi^2(10) = 69.2$, ***p* < .000,** Cramer's $V = .125$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

18. What is your productivity requirement?

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Productivity Requirement	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
	n = 1,271	*n* = 246	*n* = 99	*n* = 397	*n* = 71	*n* = 90	*n* = 335
25th percentile	75%	70%	70%	70%	60%	75%	85%
50th percentile **(Median)**	80%	80%	80%	78%	70%	80%	85%
75th percentile	85%	85%	90%	85%	80%	85%	88%
Mean	79%	77%	78%	77%	69%	79%	85%
Standard deviation	11%	13%	15%	11%	12%	9%	6%
Mode	80%	80%	80%	80%	80%	75%	85%
		Statistical significance: $F(5, 1232) = 42.3$, $\boldsymbol{p < .000}$ Conclusion: There is adequate evidence from the data to say that the means vary by facility type.					
	n = 2,310	*n* = 363	*n* = 381	*n* = 906	*n* = 88	*n* = 131	*n* = 368
Selected option: I have none. (SKIP to Q. 20.)	40.5	25.3	67.7	52.3	17.0	26.0	7.9
Did not select option	59.5	74.7	32.3	47.7	83.0	74.0	92.1
		Statistical significance: $\chi^2(5) = 398.8$, $\boldsymbol{p < .000}$, Cramer's $V = .422$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

19. Which of the following activities count toward your productivity calculation when the patient is not present? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time, part time, or per diem
- Primarily clinical service provider

Activity	Facility Type						
	All Facility Types (*n* = 2,310)	**General Medical/VA/ LTAC Hospital (*n* = 362)**	**Home Health/ Client's Home (*n* = 381)**	**Outpatient Clinic/Office (*n* = 906)**	**Pediatric Hospital (*n* ≥ 88)**	**Rehab Hospital (*n* ≥ 131)**	**Skilled Nursing Facility (*n* ≥ 368)**
Clinical team meetings.	11.9	14.4	8.4	11.3	10.2	22.1	12.0
		Statistical significance: $\chi^2(5) = 20.1$, ***p* = .001,** Cramer's $V = .095$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
In-service or informal staff training sessions.	10.1	11.3	8.1	9.2	9.1	15.2	11.7
		Statistical significance: $\chi^2(5) = 7.9$, $p = .161$ Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
Documentation.	8.4	10.2	6.6	5.7	9.1	10.6	13.0
		Statistical significance: $\chi^2(5) = 23.0$, ***p* < .000,** Cramer's $V = .101$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Care coordination activities.	7.4	11.6	5.8	4.9	6.8	9.2	10.9
		Statistical significance: $\chi^2(5) = 26.4$ ***p* < .000,** Cramer's $V = .109$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 19 continues on next page.)

19. (cont'd) Which of the following activities count toward your productivity calculation when the patient is not present? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time, part time, or per diem
- Primarily clinical service provider

Activity	Facility Type						
	All Facility Types (*n* = 2.310)	**General Medical/VA/ LTAC Hospital (*n* = 362)**	**Home Health/ Client's Home (*n* = 381)**	**Outpatient Clinic/Office (*n* = 906)**	**Pediatric Hospital (*n* ≥ 88)**	**Rehab Hospital (*n* ≥ 131)**	**Skilled Nursing Facility (*n* ≥ 368)**
Other activities; specify.	3.8	5.5	2.9	3.2	4.5	2.3	4.6
		Statistical significance: $\chi^2(5) = 6.4$, $p = .273$ Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
Nothing counts when patient is not present.	39.5	45.6	20.7	33.4	58.4	39.7	64.7
		Statistical significance: $\chi^2(5) = 186.1$, **$p < .000$,** Cramer's $V = .288$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Note. See Appendix D for a list of specified other activities, by facility.

20. Since January 2024, have you felt pressured by an employer or supervisor to engage in any of the following activities? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

    Analyses limited to respondents who met the following criteria:

    - ❖ CCC-SLP
    - ❖ Employed full time, part time, or per diem

Pressure	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* = 408)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* ≥ 1,066)**	**Pediatric Hospital (*n* = 102)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* ≥ 433)**
Provide inappropriate frequency or intensity of services	11.0	11.3	9.0	6.5	11.8	15.9	22.4
		Statistical significance: $\chi^2(5) = 84.6$, ***p* < .000,** Cramer's *V* = .180 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Provide services for which you had inadequate training and/or experience	10.3	9.3	7.8	14.0	12.7	6.7	5.5
		Statistical significance: $\chi^2(5) = 32.4$, ***p* < .000,** Cramer's *V* = .112 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Provide evaluation and treatment that are not clinically appropriate	9.9	11.3	6.4	4.9	9.8	12.8	23.0
		Statistical significance: $\chi^2(5) = 122.9$, ***p* < .000,** Cramer's *V* = .218 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
		(Question 20 continues on next page.)					

20. (cont'd) In the past 12 months, have you felt pressured by an employer or supervisor to engage in any of the following activities? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time, part time, or per diem

Pressure	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* = 408)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* ≥ 1,066)**	**Pediatric Hospital (*n* = 102)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* ≥ 433)**
Discharge inappropriately (e.g., early or delayed)	9.4	5.4	7.5	5.2	8.8	11.6	25.6
		Statistical significance: $\chi^2(5) = 163.9$, ***p* < .000,** Cramer's *V* = .251 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Provide group therapy when individual therapy was appropriate	7.7	1.7	3.3	2.2	2.0	15.2	30.4
		Statistical significance: $\chi^2(5) = 405.4$, ***p* < .000,** Cramer's V = .395 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Alter documentation for reimbursement	4.9	3.4	3.3	4.9	2.9	3.7	9.7
		Statistical significance: $\chi^2(5) = 26.0$, ***p* < .000,** Cramer's *V* = .100 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Did not feel pressured	67.1	71.1	75.7	73.1	67.6	57.3	44.2
		Statistical significance: $\chi^2(5) = 144.4$, ***p* < .000,** Cramer's *V* = .236 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

21. In your clinical practice with PEDIATRIC clients, which of the following services do you provide? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Service	Facility Type						
	All Facility Types (*n* = 2,310)	**General Medical/VA/ LTAC Hospital (*n* = 362)**	**Home Health/ Client's Home (*n* = 381)**	**Outpatient Clinic/Office (*n* = 906)**	**Pediatric Hospital (*n* ≥ 88)**	**Rehab Hospital (*n* ≥ 131)**	**Skilled Nursing Facility (*n* ≥ 368)**
Telepractice.	23.1	1.7	27.8	39.4	39.8	2.3	1.9
		Statistical significance: $\chi^2(5) = 374.9$, ***p* < .000,** Cramer's $V = .409$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Episodic care (i.e., periods of intensive therapy with breaks for generalization).	21.3	6.1	19.4	35.2	51.1	6.1	1.1
		Statistical significance: $\chi^2(5) = 312.6$, ***p* < .000,** Cramer's $V = .374$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Group services.	5.6	0.6	4.2	9.6	13.5	3.0	1.1
		Statistical significance: $\chi^2(5) = 72.9$, ***p* < .000,** Cramer's $V = .180$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
		(Question 21 continues on next page.)					

21. (cont'd) In your clinical practice with PEDIATRIC clients, which of the following services do you provide? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Employed full time, part time, or per diem
- Primarily clinical service provider

Service	Facility Type						
	All Facility Types (*n* = 2,310)	**General Medical/VA/ LTAC Hospital (*n* = 362)**	**Home Health/ Client's Home (*n* = 381)**	**Outpatient Clinic/Office (*n* = 906)**	**Pediatric Hospital (*n* ≥ 88)**	**Rehab Hospital (*n* ≥ 131)**	**Skilled Nursing Facility (*n* ≥ 368)**
Concurrent services (i.e., two patients performing different activities at the same time).	2.8	0.6	3.7	4.5	4.5	0.8	0.5
		Statistical significance: $\chi^2(5) = 26.9$, ***p* < .000,** Cramer's $V = .110$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Gender affirming care.	2.1	0.3	0.5	3.5	8.0	2.3	0.0
		Statistical significance: $\chi^2(5) = 43.8$, ***p* < .000,** Cramer's $V = .140$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Palliative care.	2.0	0.3	1.3	2.0	20.5	0.8	0.8
		Statistical significance: $\chi^2(5) = 158.7$, ***p* < .000,** Cramer's $V = .266$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
I do not serve pediatric clients.	47.1	81.2	36.5	21.3	0.0	82.6	88.6
		Statistical significance: $\chi^2(5) = 826.9$, ***p* < .000,** Cramer's $V = .608$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

22. In your clinical practice with ADULT clients, which of the following services do you provide? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Service	Facility Type						
	All Facility Types (*n* = 2,310)	**General Medical/VA/ LTAC Hospital (*n* = 362)**	**Home Health/ Client's Home (*n* = 381)**	**Outpatient Clinic/Office (*n* = 906)**	**Pediatric Hospital (*n* = 88)**	**Rehab Hospital (*n* = 132)**	**Skilled Nursing Facility (*n* ≥ 368)**
Episodic care (i.e., periods of intensive therapy with breaks for generalization).	23.2	30.1	22.3	20.8	5.7	28.8	26.1
		Statistical significance: $\chi^2(5) = 32.0$, ***p* < .000,** Cramer's $V = .120$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Habilitative services (i.e., targeting new skills rather than those acquired prior to injury or illness).	22.0	28.2	19.7	16.9	4.5	34.8	31.5
		Statistical significance: $\chi^2(5) = 70.4$, ***p* < .000,** Cramer's $V = .177$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Palliative care.	16.3	43.6	11.0	5.3	4.5	15.2	25.3
		Statistical significance: $\chi^2(5) = 317.1$, ***p* < .000,** Cramer's $V = .376$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
		(Question 22 continues on next page.)					

22. (cont'd) In your clinical practice with ADULT clients, which of the following services do you provide? *Select all that apply.*
(Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Service	Facility Type						
	All Facility Types (*n* = 2,310)	**General Medical/VA/ LTAC Hospital (*n* = 362)**	**Home Health/ Client's Home (*n* = 381)**	**Outpatient Clinic/Office (*n* = 906)**	**Pediatric Hospital (*n* = 88)**	**Rehab Hospital (*n* = 132)**	**Skilled Nursing Facility (*n* ≥ 368)**
Telepractice.	14.4	10.2	7.6	23.2	3.4	3.8	9.5
		Statistical significance: $\chi^2(5) = 104.8$, ***p* < .000,** Cramer's $V = .216$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Group services.	13.1	4.1	1.3	3.3	0.0	48.5	49.7
		Statistical significance: $\chi^2(5) = 732.0$, ***p* < .000,** Cramer's $V = .572$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Concurrent services (i.e., two patients performing different activities at the same time).	10.6	3.3	2.1	2.3	1.1	23.5	45.7
		Statistical significance: $\chi^2(5) = 614.6$, ***p* < .000,** Cramer's $V = .524$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 22 continues on next page.)

22. (cont'd) In your clinical practice with ADULT clients, which of the following services do you provide? *Select all that apply.*
(Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Service	Facility Type						
	All Facility Types (*n* = 2,310)	**General Medical/VA/ LTAC Hospital (*n* = 362)**	**Home Health/ Client's Home (*n* = 381)**	**Outpatient Clinic/Office (*n* = 906)**	**Pediatric Hospital (*n* = 88)**	**Rehab Hospital (*n* = 132)**	**Skilled Nursing Facility (*n* ≥ 368)**
Gender affirming care.	4.1	2.8	1.3	7.2	1.1	5.3	1.1
		Statistical significance: $\chi^2(5) = 41.8$, ***p* < .000,** Cramer's *V* = .137 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
I do not serve adult clients.	32.5	3.0	46.2	52.2	77.3	2.3	0.8
		Statistical significance: $\chi^2(5) = 637.4$, ***p* < .000,** Cramer's *V* = .534 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Clinician Safety

23. Does your facility provide training in workplace safety protocols? *Select one response only.* (Percentages)
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Training	Facility Type						
	All Facility Types (*n* = 2,599)	**General Medical/VA/ LTAC Hospital (*n* = 399)**	**Home Health/ Client's Home (*n* = 403)**	**Outpatient Clinic/Office (*n* = 1,031)**	**Pediatric Hospital (*n* = 99)**	**Rehab Hospital (*n* = 159)**	**Skilled Nursing Facility (*n* = 424)**
No formal training is provided.	12.5	2.5	19.4	18.4	2.0	1.3	8.5
Yes, during orientation only.	14.4	9.3	14.1	17.0	11.1	9.4	15.8
Yes, ongoing.	73.1	88.2	66.5	64.6	86.9	89.3	75.7
		Statistical significance: χ^2 (10) = 154.9, ***p* < .000,** Cramer's *V* = .175 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

24. How often do you feel safe at work? (Percentages)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Response	Facility Type						
	All Facility Types (*n* = 2,614)	**General Medical/VA/ LTAC Hospital (*n* = 399)**	**Home Health/ Client's Home (*n* = 410)**	**Outpatient Clinic/Office (*n* = 1,037)**	**Pediatric Hospital (*n* = 99)**	**Rehab Hospital (*n* = 160)**	**Skilled Nursing Facility (*n* = 424)**
Never	0.3	0.3	0.2	0.1	0.0	0.6	0.5
Rarely	1.0	0.8	1.2	0.7	1.0	0.6	1.7
Usually	42.8	50.4	53.4	35.8	48.5	41.9	45.5
Always	56.0	48.6	45.1	63.5	50.5	56.9	52.4
		Too many cells (46%) have an expected count of fewer than 5. Conclusion: Too little data are available in some facility categories to test whether responses vary by facility type.					

25. Since January 2024, which of the following safety risks have you experienced on the job? *Select all that apply.*
(Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Risk	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* ≥ 407)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* = 1,066)**	**Pediatric Hospital (*n* = 102)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* = 434)**
Mental health and stress-related concerns	36.7	40.4	30.5	35.3	52.0	39.6	40.8
		Statistical significance: $\chi^2(5) = 24.0$, ***p* < .000,** Cramer's $V = .096$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Aggressive behavior, harassment, or bullying	25.1	40.2	14.9	22.3	32.4	29.9	27.0
		Statistical significance: $\chi^2(5) = 81.6$**, *p* < .000,** Cramer's $V = .177$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Ergonomic challenges (e.g., patient transfers, workspace set up)	24.5	39.6	19.1	17.7	27.5	36.0	29.7
		Statistical significance: $\chi^2(5) = 100.0$, ***p* < .000,** Cramer's $V = .196$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Physical safety in treatment environment	10.1	8.1	18.9	9.3	9.8	4.9	8.3
		Statistical significance: $\chi^2(5) = 44.7$, ***p* < .000,** Cramer's $V = .131$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 25 continues on next page.)

25. (cont'd) Since January 2024, which of the following safety risks have you experienced on the job? *Select all that apply.*
(Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Risk	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* ≥ 407)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* = 1,066)**	**Pediatric Hospital (*n* = 102)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* = 434)**
Lack of access to personal protective equipment (e.g., masks, radiation safety gear)	7.1	8.3	6.1	3.4	2.9	6.1	18.0
		Statistical significance: $\chi^2(5) = 103.2$, ***p* < .000,** Cramer's $V = .199$ Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
Workplace violence	2.1	5.4	1.2	0.8	3.9	3.0	2.5
		Statistical significance: $\chi^2(5) = 35.3$, ***p* < .000,** Cramer's $V = .117$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
None of the above	11.0	13.5	16.7	19.1	10.8	11.6	16.8
		Statistical significance: $\chi^2(5) = 13.3$, ***p* = .021,** Cramer's $V = .071$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Other; specify:	16.6	7.4	15.4	11.2	7.8	10.4	9.9
		Statistical significance: $\chi^2(5) = 15.6$, ***p* = .008,** Cramer's $V = .077$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Note. See Appendix D for a list of specified other risks, by facility.

26. How comfortable are you reporting concerns to your employer about your own safety? (Percentages)
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Comfort Level	Facility Type						
	All Facility Types (*n* = 2,569)	**General Medical/VA/ LTAC Hospital (*n* = 400)**	**Home Health/ Client's Home (*n* = 399)**	**Outpatient Clinic/Office (*n* = 1,005)**	**Pediatric Hospital (*n* = 98)**	**Rehab Hospital (*n* = 159)**	**Skilled Nursing Facility (*n* = 422)**
Very uncomfortable	13.8	14.2	13.8	12.3	14.3	17.0	13.5
Somewhat uncomfortable	7.9	10.5	7.3	6.5	8.2	8.8	10.2
Neutral	8.9	8.8	6.5	8.1	7.1	7.5	14.0
Somewhat comfortable	19.8	21.0	13.8	18.9	30.6	23.9	23.0
Very comfortable	49.6	45.5	58.6	54.2	39.8	42.8	39.3
		Statistical significance: $\chi^2(20) = 69.7$, ***p* < .000,** Cramer's $V = .084$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Barriers

27. What are the current TOP 3 barriers to providing optimal clinical care in your facility? *Select up to 3 responses.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)
    Analyses limited to respondents who met the following criteria:
    - ❖ CCC-SLP
    - ❖ Employed full time, part time, or per diem

Barrier	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* ≥ 407)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* ≥ 1,066)**	**Pediatric Hospital (*n* ≥ 102)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* ≥ 433)**
Administrative tasks (e.g., documentation, scheduling)	52.6	44.6	55.6	59.7	66.7	56.1	36.9
		Statistical significance: $\chi^2(5) = 85.2$, ***p* < .000**, Cramer's *V* = .181 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Productivity demands / lack of time	42.4	39.6	28.1	41.4	53.4	48.8	56.7
		Statistical significance: $\chi^2(5) = 81.1$, ***p* < .000**, Cramer's *V* = .177 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Payer or reimbursement limitations	39.8	14.7	46.1	50.0	21.6	24.4	44.8
		Statistical significance: $\chi^2(5) = 194.3$, ***p* < .000,** Cramer's *V* = .273 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Insufficient staffing	26.8	37.7	23.6	19.8	38.2	39.6	29.5
		Statistical significance: $\chi^2(5) = 75.8$, ***p* < .000,** Cramer's *V* = .171 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 27 continues on next page.)

27. (cont'd) What are the current TOP 3 barriers to providing Optimal clinical care in your facility? *Select up to 3 responses.*
(Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Barrier	Facility Type						
	All Facility Types (*n* = 2,686)	**General Medical/VA/ LTAC Hospital (*n* ≥ 407)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* ≥ 1,066)**	**Pediatric Hospital (*n* ≥ 102)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* ≥ 433)**
Others have a limited understanding of the SLP's role	26.1	42.4	26.4	17.4	23.5	29.9	31.3
		Statistical significance: $\chi^2(5) = 105.1$, ***p* < .000,** Cramer's $V = .201$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Difficulty accessing necessary equipment and resources (e.g., testing and treatment materials, instrumental equipment)	23.4	27.2	23.6	21.2	22.5	18.3	28.2
		Statistical significance: $\chi^2(5) = 14.0$, ***p* = .016,** Cramer's $V = .073$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Hesitancy of colleagues to change	12.7	21.6	7.5	10.1	13.7	18.9	14.1
		Statistical significance: $\chi^2(5) = 51.4$, ***p* < .000,** Cramer's $V = .141$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Other; specify:	8.6	8.6	9.2	9.7	7.8	8.5	5.8
		Statistical significance: $\chi^2(5) = 6.2$, $p = .283$ Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					

Note. See Appendix D for a list of specified other barriers, by facility.

28. What impact have the following barriers had on providing supervision for graduate students in your setting?
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Impact	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Insufficient guidance from academic program							
	n = 1,707	*n* = 288	*n* = 212	*n* = 723	*n* = 75	*n* = 104	*n* = 256
No impact	58.9	55.6	66.0	59.3	50.7	51.0	60.2
Minor impact	24.9	25.7	19.3	27.1	28.0	29.8	19.9
Moderate impact	11.6	34.0	25.1	10.0	13.3	14.4	15.2
Major impact	4.5	5.9	3.8	3.6	8.0	4.8	4.7
		Statistical significance: $\chi^2(15) = 23.1$, $p = .081$ Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
Insufficiently prepared students							
	n = 1,713	*n* = 286	*n* = 214	*n* = 728	*n* = 76	*n* = 106	*n* = 257
No impact	43.0	30.4	63.1	41.9	27.6	25.5	54.1
Minor impact	28.4	33.6	20.1	28.6	32.9	34.9	22.6
Moderate impact	19.6	24.1	11.2	20.1	25.0	29.2	17.1
Major impact	9.0	11.9	5.6	9.5	14.5	10.4	6.2
		Statistical significance: $\chi^2(15) = 90.8$, ***p* < .000,** Cramer's $V = .135$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 28 continues on next page.)

28. (cont'd) What impact have the following barriers had on providing supervision for graduate students in your setting?
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Impact	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Lack of administration support							
	n = 1,719	*n* = 292	*n* = 218	*n* = 723	*n* = 76	*n* = 106	*n* = 257
No impact	58.4	53.4	63.3	62.8	47.4	51.9	52.5
Minor impact	22.2	26.4	18.3	20.2	26.3	29.2	22.2
Moderate impact	12.3	12.3	11.9	10.9	17.1	13.2	15.2
Major impact	7.0	7.9	6.4	6.1	9.2	5.7	10.1
		Statistical significance: $\chi^2(15) = 26.2$, ***p* = .036,** Cramer's $V = .072$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Limited supervision training							
	n = 1,712	*n* = 287	*n* = 214	*n* = 728	*n* = 77	*n* = 105	*n* = 257
No impact	58.5	57.5	57.5	61.3	48.1	56.2	54.5
Minor impact	23.2	25.8	22.4	21.8	28.6	27.6	22.6
Moderate impact	12.8	11.8	12.1	12.5	15.6	9.5	16.0
Major impact	5.5	4.9	7.9	4.4	7.8	6.7	7.0
		Statistical significance: $\chi^2(15) = 16.2$, $p = .368$ Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					

(Question 28 continues on next page.)

28. (cont'd) What impact have the following barriers had on providing supervision for graduate students in your setting?
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Impact	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Limited time							
	n = 1,759	*n* = 297	*n* = 222	*n* = 739	*n* = 76	*n* = 106	*n* = 268
No impact	26.3	22.6	35.6	25.7	15.8	22.6	26.5
Minor impact	22.5	25.9	15.3	25.2	23.7	29.2	14.2
Moderate impact	23.8	26.9	18.9	24.4	31.6	21.7	20.9
Major impact	27.4	24.6	30.2	24.8	28.9	26.4	38.4
		Statistical significance: $\chi^2(15) = 53.8$, ***p* < .000,** Cramer's $V = .103$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
No additional compensation							
	n = 1,756	*n* = 294	*n* = 231	*n* = 738	*n* = 75	*n* = 104	*n* = 262
No impact	26.3	22.8	35.1	26.0	17.3	20.2	26.0
Minor impact	17.0	21.1	10.8	16.8	16.0	20.2	16.4
Moderate impact	20.0	20.4	18.6	21.1	25.3	21.2	16.4
Major impact	36.7	35.7	35.5	36.0	41.3	38.5	41.2
		Statistical significance: $\chi^2(15) = 26.5$, ***p* = .033,** Cramer's $V = .072$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 28 continues on next page.)

28. (cont'd) What impact have the following barriers had on providing supervision for graduate students in your setting?
Analyses limited to respondents who met the following criteria:
- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Impact	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Previous bad experience							
	n = 1,708	*n* = 289	*n* = 212	*n* = 724	*n* = 76	*n* = 105	*n* = 255
No impact	61.3	50.9	75.0	62.2	56.6	51.4	63.1
Minor impact	22.5	29.8	9.4	22.7	23.7	31.4	20.4
Moderate impact	9.3	10.0	9.0	9.1	10.5	11.4	9.4
Major impact	6.9	9.3	6.6	6.1	9.2	5.7	7.1
		Statistical significance: $\chi^2(15) = 45.8$, ***p* < .000,** Cramer's $V = .096$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Reimbursement challenges							
	n = 1,708	*n* = 286	*n* = 215	*n* = 723	*n* = 75	*n* = 105	*n* = 257
No impact	69.8	77.3	66.0	69.0	78.7	75.2	60.3
Minor impact	12.0	12.6	7.0	12.0	8.0	14.3	15.6
Moderate impact	8.7	6.3	8.4	10.0	8.0	5.7	10.1
Major impact	9.5	3.8	18.6	9.0	5.3	4.8	14.0
		Statistical significance: $\chi^2(15) = 58.2$, ***p* < .000,** Cramer's $V = .108$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 28 continues on next page.)

28. (cont'd) What impact have the following barriers had on providing supervision for graduate students in your setting?

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem
- ❖ Primarily clinical service provider

Impact	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
Setting does not allow							
	n = 1,690	*n* = 274	*n* = 235	*n* = 708	*n* = 72	*n* = 100	*n* = 257
No impact	84.3	88.3	68.9	88.7	80.6	90.0	80.2
Minor impact	6.2	4.7	8.5	4.7	9.7	7.0	8.9
Moderate impact	3.8	2.6	7.2	3.1	4.2	1.0	5.1
Major impact	5.7	4.4	15.3	3.5	5.6	2.0	5.8
		Statistical significance: $\chi^2(15) = 79.5$, ***p* < .000,** Cramer's $V = .127$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					
Other; specify							
	n = 95	*n* = 8	*n* = 17	*n* = 22	*n* = 4	*n* = 2	*n* = 18
No impact	36.4	(*n* < 25)	(*n* < 25)	(*n* < 25)	(*n* < 25)	(*n* < 25)	(*n* < 25)
Minor impact	5.2						
Moderate impact	8.6						
Major impact	49.8						
		Too many cells (88%) have an expected count of fewer than 5. Conclusion: Too little data are available in some facility categories to test whether responses vary by facility type.					

Note. See Appendix D for a list of specified other barriers and impacts, by facility.

29. What suggestions do you have for addressing the barriers to supervision of students at your work setting?
    Analyses limited to respondents who met the following criteria:
    - ❖ CCC-SLP
    - ❖ Employed full time, part time, or per diem
    - ❖ SurveyMonkey/electronic survey version only

See Appendix D for a list of specified other suggestions, by facility.

Demographics

30. Which <u>one</u> of the following best describes where you work?
    Analyses limited to respondents who met the following criteria:
    - ❖ CCC-SLP
    - ❖ Employed full time, part time, or per diem

Area	Facility Type						
	All Facility Types (*n* = 2,573)	**General Medical/VA/ LTAC Hospital (*n* = 394)**	**Home Health/ Client's Home (*n* = 393)**	**Outpatient Clinic/Office (*n* = 1,030)**	**Pediatric Hospital (*n* = 98)**	**Rehab Hospital (*n* = 159)**	**Skilled Nursing Facility (*n* = 419)**
City/urban area	43.3	54.8	35.9	40.6	77.6	61.0	29.8
Suburban area	40.5	31.5	49.6	43.2	18.4	32.1	44.2
Rural area	16.2	13.7	14.5	16.2	4.1	6.9	26.0
Not currently employed (SKIP to Thank you at the end of the survey.)	**Removed from analyses**						
		Statistical significance: $\chi^2(10) = 153.1$, ***p* < .000,** Cramer's $V = .175$ <u>Conclusion</u>: There is adequate evidence from the data to say that the responses vary by facility type.					

31. In what state is your primary employment FACILITY located?

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ Employed full time, part time, or per diem

Region and Division	Facility Type						
	All Facility Types (*n* = 2,685)	**General Medical/VA/ LTAC Hospital (*n* = 408)**	**Home Health/ Client's Home (*n* ≥ 423)**	**Outpatient Clinic/Office (*n* ≥ 1,064)**	**Pediatric Hospital (*n* ≥ 100)**	**Rehab Hospital (*n* = 164)**	**Skilled Nursing Facility (*n* ≥ 433)**
Northeast	**17.6**	**18.1**	**22.2**	**14.5**	**17.6**	**15.2**	**21.2**
Middle Atlantic	12.0	13.0	15.8	9.3	9.0	12.2	14.1
New England	5.5	5.1	6.1	5.2	8.0	3.0	7.1
Midwest	**24.7**	**24.3**	**16.1**	**25.0**	**27.5**	**27.4**	**31.4**
East North Central	17.0	16.2	12.3	16.4	21.0	17.7	22.4
West North Central	7.8	8.1	4.0	8.6	6.0	9.8	9.0
South	**38.8**	**34.6**	**37.4**	**41.8**	**37.3**	**41.5**	**35.1**
East South Central	6.6	6.1	3.8	7.6	4.0	7.3	7.8
South Atlantic	20.5	19.6	20.1	22.3	21.0	18.9	17.3
West South Central	11.7	8.8	13.5	11.9	13.0	15.2	10.1
West	**18.9**	**23.0**	**24.3**	**18.7**	**17.6**	**15.9**	**12.2**
Mountain	7.9	8.6	13.0	6.5	6.0	7.9	6.5
Pacific	11.0	14.5	11.3	12.2	12.0	7.9	5.8
		FOR ALL 4 REGIONS: $\chi^2(15) = 64.0$, ***p* < .000,** Cramer's $V = .091$ FOR ALL 9 DIVISIONS: $\chi^2(40) = 101.2$, ***p* < .000,** Cramer's $V = .088$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

Note. Division frequencies may not equal those of the region, and column sums may not equal 100% because of rounding. See Appendix B for lists of states in each division and region.

32. How many years have you been employed in the speech-language pathology profession? *Exclude your clinical fellowship. Round to the nearest full year. Enter "0" if you have never been employed as an SLP.*

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- Years reported: 1 or more

Experience	Facility Type						
	All Facility Types (*n* = 2,598)	**General Medical/VA/ LTAC Hospital (*n* = 397)**	**Home Health/ Client's Home (*n* = 406)**	**Outpatient Clinic/Office (*n* = 1,032)**	**Pediatric Hospital (*n* = 97)**	**Rehab Hospital (*n* = 157)**	**Skilled Nursing Facility (*n* = 424)**
25th percentile	7.0	9	11	6	7	6	8
50th percentile **(Median)**	15.0	16	18	14	13	13	16
75th percentile	25.0	25	29	25	24	21	27
Mean	17.3	18	20	16	16	16	18
Standard deviation	12.0	11	12	12	11	12	12
Mode	2.0	14	17	3	5	3	1
		Statistical significance: $F(5, 2507) = 7.7$, $\mathbf{p < .000}$ Conclusion: There is adequate evidence from the data to say that the means vary by facility type.					

33. Identify any graduate degrees you have earned. *Count only actual earned degrees—not equivalencies or certificates—and do not include degrees expected but not yet conferred. Select all that apply.*

Analyses limited to respondents who met the following criterion:

- ❖ CCC-SLP

Degree	Facility Type						
	All Facility Types	**General Medical/VA/ LTAC Hospital**	**Home Health/ Client's Home**	**Outpatient Clinic/Office**	**Pediatric Hospital**	**Rehab Hospital**	**Skilled Nursing Facility**
	n ≥ 2,687	*n* ≥ 408	*n* ≥ 425	*n* ≥ 1,065	*n* ≥ 102	*n* ≥ 163	*n* ≥ 435
Master's	95.4	95.6	93.9	95.7	94.2	95.7	96.6
Clinical doctorate (e.g., SLPD, CScD)	1.2	1.7	1.2	1.1	0.0	0.6	0.7
Research doctorate (i.e., PhD)	1.0	0.5	0.0	1.7	2.0	0.6	0.2
Other doctorate; specify:	0.4	0.7	0.2	0.4	0.0	0.0	0.2
Recoded, combining doctoral degrees							
	n = 2,597	*n* = 396	*n* = 404	*n* = 1,032	*n* = 98	*n* = 159	*n* = 423
Master's	97.5	97.0	98.5	96.7	96.9	98.1	98.8
Doctorate	2.5	3.0	1.5	3.3	3.1	1.9	1.2
		Statistical significance: $\chi^2(5) = 8.2$, $p = .146$ Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					

Note. See Appendix D for a list of specified other doctoral degrees, by facility.

34. On what type of device did you take this survey? (Percentages).

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- SurveyMonkey/electronic survey version only

Device	Facility Type						
	All Facility Types (*n* = 1,198)	**General Medical/VA/ LTAC Hospital (*n* = 189)**	**Home Health/ Client's Home (*n* = 174)**	**Outpatient Clinic/Office (*n* = 473)**	**Pediatric Hospital (*n* = 47)**	**Rehab Hospital (*n* = 79)**	**Skilled Nursing Facility (*n* = 220)**
Desktop computer	12.0	11.6	8.6	13.7	19.1	13.9	7.3
Laptop computer	24.3	19.6	23.0	30.0	21.3	25.3	17.3
Tablet	2.6	1.6	4.6	2.5	0.0	2.5	2.3
Mobile phone	61.0	67.2	63.8	53.7	59.6	58.2	73.2
		Statistical significance: $\chi^2(15) = 38.0$, ***p* = .001,** Cramer's $V = .104$ Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

35. What were the main reasons you decided to complete this survey? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- ❖ CCC-SLP
- ❖ SurveyMonkey/electronic survey version only

Reason	Facility Type						
	All Facility Types (*n* = 1,288)	**General Medical/VA/ LTAC Hospital (*n* ≥ 199)**	**Home Health/ Client's Home (*n* ≥ 191)**	**Outpatient Clinic/Office (*n* ≥ 509)**	**Pediatric Hospital (*n* ≥ 52)**	**Rehab Hospital (*n* ≥ 83)**	**Skilled Nursing Facility (*n* ≥ 231)**
I wanted to share my experiences.	39.7	41.5	32.5	42.2	38.5	36.9	40.3
		Statistical significance: χ^2 (5) = 6.2, *p* = .292 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
I believe ASHA will use this survey to help SLPs in health care settings.	37.3	36.0	35.6	37.7	34.0	34.9	39.7
		Statistical significance: χ^2 (5) = 1.4**,** *p* = .923 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type					
Invitation email for the survey.	36.5	39.5	32.5	38.5	38.5	43.4	30.6
		Statistical significance: χ^2 (5) = 8.2, *p* = .143 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
I believe ASHA will use this survey to help the CSD profession.	25.0	21.6	24.1	30.4	18.9	20.5	18.5
		Statistical significance: χ^2 (5) = 16.4, ***p* = .006,** Cramer's *V* = .114 Conclusion: There is adequate evidence from the data to say that the responses vary by facility type.					

(Question 35 continues on next page.)

35. (cont'd) What were the main reasons you decided to complete this survey? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- SurveyMonkey/electronic survey version only

Reason	Facility Type						
	All Facility Types (*n* = 1,288)	**General Medical/VA/ LTAC Hospital (*n* ≥ 199)**	**Home Health/ Client's Home (*n* ≥ 191)**	**Outpatient Clinic/Office (*n* ≥ 509)**	**Pediatric Hospital (*n* ≥ 52)**	**Rehab Hospital (*n* ≥ 83)**	**Skilled Nursing Facility (*n* ≥ 231)**
Reminder emails about the survey	23.4	23.0	25.7	23.0	23.1	22.9	23.3
		Statistical significance: χ^2 (5) = 0.6, *p* = .987 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
Learning about how the survey results will be used in the future.	13.8	15.5	10.9	15.1	15.4	13.3	11.2
		Statistical significance: χ^2 (5) = 4.0, *p* = .547 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
The email from ASHA telling me the survey was forthcoming.	12.2	11.0	12.6	12.4	11.5	8.4	13.8
		Statistical significance: χ^2 (5) = 2.0, *p* = .852 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
I like taking surveys.	7.2	6.0	6.8	9.0	5.8	8.4	5.6
		Statistical significance: χ^2 (5) = 4.1, *p* = .541 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					

(Question 35 continues on next page.)

35. (cont'd) What were the main reasons you decided to complete this survey? *Select all that apply.* (Percentages; we changed the order of responses from alphabetic to descending order of frequencies for this table.)

Analyses limited to respondents who met the following criteria:

- CCC-SLP
- SurveyMonkey/electronic survey only

Reason	Facility Type						
	All Facility Types (*n* = 1,288)	**General Medical/VA/ LTAC Hospital (*n* ≥ 199)**	**Home Health/ Client's Home (*n* ≥ 191)**	**Outpatient Clinic/Office (*n* ≥ 509)**	**Pediatric Hospital (*n* ≥ 52)**	**Rehab Hospital (*n* ≥ 83)**	**Skilled Nursing Facility (*n* ≥ 231)**
Learning about how the survey results have been used in the past.	4.1	3.5	4.2	2.8	5.8	6.0	4.7
		Statistical significance: χ^2 (5) = 3.9, *p* = .564 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					
The postcard that I received in the mail	1.3	1.0	0.5	2.2	0.0	2.4	0.4
		Too many cells (42%) have an expected count of fewer than 5. Conclusion: Too little data are available in some facility categories to test whether responses vary by facility type.					
A friend or colleague completed the survey.	0.7	0.0	1.0	0.8	1.9	0.0	0.4
		Too many cells (50%) have an expected count of fewer than 5. Conclusion: Too little data are available in some facility categories to test whether responses vary by facility type.					
Other; specify.	10.4	11.6	9.9	10.6	7.5	9.6	10.3
		Statistical significance: χ^2 (5) = 0.9, *p* = .972 Conclusion: There is not enough evidence from the data to say that the responses vary by facility type.					

Note. See Appendix D for a list of specified other reasons, by facility.

Appendix A

Facilities

Facilities comprising the six health care facilities for which data are provided in the frequency tables:

"General/VA/Military/LTAC/University Hospital"
- General medical hospital
- Veterans Affairs (VA) hospital/medical center
- Military hospital
- Long-term acute care hospital (LTAC) hospital
- University hospital

"Home Health/Client's Home"
- Home health agency
- Client's home

"Outpatient Clinic/Office"
- Clinic chain or franchise
- Outpatient rehabilitation center
- Private physician's office
- Speech-language pathologist's or audiologist's office
- Speech and hearing center or clinic
- Speech/language clinic

"Pediatric Hospital"

"Rehab Hospital"
- Rehabilitation hospital

"Skilled nursing facility/Subacute care"
- Skilled nursing facility
- Subacute/transitional care

Appendix B

Regions of the Country

Regions of the Country

Northeast

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

South

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

Midwest

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

West

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

Appendix C

Statistics

Statistics used in this summary report include the following notations and descriptions:

Notation	**Description**
Response rate	The percentage of individuals who were included in the sample, minus any who were ineligible $RR = \frac{(C + P)}{S - (Ret + I)}$ Where RR = Response rate C = Number of completed surveys P = Number of partial surveys S = Sample size Ret = Ineligible because of retirement I = Ineligible for other reasons (e.g., does not work in schools, no longer in the field on leave of absence) $RR = \frac{2{,}693}{15{,}000 - (7 + 497)} = \mathbf{18.58\%}$
n	The number in the sample. In this report, the number of people who answered a particular question.
Mean	A measure of central tendency; an average. Add the total of all the values and divide by the number of items. Example: (1 + 1 + 7 + 34 + 88) / 5 = 26.2
Standard deviation	A statistic that shows the spread of scores in a distribution. Used with means. The larger the standard deviation, the more widely the scores are spread out around the mean.[1] About 68% of the measurement is between 1 standard deviation greater than and 1 standard deviation smaller than the mean; 95% are plus/minus 2 standard deviations. Example: (1 + 1 + 7 + 34 + 88) Standard deviation = 37.1 Therefore, 68% of the responses are between -10.9 and 63.3
Median	A measure of central tendency. Arrange the values in order, from lowest to highest. Select the value in the middle position. Example: 1, 1, 7, 34, 88 Median = 7
	(Appendix C continues on next page.)

Notation	Description
Mode	A measure of central tendency; an average. The value that occurs more frequently than any other value. Example: 1, 1, 7, 34, 88 Mode = 1
Statistical significance	Describes whether a value is larger or smaller than would be expected by chance alone. Note that a large sample size can lead to results that are "statistically significant" even though the results themselves may not have substantive or practical significance. This is particularly true for chi-square (χ^2) tests.[1]
Chi-square (χ^2)	A test used to assess the statistical significance of a finding where the variables being assessed are nominal (e.g., annual salary and hourly salary) or ordinal (e.g., excellent, good, fair, and poor). It measures whether there are statistically significant differences between the observed frequencies and the expected frequencies of two variables. The larger the observed frequency is in comparison with the expected frequency, the larger the χ^2 statistic and the more likely the difference is statistically significant. When the sample size is large, large χ^2 values (that is, ones that that are statistically significant) can be obtained even for weak associations.[1]
Cramer's *V*	A measure of the strength of the association, used with χ^2 statistics to identify the meaningfulness of a relationship. The χ^2 value may be large with a small probability ($p < .05$) of having occurred by chance. That is, it is "statistically significant at the .05 level." Cramer's *V* is a measure of how strong (practically important) the relationship is between the variables. The larger the Cramer's *V*, the stronger the association.
ANOVA (*F*)	*F* is the statistic computed when conducting an analysis of variance (ANOVA). *Analysis of variance* measures the differences between means on two or more variables. It is used when independent variables are categorical and a dependent variable is continuous.[1]
p	Probability. Found in expressions such as $p < .003$ meaning "The probability that this result could have been produced by chance is 1 in 3/1000ths. The smaller the number, the less likely that the result was due to chance. The *p* value is the actual probability associated with an obtained statistical result, such as χ^2 or *F*.[1]
df	Degrees of freedom. The number of values that are free to vary when computing a statistic. Used in interpreting both a χ^2 and an *F* ratio. It is calculated in a cross-tabulation as (R – 1) (C – 1) or (the number of rows minus 1) times (the number of columns minus 1). In a 3 × 4 table, *df* would be 6.

[1] Vogt, W. P. (1993). *Dictionary of statistics and methodology.* Sage.

Appendix D

Open-Ended Responses

Question 6. Other Health Care Facility, Specified

Forensic SLP
Health care IT
Health plan
Independent living & schools
Medical reviews utilization management - independent review organization (IRO)
Multiple facilities [respondents selected multiple responses, despite the instructions to select only one] (*n* = 53)
N/A: Work within utilization management
Private practice clients teletherapy
Telehealth
Telehealth for Early Intervention Agency.
Telepractice
Teletherapy (*n* = 3)
Teletherapy servicing clients across the lifespan
Virtual

Question 8. Other Salary Bases, Specified

General/VA/Military/LTAC/University Hospital

Hourly + stipends (travel contract)

Home Health/Client's Home

I am the owner of my practice
I'm the owner of my private practice so per visit
Private practice, after all bills
Self employed (*n* = 2)
Paid hourly but guaranteed 40 hrs/week
Per CPT code
Per unit, units vary on service
Poor insurance reimbursal
Self-employed (*n* = 2)
Salary plus per diem for cases above productivity

Outpatient clinic/office

Owner (*n* = 2)
Owner distributions
Owner draw (*n* = 3)
Owner's draw as I own the private practice
I'm the owner; salary and owners draw
Owner distributions
Owner, non-salaried
Private practice owner
Based on the income I produce
Company owner, so whatever is leftover, approx 50-60k annually
Building my practice and not taking income yet
Distribution
Profit
Self employed
Grants
Hybrid annual and per patient
Per hour salary with productivity bonuses
Per unit
Private - multiple sources
Salaried
Salary and S-Corp earnings
Not relevant to your request

Pediatric Hospital

Semi retired- PRN as a rehab case manager now

Rehabilitation Hospital

Hourly plus stipends. I'm a traveler.
Salaried part-time but HR changed us to hourly clocking
Weekly

Skilled Nursing Facility

Per billed unit
Per visit as a 1099, hourly as a W-2 employee

Other Facility

Self-employed, insurance reimbursement

Question 15. Other Components of Clinical Ladder, Specified

General/VA/Military/LTAC/University Hospital

Complex system of earning 'points' for different activities that show involvement in initiatives, education or administration.
Demonstrating leadership
Education to the department and other services
Presentations to staff and projects to better the department
Productivity
Senior SLP; Clinical Specialist
Staff in-services, community service
Student supervision, department contributions/ projects
We have requirements for staff education – in-services, handouts, journal reviews – that we have to do in addition to all the other stuff
It does not result in increased salary, just "level"; doesn't really mean much
Our ladder does not offer incentives to further specialize or other than to maintain the Cs
Not sure, I'm not eligible since I'm PRN
Unknown. I am PRN and the clinical ladder is not available to me

Outpatient clinic/office

Advanced clinical competence, service, clinical education, academics Leadership/ supervisory roles
Performance improvement projects, community service
Portfolio submission, adjunct faculty, guest lecturer
Program improvement initiatives, clinical documentation/case studies, education of other staff
Providing in-services, observing/being observed by OT/PT
Research opportunities, committees
Completing a project that has value to the health system.
CEUs completed, serving on different teams
SLP 1 clinician, SLP 2 clinician and program leader, SLP 3 manager
Standard academic promotion for teaching, clinical, scholarship, and research
Supervisory positions funded by institution
Leadership/ supervisory roles
Volunteer at community events
Community service, public health education or participation
Volunteer for hospital community events, education in-service in the hospital
I am a sole provider

Pediatric Hospital

Any work outside of basic job duties; leadership qualities
Giving lectures at staff meetings, training others
Participation in organizational activities, participation in external activities/community, presentations, lecturing, special projects (we have to submit a portfolio)
Participation in specific projects or volunteering activities
Protocols, etc. for hospital
Teaching/supervision of grad students

Rehabilitation Hospital

Committees, presentation, supervision
Dissemination and implementation of EBP within the organization, membership to professional organizations, mentorship and supervision experiences, presentations (internal and external)
Helping the department with projects, policies, committees, education etc.
Hospital initiatives
Participation in hospital-wide initiatives
Presentations at national and state conferences, sitting on boards within the hospital, training other SLPs, etc.
Professional and community involvement, service to the profession (e.g., presentations, grand rounds, participation in mentorship programs, supervising graduate students and CF supervision, high school and university guest lectures/outreach)

Research, presentations in the community, memberships
Senior status
Special projects, subject matter expertise
Students, discipline and multidisciplinary in-services, facility-wide projects
Unsure - not eligible as PRN

Skilled Nursing Facility

Clinical knowledge areas
Rehab manager not discipline specific

Question 16. Other Reasons for Salary Increase, Specified

General/VA/Military/LTAC/University Hospital

Annual increase, 2%
2% cost of living increase
Cost of living
Company annual 2% increase
Same 1% everyone in the hospital received.
Company bonus
Annual raise (*n* = 2)
Annual increase in addition to across the board union increase
Advancement on the career ladder
Step increase for years worked
They call it merit but it's the same rate given to all employees regardless of performance
Became lead therapist. Now I'm at the top, unless I want to go into management (which I don't)
Epic trainer
Market adjustment (*n* = 13)
Market analysis
Market increase (*n* = 2)
Market shift
Department-wide market adjustment
Increase market rate
Yearly market analysis
New job
New position
Switched jobs
Job change with years of experience
Got hired
Change from contractor to employed
Change to different hospital in same year
Company realized we were underpaid compared to similar facilities.
Cost analysis review, compared to other hospitals in the area
Hospital desperate not to lose therapists
In order for the hospital to stay competitive
Threatened to leave
Joined a union
Union job
Union contract
Union contracted increase
Union Negotiated benefit
Union negotiation (*n* = 3)
Union wage grid increase
Agreement via union contract
Required cost of living adjustment per collective bargaining agreement unrelated to ASHA
CBA increase (union)
Continuous denials to increase pay, despite administrative duties.

Home Health/Client's Home

$1 a year
Annual raises only
Automatic
Company-wide change of rate
Raise given across hospital system
Reimbursement rate increased
Years of employment
Florida Medicaid increased rates
Increase in Medicaid rates
Government funding increase (EI)
State law increased funding for EI providers
State rate reform
State increased salary/hrly rate
Reimbursement rate increased
Statewide pay increase
I own the facility.
I'm self employed
I started my own private practice
Owner of my private practice; I charge per visit
Practice owner
Private practice
Started my own business, so I now control the compensation
Self-employed, growing caseload allowed me to pay myself more
I decided to raise my hourly rate.
Went from per diem to part time
Reduced work week to 30 hrs
Also, for PRN hours that I work in addition to my regular part time hours, I requested a raise (after 7 years at same rate) (inc from 45 to 50)
Access to board rate increase
I approached the director for a raise.
My organization needed to retain professionals
Salary gap analysis
Market review
I quit. They begged me to come back.

Negotiated at new company
Union
Union negotiation
Union-negotiated rate
Bargained Union tiered structure
Have not received increased in years
Medicare cuts mean no raises

Outpatient clinic/office

Annual raise (*n* = 3)
Annual fee increase
Generic 2% increase
To keep people happy with 2%
Company wide cost of living increase 3%
Facility provides annual increases for all employees in good standing
Across-the-board sm. Increase
Yearly contract increase
Yearly increase
Yearly raise
Yearly review
Change in salary/bonus structure
When local district does
Clinical ladder
Retention bonus
Changed employer (*n* = 2)
Changed setting/employer
Changing jobs/companies
I changed facilities to get a rate increase. My previous hospital had not increased hourly rates in over 17 years
Left low-paying job
Job change
New position
Position change
Switching jobs (per visit —> salary)
ASHA Certification
CF completed
Temporary preceptor pay for mentoring new employees, organization wide market increase
Added more tx visits/day
Additional responsibilities, change of position to team lead
Insurance reimbursement increase
Length of time with company
Increase in hourly rate
Years worked at the organization. Yearly salary increases are insultingly low.
Had to beg/say I would have to leave if I didn't get one. Then they gave me a 50 cent raise.
Market adjustments (*n* = 2)
Market analysis (*n* = 2)
Market analysis pay adjustment
Market increase
Market raise + years experience
Market rate adjustment
Market reset
Pay grid
To keep in line with other companies in the area
Hospital wide market adjustment
MEDICAID
Medicaid increase
MEDICAID increased rate
Medicaid rate increase
Owner
Owner - do clinical and admin
I am the owner so dependent on the revenue annually.
I bought the practice
I increased my private practice rates
Increases as owner, not based upon SLP
I raised my rates
I started my own practice (*n* = 2)
I'm self employed so I increased rates to keep up with overhead and cost of living. I make about .65 of my session rate
My wife and I run a private pediatric practice so this does not really apply to us in the same way as a treating therapist.
Self employed
Sole proprietor, private practice
Practice [reverve] increase
Profit
Raised client rates
Union contract
Union contract and step increase
Union wage increases
Unionization
New union member
Office rent increase
More employes
I work for a nonprofit and we are being "leased" to a hospital so I got a huge raise from 68,00 to 93,000
Self advocacy after being paid less than all my colleagues for a year
State board notified that SLP staff had not received a raise over the last 4 years. They

recognized importance of keeping current staff and provided a 5.5% raise to all staff
Survey analysis

Pediatric Hospital

All employees get ~3-4% (not merit based)
Annual pay increase
Annual raise
General all increase
Market adjustment (*n* = 3)
Market analysis
Market analysis and adjustment
Market price adjustment
Comp. analysis
Safety pay increase
Salary adjustment
Changed jobs
Union contract (*n* = 2)
Union contract / yearly bonuses not linked to performance
Only because we are unionized
I was underpaid for the first 12 months of my current employment. I found out from a colleague that I was making the least but had more years of experience and the most job responsibilities (I developed a feeding program in a level 3 NICU from scratch). I only got to $49 a month ago and it was because I brought this to everyone's attention. I am still underpaid for my leadership role.
I have never received an increase since working for this hospital since 2015
Took pay cut - school I do eliminated four private practice so that they will pay rest because of poor reimbursement for speech cases

Rehabilitation Hospital

Always 3%
Annual 'step' increase, union-related annual increases
Organization wide annual raises
Bonus related to hospital goals and achievement
Company gain share
Interpreter
Job change
Changed positions
Went from full time to PRN
Corporate takeover
Market adjustment (*n* = 4)
Market analysis (*n* = 2)
Market survey adjustments
Market survey analysis
Moving up clinical ladder
Rate adjustment
Retention measure
Labor agreement
Pay scale is negotiated by union representing nurses and other healthcare professionals including therapists.
Employer fear of SLP taking other job position
No raise offered or available when asked
No specific reason. Corporations do not provide merit based or performance evaluation raises. Clearly your survey is out of touch with the current HR standards.

Skilled Nursing Facility

Standard 1%
"Cost of Living" that was not comparable to actual cost of living increases
Only 86 cents in the past 6 years
Employee raise
Yearly increase from review
Changed jobs (*n* = 3)
I changed jobs.
Change of companies (*n* = 2)
Changed jobs and asked for more with new company
Job change
Job hopping
New job (*n* = 2)
New job setting
Incentive for new position
Left for new position
Left to get raise
Different company
New therapy company
Started new job
Started 4/2025
Employer change
Proper wage scale for area

The company gets a lump sum, the administrator decides who gets what. Not merit based. Usually around 1%.
Request a salary raise
Requested
Requested a COLA raise. Did not receive it
Requested a raise to stay at current location
Asked for one
I got an increase to retain employment with the company.
Other job offer resulting in negotiation
Negotiated
Negotiation: raise or quit
I negotiated.
I requested increase.
Only because I persistently asked. Not because it was offered.
Personal advocacy
Going from company benefits to Medicare
Company discretion - not merit based or cost of living
Demands upon new potential employers as experience increases, switching to PRN as my household insurance needs are met through spouse
Earned my CCCs
Supervisory, [regional] role
Employee request 2/2 no raise in 4 years.
PRN services
PRN work instead of full time
Productivity met
Fought to raise with therapy team
Found another SNF paying more & threatened to leave, which is the only way to get a raise in this field.

Other Facility

Bilingual
Bonus - additional services outside of primary role
Contract work
I own the business.
Incentive pay
Increase in hours/locations
Insurance rate change
Negotiations
Push to leadership from manager
Union negotiated increase

Question 19. Other Activities That Count Toward Productivity, Specified

General/VA/Military/LTAC/University Hospital

Administrative duties
Any one hour education/training
Chart review
Chart review. We get "bonus units" for evaluations (30m for swallow evals, 45 m for speech evals, 75m for MBS and FEES)
Consults, attempts
Depends if eval or treat
Documentation only when billing aphasia and cog testing codes
Discussion with family or unpaid caregivers as authorized by the patient and as coded accordingly.
Family education
Family education/training
Graduate students
Mandatory staff meetings
Must complete 9 pts in 8 hours & all caseload/ workload care coord.
Only billable minutes count toward productivity
Only mandatory department meetings (x1 month)
Prep for MBS studies
Productivity is unit based.
Training new staff or students CFY
Variable; documentation/coord care
e-mails/clerical tasks or projects for department
We get a certain number of units per service, so if you are efficient this can include documentation time.
We take meeting time out of our calculation for productivity. Staff meetings and mandatory hospital training only
Don't know
N/A
None, it's only direct patient care or number of procedures billed/sessions billed

Home Health/Client's Home

100 miles
Drive time
Mileage
Travel, ASHA CEA prep
AAC eval reports
Annual modules
Client visits only home health
Insurance, billing, scheduling
Professional development
Required state training
Supervision/clinical support
N/A. I own the facility.

Outpatient clinic/office

Drive time
Administration duties
Coded differently for different things. Admin, education, etc. time vs patient time.
Acute care
CF training and observation
Clinical coordination for students
Collaboration meetings
Community events
Consults with parents/teachers
Continuing ed
Create content
Documentation for eval only
Some documentation
Organizational educ/annual training
Performance improvement
Plan of care, re-evaluation paperwork
Progress reports - 15 min, eval doc 1 hour
Regarding BILLED productivity which has a 57% requirement
Supervision hours: 2 hours per SLPA/CF
Tasks involving CARF
Treatment planning, progress notes, consultation with other providers/ teachers/parents
We are still paid if a pt cancels. We do not have dedicated doc/non pt care time in our procedure.

Pediatric Hospital

CEUs
Family meetings and caregiver education
Hospital based competencies required
Specific training must be approved
Student meetings if mentoring
Supervisory duties; mentoring; continuing ed
Travel, ASHA CEA prep

Rehabilitation Hospital

Caregiver training under the new billing code
Daily Interdisciplinary Team Conferences about each patient
Family training for unpaid family caregiver, in person, each 30 mins
Overall--6.5 of 8 hours for treating therapists and adjustment for above items or special assignments
Parent education
Team leader coverage
Time speaking to nursing/doctors

Skilled Nursing Facility

Care plans due to new codes
CPT 96125 test scoring
Caregiver education
Chart review [M2]
Consultation time
Dependent on payer
Depends on insurance payer
Depends on their insurance
Eval write up
Family education
Family meetings if patient is not present
I count documentation for med B patients and counseling/education with staff and families for all pts even if the pt is not there.
Scheduling time between PT/OT who have for extended periods of time , waiting for staff to prepare be available for treatment
Screening
Screenings
Screens
Training with SLP support team
None but d the above
Not specified

Other Facility

Doc at point of service
Family/caregiver training
Other admin type/insurance
Side projects
Staff in-service/ED
Supervision

Question 25. Other Safety Risks, Specified

General/VA/Military/LTAC/University Hospital

Aggressive patients
Agitated patients
PT violence/aggression
Behavioral health patient set self, room on fire and attempted
Concern for patient's family with a gun led to armed police swarming into the unit I was treating on
Crime in area surrounding workplace
There was a shooting outside the ED that they didn't tell the staff about.
Bullying by SLP supervisor
Bullying from managers
Sexual harassment
Specific colleague who creates hostile work environment
Increased admin responsibilities within same schedule, title
Stress from increase patient caseload
Jobs outside my practice
Other employees not using safety measures, which negatively impacts my safety.
Poor communication between departments
Burnout
Lots of changes and upgrades with computer systems with little advance notice
N/A (*n* = 3)
NA (*n* = 2)
None (*n* = 10)
N/A - Did not occur
Nothing significant

Home Health/Client's Home

Access to homes, related to weather
Driving safety due to weather
Aggressive dogs in people's homes
Entering homes with aggressive dogs
Families not wanting to place their dogs in another room, crate or outdoors
Dog bites
Pet violence/attack
All PPE is provided by me, a contracted employee. Physical safety relates to the homes I provide services in, not the office of my agency.
Asked to refuse disposable gowns and masks
Because of city I work in, only
Dangerous neighborhoods
Neighborhood
Some neighborhoods in EI
Some unsafe areas
Unsafe home area anxiety
Unsafe homes
Unsafe neighborhoods (*n* = 2)
Visiting unsafe homes
Drug houses
Patients under the influence in their home
Occasionally have to travel to areas w/ large homeless population
Home health setting
Home-health related
In homes/apartments
Typical home visiting safety concerns
Poor heat and cooling in old building
Increased pt behavior
Medications
Occ slip/fall risk
Parent lies about fraudulent billing
Decreased advocacy by supervisor
Unwritten rules and some negative feels when bringing up issues or concerns
Tech trouble
N/A (*n* = 9)
NA (*n* = 3)
No issues
None (*n* = 15)

Outpatient clinic/office

Aggressive clients
A specific biting patient
Injury from client behavior
High school fight
Abusive parent
Children with ASD becoming violent, biting, hitting but not knowing they are causing harm

I regularly see patients with a history of behavioral regulation difficulties
Violent patients/families
Parent of patients being upset
I am on Worker's Comp as attacked by patient
Workplace bullying & gossip & exclusivity
Coercion, general unease related to job security
Emotional manipulation to see more patients for better reimbursements
Pressure to bill when ill
Attitude
Bomb threat
Cleanliness
Environmental concerns (very old building, concerns about mold, water leakage, etc.)
Unsafe cleaning protocols
All colleagues stopped masking
Patients of the pain clinic in our building (upstairs)
Physical safety in neighborhood
Crime in area of the clinic
Entering/leaving building alone without security options
Frequent homeless/needle use behind building
Homeless entering work place
Homeless occasionally sleep at the entrance to building and I am the first to arrive in the mornings
Lack of workplace security
Physical health/protection reinfection/ contamination prevention (bed bugs)
Work life balance stressors
Driving hazards
Most of these applied before I opened my practice.
I'm not sure what kind of information this is fishing for. I'm not sure how workplace safety has to do with the fact that Asha does nothing but put a financial burden on its members at the end of each year while providing very little benefits to membership.
I'm my own boss.
N/A (*n* = 9)
NA (*n* = 2)
N/A - None
None (*n* = 37)
None - work from home
None; my facility
WFH - None

Pediatric Hospital

Aggressive behavior in pediatric patients
Many of our patients are not here legally or [???]
Surrounding area/community violence and harassment
Homeless in parking lot
Stalking by a prior parent in the community
Only staff present during after-school hours in the clinic while still seeing patients
Ongoing pressure to increase volume but not quality of care
Productivity billing; [espidnt]
Untrained leadership
Needing support for being behind on documentation and fearing discipline
Being underpaid felt like systemic racism and has taken a toll on my presence at work.
Stress due to limited paperwork and prep time
NA
None (*n* = 3)
None to report

Rehabilitation Hospital

Aggressive patients
Aggressive behavior--verbal/physical--from patients
Agitated patients due to head injury, dementia, mental illness, etc.
Challenging behaviors from family members; agitated TBI patients
Patient agitation/aggression
Specifically related to patients, not staff/ employees
Cleanliness
Infectious disease exposure
Unsafe office conditions
Being ignored by a director for no apparent reason.
Discrimination: i.e., microaggressions
Time pressures that result in unsafe patient treatment
Changed to non-clinical role
N/A (*n* = 3)
NA
None (*n* = 7)
None of the above (*n* = 2)

Skilled Nursing Facility

Active shooter threat
Inappropriate serial behavior of patients.
Patients with drugs
Sexual advances by male patients is very common
Sexual harassment
Sexual harassment from patients
Verbally abusive patients (occasionally)
Family entitlement anger
Bad lighting at night walking to car
Mold in building/offices
Mice, aggressive behavior, sexual harassment from patients
Facility staffing shortage
Poor staff carryover
Precautions not properly labeled
Poor communication regarding provider/ patient PPE needs and requirements prior to entering the building or unit
There's never gloves readily available
COVID never ends! Have to take off work multiple times with no sick time/pay.
Facility refusing accept and to test for COVID despite exposure and clinical s/s. They are of the mind set.. don't ask don't tell
Intentional staffing refusal to follow ST recommendations
Access to edible tx materials for dysphagia tx
Mental health concerns of coworkers that are unsafe
Poor work/life balance
Not enough physical space with staff/patient ratio
Pressure not to report concerns regarding nursing care.
Risk of losing license to fulfill employer protocols, threats of job loss
Stress re: productivity requirements
N/A (*n* = 4)
NA
None (*n* = 14)
No safety risks

Other Facility

Behaviors with patients
Exclusive behavior related to LGBTQ identify
NA (*n* = 2)
None (*n* = 5)
None of the above

Q. 27. Other Barriers to Providing Optimal Care, Specified

General/VA/Military/LTAC/University Hospital

Admin not understanding our worth
Direct administration
Challenges with admin support
Corporate policies/resistance
Consistency of staffing
Weekend insufficient staffing
When census is high only
Scheduling (*n* = 2)
Staff attitude
Staff compliance to recommendations
Lack of colleagues' competency
Underfunding of pts/hospital
Funding
Occupational therapy encroaching, providing dysphagia services
Difficulty between hospital and Homecare days
Pulled into matters that should be managed by others on the care team
Lack of radiologists for MBS
Availability of radiology
Management's poor knowledge of [unintelligible] workings & staff needs
Poor willingness by management to initiate new evidence based practice approaches
Working with PTs in other administrative roles in matrix and I am only SLP and they devalue me.
Inappropriate consults taking up time
Insufficient time to work with patients
Time/resources dedicated to continued education/training
Constant educational modules
Documentation counting against productivity. Many departments to inform separately re diet changes.
Performing nursing cares so the it is ready for therapy (oral hygiene, clean up pt, take to bathroom, etc.)
Supervision of students encouraged but not weighted toward productivity
Space; room
EOL/ palliative
Inconsistent dangerous even changes in practice and education for new grads
N/A
NA (*n* = 2)
No barriers (*n* = 2)
No TX time
None (*n* = 2)
None of these
None. No barriers.

Home Health/Client's Home

Lack of collaboration
Lack of team collaboration
Lack of communication from PCPs
Lack of support from management
Communication with staff
Collaboration between disciplines
Access to social workers and mental health for families
Caregiver/teacher buy-in
Good interpreter services for languages other than Spanish
Don't agree with EI not assigning Speech Services when the child needs them, specifically when their communication score is the lowest by far on the evaluation and they put DI 2x/wk and no Speech services.
Health of the child - very fragile
Overstimulation in work environment -- in home EI
Being asked to do the work of nurses (i.e. Med reconciliation, staging wounds, and assessing mobility at Start of care appointments and ongoing appointments)
Fluctuating caseload numbers
Availability of materials
Company limiting frequencies
Electronic medical record
FEES is not possible per the laws in my state for SLP to do independently
Limits in natural environment
Limits on telehealth recertifications
Risk of losing telehealth for Medicare
State expects us to provide "coaching" method, but still bill as therapy services
Tech trouble
Driving & gas mileage, [C Sert} cancellations
Travel time, new referrals
No pay for cancellations

No reimbursement for client cancellations
Changes with insurance coverage/timely insurance authorizations
I work because I enjoy it. I am 83.
Caseload was too high so I left my job and became self-employed instead
I am a contractor so I do not have many barriers. I would never take an employee position as an SLP bc of all of the issues mentioned in this survey - overworked, productivity levels, etc.
I am management for my company.
I do it all - sole provider.
None I am a sole proprietor private practice owner.
N/A (*n* = 2)
None (*n* = 2)

Outpatient clinic/office

Lack of support by ASHA!
Again, as employers we go out of the way to provide all that we possibly can to our staff in the way of support and benefit. The continuing abysmal reimbursements in a primarily Medicaid dominated area make operating a growing business difficult. ASHA become more concerned with promoting social issues than Lobbying and advocating for appropriate rates of reimbursement.
Manager is not an SLP - limited understanding of SLP role
PTs in management - not understand ST and [hiring] appropriately
Attendance
Lack of SLPs
Shortage of SLPs
High need for after school SLP staffing
Lack of SLPs with specialization in dyslexia/LD
Underprepared SLPA and CF
Insufficient training across all areas. Stemming from graduate school.
Insufficient training for medically complex patients
Major life changes in staff which results in turnover (marriage, babies, moving, etc.)
Frequent staff shifts
CEUs
CEU Reimbursement
Need for further training/education that employer will not provide or fund.
No reimbursement for continuing education
Lack of continuing education support
Lack of knowledge in specific areas
Lack of safety training for behavioral patients combined with management's resistance to obtaining this training
Complexity of caseload
The demands of complex children is exhausting and burn-out is a heavy concern without having adequate training for the sensory differences and aggressive behaviors we now see.
Currently the only bilingual SLP on the team so I have little time for admin duties
Overly demanding parents
Parental involvement
Interdisciplinary support in-house or established network with other providers (I.e., OT, PT, nutrition/dietician, lactation, psychologist, etc.)
Employee burnout
Poor coworker morale
Scheduling
DOCUMENTATION!!!!
Documentation time
Paperwork
Difficulty getting patients' answers and access from medical specialists. Access limitations - transportation, scheduling etc.
Support staff do not consistently work wait list or schedule patients in a timely fashion
Financial stress
No merit-based pay
Fear and anxiety of federal gov't roll on medicine
Funding for new materials/supplies/equipment
Medicaid reimbursement too low
MEDICAID reimbursement so low in my state that most private practices don't take it.
I was previously providing telehealth to 12+ patients when needed and now with Medicare decision no longer able to provide ; since COVID MEDICAID reimbursement so low in my state that most private practices don't take it.
Our clinic charges for all activities related to a client (such as planning for sessions and creating materials) so there is some hesitancy to plan and prep in ways I would if

client did not have to pay for it. Other factor can be inflexibility of administrators
Payor/reimbursement limitations are the primary barrier to pt care. Outpatient services, esp in regards to AAC, are frequently needed concurrently w/ home care. Patients are forced to choose between outpatient and home care services, which results in poor QOL outcomes in the long-term.
Insufficient reimbursement and flexibility in ways to charge for all services - it's disgraceful.
Time spent addressing denials, prior authorizations, etc.
Time to research/implement EBP
Takes several months for outpatient MBSS
Space
Treatment space
Lack of space for activities
Safety in TX room with pediatric patients
Patients and transportation
I run my own practice & have staffing challenges.
N/A (*n* = 2)
N/A in current role
NA (*n* = 3)
No barriers (*n* = 2)
None (*n* =10)

Pediatric Hospital

Administration
Healthcare financial
Bureaucratic barriers (i.e., poor leadership, ineffective teams)
Ergonomic challenges, space to chart in unit
Insufficient physical space
Sufficient training for new staff
Staff ill prepared/lack of adequate training
No scheduler
Lots of meetings
Lack of control over my schedule
Referrals from state [OPENING]
Poor workplace dynamics/relationships between team members
Cost of e-learning, certification training
Lack of training opportunities
Very low reimbursement rate
Families access to reliable transportation or services to assist with the financial burden of missing work to bring their child to therapy.
Patients fearful of deportation/canceling appointments
Language barriers

Rehabilitation Hospital

Inappropriate referrals
Inappropriate patients admitted to inpatient rehab
We get ordered when they're about to discharge
Limited minutes allotted for sessions, pressure for group sessions instead of individual
Short length of stays
Improved preparation of patients prior to leaving acute care and coming to acute rehab (e.g., downsizing trach, or swapping from cuffed to cuffless trach, having had met an SLP while in acute care... there are lots of missed opportunities)
Insufficient support staff, non-clinical staff given roles that negatively impact clinical care
Quality nursing staff shortage
Other team members (PT, OT, doctors) may need education on limitation for ability of the SLP to change cognitive status of individuals with dementia or sometimes medication induced issues
Failure to inform patients of their weekend schedules
Experienced SLPs vs. less experienced SLPs don't follow plan of care
Fatigue and stress due to job requirements outside of patient care.
The lack of productivity equipment, for example, dictation machines to make the process of documentation quicker efficient
N/A
NA
None (*n* = 4)
None at this time
Nothing

Skilled Nursing Facility

All of these choices are applicable
Pressure to provide concurrent and group therapy when not appropriate.
Restrictions on allowing SLP to determine daily treatment minutes. DOR dictating minutes.
Limit time spent with patient

Limited policy change w/ updated research
Due to the caseload, patients are 3x/wk vs. 4x/wk. A per diem is not available to help.
Sometimes the patients are very demanding and I do not have enough time to do point of care documentation. However, I love what I do and would rather serve the patients and give them what they need.
Nurse/CNA follow through
SNF staff and lack of follow through
Uneducated CNAs
Very poor nursing care
Too many DEI hires
Going to multiple facilities in a day
Lack of adequate and dedicated treatment and documentation space
Priv. treatment space
Language barrier; decreased aspiration insight
Inability to have instrumental swallow tests for pts
Having frequent COVID and Flu outbreaks
Managed care cutting prematurely
Insurance co-pays
I do not treat pts.
N/A
NA
None (*n* = 4)

Other Facility

Clients agreeing to teletherapy. Clients agreeing to private pay
N/A
No barriers, private practice
None
None applicable
None apply

Q. 28. Other Barrier and Impact, Specified

General/VA/Military/LTAC/University Hospital

I have not supervised graduate students	No impact
No SLP graduate students at hospital	No impact
Additional equipment	Moderate impact
Contractual challenges	Moderate impact
CCC required	Major impact
Contacts	Major impact
In my setting, students are [unintelligible]; no degree, no license – no reimbursement	Major impact
My specific role – driving, lots of settings, etc.	Major impact
No monetary compensation for taking students	Major impact
Staffing	Major impact
The inconsistency between teachers and clinician supervisors puts strain on the supervisors who are actually practicing	Major impact

Home Health/Client's Home

I do not provide supervision (*n* = 9)	No impact
Not applicable	No impact
None of the above	No impact
Because of the nature of my job and traveling to people's personal homes I do not take students.	
My clinical specialty (dyslexia treatment) does not allow students to treat	No impact
Self employed; no additional employees	Minor impact
SLPs unwilling to take on additional work without pay.	Moderate impact
Unique setting	Moderate impact
A home health agency we contract with WILL NOT let SLPs treat any of their clients	Major impact
I don't supervise graduate students due to time constraints.	Major impact
I haven't supervised anyone yet	Major impact
In homecare, the student would be driving in my vehicle all day, it's too much every single day; also I worry about liability issues if I am in an accident with the student in my car, I don't want to be liable for any injuries, etc. It gets expensive for students to drive themselves due to a large service area, with lack of time outside drive times to review patients/document, prep time, etc. not enough hours in the day if student does not drive with me.	Major impact
Limited work hours	Major impact
My organization does not allow clinical rotations for students, only CF opportunities.	Major impact
No consistent visits	Major impact
Not allowed	Major impact
Pay for mileage	Major impact
SLPs not getting CCCs, thus unable to supervise	Major impact
Student would not get enough hours in home health	Major impact
Travel	Major impact

Outpatient clinic/office

I do not supervise graduate students (*n* = 3)	No impact
My clinical specialty (dyslexia treatment) does not allow students to treat	No impact
No affiliation with any schools	No impact
Not enough students	Minor impact
No students	Minor impact
Experienced SLPs in setting; most are barely out of CFY	Moderate impact
Location	Moderate impact
Students coming with politicized rather than evidence-based views/thinking	Moderate impact
Abbreviating treatment time to see more patients because or reducing reimbursement	Major impact
Confidence	Major impact
Contractual issues	Major impact
Graduate student clinicians should be paid for the treatment that they provide	Major impact
I have a private practice that is telepractice only.	Major impact
It would be SO much more efficient and helpful if ASHA would allow virtual supervision of Grad students - virtual observation are 100% sufficient to help and guide CFs and grad students.	Major impact
No interest	Major impact
Not allowed to require mask	Major impact
Not licensed/certified long enough to supervise students yet	Major impact
Part time	Major impact
Requires more time to train	Major impact
We have never had a student.	Major impact

Pediatric Hospital

I have not done supervision yet	No impact
I am not directly involved in planning or overseeing graduate students in my facility	No impact
I won't take students if I'm not compensated, so I just take those that do.	No impact
NICU requiring some practice prior to independency	No impact
My schedule of part time	Moderate impact
Staff reluctance due to perceived extra work	Moderate impact
Caseload	Major impact
Major impact - Graduate programs expecting placements to provide the bulk of clinical training.	Major impact
No space for another person	Major impact
Our SLP department has not accepted a student since pre-covid. And I have personally never felt comfortable to take on a student given difficulties managing my day-to-day work and knowing there's no accommodations for having a student. Meaning, if my productivity went down due to training, we would be told that our dept as a whole has not been productive enough to hire another SLP to fill open positions.	Major impact
Parents do not want their child to be the trainee's "guinea pig". We are expected to teach with no time to teach and no physical space for students.	Major impact
Students' level of immaturity and unprofessional behavior	Major impact

Rehabilitation Hospital

I've never supervised a graduate student.	No impact
Fluctuation in training in dysphagia.	Minor impact
Rehab only allows one student at a time with all disciplines	Moderate impact
Lack of schools in the area	Major impact
Student lack of professionalism	Major impact

Skilled Nursing Facility

Not supervising (*n* = 9)	No impact
NA	No impact
I'm not interested.	Minor impact
Not qualified to supervise grad students	Minor impact
Location	Moderate impact
Productivity requirements remain the same with students, this is still something that is reviewed and large factor in regards to me qualifying for a raise	Moderate impact
School's unrealistic expectations of the student i.e. student has to leave "full time" externship to attend classes full time.	Moderate impact
Higher productivity if taking a student 100-110%, unobtainable	Major impact
Do not supervise students	Major impact
I'm a new SLP.	Major impact
My company's delays in completing contract obligations	Major impact
No CEUs to supervise students	Major impact
No Continuing Education Units granted for supervising SLP's	Major impact
None reached out	Major impact
Not allowed 2d PRN state	Major impact
Not enough hours to support	Major impact
Productivity requirement remains the same even if I have a student. This precludes ability to have a student and provide adequate student training and supervision	Major impact
Severely overextended in present work situation…	Major impact
Virtual SLP programs do not prepare them.	Major impact

Other Facility

Not supervising anyone	No impact
Working in non clinical role	No impact
My last student should never have advanced to clinical practicum. She had been a SLPA, and most likely excelled at that, but was not equipped to do evaluations and create goals and care plans.	No impact
PRN unable	Major impact

Q. 29. Suggestions to Address Barriers to Supervision

General/VA/Military/LTAC/University Hospital

Compensation.
Additional compensation for the supervising SLP would drastically increase the motivation to provide training and supervision of a student on top of managing a demanding, high acuity caseload. Reducing the productivity requirement of the supervising SLP is necessary to provide adequate time for quality supervision of a student.
Additional compensation. productivity breaks and/or bringing in per diems during the first few weeks of training a grad student
Compensation or CEU's for the extended length of time we provide supervision. 3+ months of full time supervision to receive a 200$ check is insulting to our efforts
Offer CE credit to clinical supervisors
Compensation to clinical supervisors/stipend. The importance of building it into the supervising productivity
Compensation would be appropriate given the amount of time we spend with students that limits our ability to treat patients.
Encourage increased pay
Get a differential to compensate for the extra energy, time, etc. with a student
Increase pay or decreased patient on caseload
Increase pay/compensation and allow for lower caseload/reduced productivity requirements for clinicians taking on students.
Pay supervisors for supervising
Pay us for it. Takes time and money out of my pocket as it takes me twice as long to c a pt
Preceptor pay
Provide compensation
Providing compensation
Reimbursement for supervisors. Education for supervisors beyond the current requirement
Incentivizing clinicians to take students.
Supervisors should be allotted some form of additional compensation.
More support and compensation from both the academic institution and our company
Additional time for teaching and increased pay.
There should be a national standard for compensation or some other benefit that makes taking a graduate student more enticing to both SLPs and their employers. Also, in a fast paced setting like acute care, we have SLPs that are willing to take graduate students, but the barriers of our workload and productivity steer away our leaders from accepting them.
All SLP staff participating
Allow decreased productivity/increased documentation time initially during internship to TEACH the student in between sessions rather than just have them follow you around silently so you can get through your workload.
Allow meetings with students to impact productivity (i.e. if we have a meeting we are able to see one less patient). Other barriers include the process to be able to take on a student (i.e. EMR trainings).
Being able to adjust productivity targets to staff who supervise students; meeting targets is linked to staffing levels.
Difficulty with managing time with teaching student vs expectations to see patients
Less students at a time. More opportunity for non clinical training/discussion time with them. Breaks from students to allow me to feel less burnout.
Difficulty with supervision DT dates/times present in main facility
Flexibility w/ productivity goals w/ student supervision, at least for the first half of the internship. allowing time for collaboration
Hospital administration/managers are primarily concerned about productivity and billing. Though they allow students, they do not allow any additional time for training and provide no resources to supervisor/student. Additionally, supervisors need to be compensated extra.
Increased collaboration from schools to hospital administrators.
It’s really the SLP supervisor management of our team and how that has negatively impacted the lack of a cohesive SLP team.
Legal has to approve University Students and they must have a contract. If establishing a

new contract, it delays their start time for practicum.
Lower productivity requirements if supervising students
People cannot afford to live attending unpaid, skilled work.
Provide coverage so that I can take the time to teach properly instead of working 4 extra hours at the end of the day to catch up.
Reduced productivity requirement and in return reimbursement for the facility (not therapist).
Staffing. Change in hours.
Supervision guidance specific to infant and pediatric feeding. And more education at the graduate level
We need a point person in charge of scheduling and appointing SLP students to staff
We would need a solution to our staffing issue
A streamlined process for students to find a student placement (e.g., students "cold-calling" looking for placements. As a university hospital, we typically take students from the university, but students from all over call saying their program "makes" them locate placement options.
Basic medicine education needs to be incorporated into graduate programs. Graduate students have no concept of medicine at all when they come into my hospital.
Better preparation of students-not “simulation” cases!
Colleges and universities need updated medical and dysphagia coursework that matches current best of practice guidelines
For students to have completed dysphagia coursework with good performance prior to coming to the acute setting
Graduate programs are focusing a lot on language, artic, cognitive, feeding. There is a lack of acute care, medical based care and dysphagia. No MBSS, FEES in depth training etc.. These are skills needed to come out and be considered and hired for acute care and not in the current students. Universities need to hire professors to teach these classes to again to then get these students ready for practicum and then the career setting. Hospitals do not accept students because they do not have the coursework and on bookwork class is not enough.
Graduate programs generally do not provide enough training for medical SLPs. It is just too different from school based SLPs and should really be a separate discipline entirely.
Graduate programs need to better prepare students for clinical documentation, dysphagia and MCI.
Graduate programs need to change. Curriculum needs to be either 2 tier for education track vs medical track or there needs to be more robust education surrounding dysphagia.
Graduate programs need to provide more rigorous coursework pertaining to medical settings
Have better coursework and hands-on training to prepare students for medical responsibilities
Having a clear understanding from the graduate program of what is expected from the student in terms of preparedness before selecting a candidate. I have never been compensated for supervising a graduate student, but this makes sense given the significant amount of effort and extra time (e.g. staying late to complete documentation that was delayed due to training/teaching or that was not finished by the student and they had to leave early for class)
I have had only a few students prepared to treat patients early in their placement in acute care, generally due to a lack of solid understanding of normal swallow function as well as lack of understanding of general medical knowledge (e.g. respiratory system diseases like COPD) which limits their ability to make informed care decisions. Most students have completed MBSimP yet struggle to use that knowledge in decision making
Improved & adequate time for student education of acute care setting, skills. The organization’s willingness to modify productivity requirements for SLPs providing the supervision.
It would be nice if instructors would actively treat clients so students could observe expertise in action!!!
Lately the students I have had are so poorly prepared. They completely lack motivation and initiative. Productivity restraints also do

not allow for additional “on the job training”. Lack of additional compensation is also a factor. I would suggest having a more rounded student, someone who has actually had a real job and interactions with people, not just a student with good grades. Encourage employers to even just give a bonus to supervisors, as this does take a lot of time and energy.

Make it easier for student to obtain facility based computer access for clinical documentation

More classes need to be focused on general training within healthcare; understanding co-occurring medical conditions and impacts on our roles, etc.

Our setting specifically serves neonatal infants. Very few students are receiving instruction in pediatric dysphagia, much less neonatal dysphagia. Students are coming with minimal knowledge of the skill set required. And if they do have knowledge of pediatric dysphagia, they are seeking the education on their own prior to beginning their placement with us.

Prepare students better. Students shouldn’t be taking classes at the same time as the externship. Classes pertinent to the setting should be completed before the externship not concurrently.

Preparing students better for medical settings, compensation for students

Standard student training and education prior to start of internships.

Students are ill prepared for acute care. They lack basic knowledge of medical terminology, anatomy and physiology of breathing and swallowing. We have encountered students with poor writing skills. Graduate programs need to allow students to specialize in a given area. We are not able to hire PRN therapists that are new graduates because they don’t have the knowledge or skills needed to work with medically complex patients. We have hired a few then have had to let them go since they were not prepared for this setting.

Students are not prepared for medical settings and often do not have skills to document. Time is spent on the basics rather than experienced.

Students being more prepared for an acute medical setting

The students and CF candidates that I have worked with in the past 10 years are unprofessional, lack skills, are not receptive to feedback. They are overconfident and lack professionalism. I have found new hires that are CF or recent graduates to have terrible bedside manner, shoddy clinical skills, inappropriate and poor documentation and lack of empathy. Any time I bring specific concerns to my employer, they are ignored and the person gets pushed through to the next steps. This makes it an unpleasant experience for me and ultimately hurts the profession. ASHA does not adhere to the strict standards they once did and this is much worse post covid. Supervision should be far more strict and productivity should be waived for supervisors.

There needs to be a specific medical track in grad school and anyone with interest in health care needs to take courses in that track. Too much time is wasted on language development, articulation and stuttering and VERY little to the multitude of factors that go into being a good clinician in a healthcare setting which has MUCH higher stakes and learning curve than articulation therapy.

There needs to be better pre-requisite courses for those wanting to obtain a job in a medical setting (i.e., med term, anatomy I & II). In addition, in graduate school dysphagia should not be a short class and there likely needs to be an advance dysphagia course offered.

Work with students level of respect. I’ve supervised several CFY and at least half were cocky, disrespectful and over confident.

Expectation for various levels of independence along the way

ASHA to provide compensation for taking a student. Example: free access to Online Con Ed or give SLPs a discount on annual Dues for taking students.

ASHA has to delineate medical SLP track from school-based track and require more medical focused training. Students are not prepared for working with medically complex patient populations. Require compensation for all Supervising Clinicians.

ASHA needs to moderate graduate school programs and what is being taught the students and new grads do not seem to know

how to develop actual clinical judgment and it is putting patient's lives at risk- All over the country there are problems with the current students and new grads disrespecting and challenging supervisors - It is pretty sad - By and large some new grads we have hired are putting patients at risk and it isn't just because they are new - we have a big problem on our hands in our field and ASHA will need to figure out how to respond - Seems the medSLP collective is part of the problem.

ASHA to provide compensation for taking a student. Example: free access to Online Con Ed or give SLPs a discount on annual Dues for taking students.

I don't anticipate funding, but if it were possible for ASHA to facilitate policy to encourage employers to reduce productivity/other administrative demands with a student, we could focus on critical thinking more often than just scraping the surface of the caseload.

My coworker who has taken over supervision of students does not provide the expectations nor adequate training for students to complete all responsibilities under our clinical requirements for supervision

We have no barriers.

We actually accept 3 SLP students annually at our organization.

I am more than willing to serve students, and actually have a great caseload. I am about an hour away from the nearest university so most of the time, the students elect for placements closer to where their school and thus their apartment etc. are located.

NA

None (*n* = 5)

None outside of requesting to see some of the funds that are given to the facility for my service.

Does not apply

I am primarily administrative. So the caseload numbers fluctuate and it isn't sustainable for getting a student hours.

I do not supervise students.

Home Health/Client's Home

Compensation for teaching and supervision of students

Compensation, so much time is spent with a student and CF that is not paid. Volunteering isn't worth the time as it takes time away from my earning as I'm paid per visit, so it's really a cut in pay.

Increased financial compensation for mentoring

Pay increase for supervision.

Provide compensation

Providing clinician with a stipend for taking on a student or CF

Supervision stipend

Universities should offer a stipend to SLPs willing to complete Clinical hours and the CFY year.

Employer does not allow supervisors to accept anything for supervising

Give CEUs for supervision

Have to increase reimbursement -- it is important for us to be able to provide the awesome care that we do, WHILE training others. However, if the company doesn't see that SLPs are adding to their bottom line, then they don't want us to spend extra time ALSO supervising grad students. On another note, why would I encourage someone to go into a field that is dying? My reimbursement is much lower than PT/OT, which is why I have to work off the clock. The amount the company makes from one visit barely covers my wages/benefits and contributes nothing to their bottom line. There is no incentive for them to pursue hiring more SLPS -- the more you higher, the more revenue you lose. Its frustrating and leading to area private practices engaging in unethically SHORT (20 min) therapy sessions for both peds and adult clients in order to stay afloat.

As ASHA requires CFs to receive supervision and requires supervisors to put in the time and effort to maintain training related to supervision, it only seems fair that supervisors receive some sort of compensation for the time they are putting towards this extra responsibility. I spend multiple hours a week providing supervision to my CF, and my employer should not be the one having to compensate me for this time.

Developing a program

Being able to hire more SLPs to fill the role. Most applicants are SLPA
Difficult to get university to agree to our contract
Home health and per visit pay is not conducive for students
I don't know how to make the time to focus on a grad student when I hardly have the time to see all my clients and complete documentation.
I've shared students with colleagues, having them 2-3 days/week instead of full time.
Immediate feedback, honesty and transparency of expectations
Increased communication with colleges and universities
Just making sure students are assigned to the strongest and most experienced SLPs.
Providing mandatory time within the paid workday to teach students and collaborate to plan sessions.
My organization requires that a new therapist have at least one year of home care experience.
No training. Difficulty understand the responsible due to lack of training.
Trainings in supervision from the university
Setting-specific protocols for students and supervisors
Support from programs and employers
Training and support
Virtual or in-person meetings with academic program on expectations and role before accepting position
Would love to have a state supported mentorship program for teens and college students interested in the career.
Don't supervise at this time.
My company does not encourage it because I traveled to several buildings and it would be difficult to coordinate with a student and they are correct.
My setting is not conducive for supervising graduate students.
I would be happy to supervise students, but my organization doesn't allow any students in either Home Health or Inpatient settings.
We don't take students.
I don't see students.
I don't supervise.
N/A
N/a
Na (*n* = 3)
NA
None
Idk

Outpatient clinic/office

Additional compensation
Additional compensation for supervising. I can't supervise a student or CFY and treat patients at the same time. Employer expectations and ASHA requirements/insurance/government requirements are not in alignment
Compensation and better training
Compensation to in turn provide schedule block for teaching
Get universities to provide reimbursement for supervising
Increased pay during supervising hours, clear onboarding protocols for students
Lobby for better pay befitting the expertise of therapists and do away with ridiculous limitations of one time charges - communication is a vital human skill and should be supported and valued as such so that you can fully support the broad expertise a speech and language therapist has.
Paid time or dedicated time for supervision.
Pay for supervision of students
Pay supervisors. Students are paying for those credits to the university. A portion could go to the supervisors in the trenches doing the work.
It would be nice if supervisors received a stipend, but reimbursement rates would have increase, since it's been 20+ years. :(
Programs should pay preceptors
Provide incentives for taking students
Provide pay to students
Provide some compensation for being a supervisor.
Should have a stipend offered or productivity rates lowered
Allow supervisors to be paid for the time they spend supervising
If there was a way to both receive pay for supervision and ensure students are better prepared for clinical settings (especially if we get rid of the policy that a student who doesn't

pass is stuck with their supervisor until they do) then I'd be willing to supervise again.
If workplace allowed increase in pay or stipend and time in schedule when agree to supervise a graduate student or CF
The expectation that we will take on a HUGE amount of extra work for no extra pay. Why is this a universal expectation? People—including employers don't see our jobs as hard as they are.
We need to be PAID for our time to supervise!!! Otherwise I will never be able to do it.
I supervise because it is good for the field of speech pathology to help future therapists, but it would be nice to receive some form of compensation for the extra work. Not sure where the compensation should come from though.
Payor restrictions likely most impactful
Better insurance reimbursement
Academic programs making easier to supervise and even provide a stipend
Allowing time for supervisors to meet with students. Increase in pay for the role of supervision.
Allowing for time (productivity carve-out) or compensation for extra time spent would make it more doable.
Offering time for clinical feedback/student training and compensation for providing student supervision.
Schedule limitations for students as well as workplace demands often make it hard to provide quality supervision. Compensation for taking students would be helpful.
More administrative support and compensation from *somewhere* for the extra time that needs to be dedicated to give these poor grad student the support that they need.
Additional administrative assistance for completing additional paperwork associated with student supervision. Financial incentives for student supervision would be nice, but don't seem very plausible. Grad school programs with better medical education prior to placement would help better prepare students for medical placements and ease the burden on the supervisor.
As a private practice SLP I have no extra time to manage and train students. I can barely keep up with all the demands as it is. My reimbursements shrink yearly and the paperwork demands increase.
As a solo practitioner the time involved is significant so cannot supervise on an ongoing basis. Impacts my ability to get the daily tasks done and puts me way behind. Rewarding. But cannot supervise on a regular basis. Students should have more clinical therapy comfort. Online clinical training does not seem to transfer to real world clinical setting. Most students notice that right away.
I currently couldn't take on a student with all the demands of running private practice and low reimbursement rates.
Clear expectations for the site
Better communication
Better guidelines company wide. There is no clear cut time to meet and no plan in place for different levels of clinical education
Decrease restrictions on virtual supervision!
More training for supervision
Encouraging staff to take students as many feel it is too much extra work and will make it difficult to meet productivity
Having more than 45 minutes of blocked time on my schedule so I can review patient care with the student as well as documentation.
Helping higher up SLPs see the benefits in taking students. In previous positions, employers were concerned about productivity and would not allow us to take a student as often as we wanted
I think more documentation time should be provided
Increase time allotted to meet with students to review daily cases. Typically, it happens off the clock or during my lunch break because I am booked solid all day with clients.
Leniency on productivity expectations, stipend, CEU reimbursement
More communication with the student.
More time for observation and feedback
More time for student evaluation, standardized expectations, pre-post testing/outcome measure
More time with my team to discuss paths to success and how to best support students. Support and initiation from programs.
My goal is to provide graduate students with the best clinical rotation so there is negative impact regardless of demands of the job

My setting is conducive for students.
Need more time to allow students to do paperwork, be able to meet & discuss clients, treatments, etc.
Often a lack of preparation, lack of staff to provide supervision, lack of time, no developed plan
Protected time to train and support student learning, better guidelines of what is expected of them from their schools
Reduced productivity, increase in pay, breaks from supervision (e.g. alternating years)
Set specific time for supervision- not afterwork hours
Setting realistic expectations regarding preparing for variation of clients/patients' needs as well as documentation time.
Supervisors need to be given more time to perform supervision duties and have a lighter caseload than other SLPs on staff
There needs to be an allotment of time required to educate students. It is not possible to do a great job with student placement and maintain productivity
There needs to be time built into the schedule for reviewing documentation with students.
Time with students, without patients, needs to be counted as productive time
We can't even take on students for the amount of turnover and constantly taking on CFYs to fulfill gaps, then after a year they resign, and we start over.
We have to interview so many. I wish there was an easier way to vet them.
We need more staff and adequate time and reimbursement for training/supervising students
Advocating to insurance companies to increase reimbursement for services
Reimbursement rates must increase in order to support lower caseloads, improved staffing, and/or decreased productivity requirements in order for experienced clinicians to be willing and able to provide optimal clinical placement experiences.
Allow other universities to have access to the facility.
Better practicum preparation at universities, passing a board exam to become an SLPA
Better preparation from institution (i.e., interview prep, resume present, interest areas clear etc.)
Better reimbursement from academic programs for taking a student
Better training, and more consistent guidance across schools.
Centralized requirements. Programs differ greatly in requirements, which can be challenging for the supervisor to learn and pace. Also, grading rubrics are too complicated and must learn each one individually.
More collaboration with schools so that they understand the requirements for the graduate clinicians to be successful in our clinic setting
Supervisors should be rated as well to ensure the quality of the supervision is consistent and they are not taking on students to work less. A rubric of what needs to be done should be provided where both student and SLP check off items. For example actual experience with conducting evaluations, writing reports, discussions on why or how to prep or determine which test is most appropriate. Something similar to what we do for a fellowship period. University programs should not be penalized for students that need to repeat a clinical practical to encourage them to actually have a consequence for poor performance. Most students know the university won't fail them because it affects their graduation or program competition stats.
Emphasize science rather than activist thinking in graduate programs
Grad programs need to require more exposure to standardized testing. Grad programs need to teach myofunctional therapy and oral motor in the context of pairing them with functional skills. This is now research based evidence!
Graduate school programs needs to get students more prepared for adult medical settings
Graduate schools are not being diligent enough about looking for settings. Many times the placement coordinator is offsite and not even an SLP. They are just looking for a space to fill and they overlook the opportunity that is available.
Graduate student clinicians should be paid as if they were an SLPA for the treatment that they

provide while obtaining their graduate student clinicians hours.

Graduate students NEED adult based clinic experience prior to externships. Graduate programs should be responsible for providing that exposure and ensuring that students are competent in completing a basic session for aphasia, dysarthria, dysphagia, voice, etc. prior to externships. Cramming clinical training of ALL adult topics clinically within 1 semester does not fully prepare students for a medical CF. Our profession relies on good CF supervision to bridge that gap, but it can not always be counted on given variations in staffing, locations, etc.

Guidelines for courses taken before specific placements.

Have them be better prepared. Give them realistic expectations of the workplace.

I believe it would be beneficial for students to be able to begin to specialize training in final year of education. (pediatrics, adult, school, outpatient, inpatient, etc.)

If they are not prepared to handle our caseloads, parents and caregivers can be hesitant to allow students to participate in treatment.

Include more medically-focused coursework starting in undergraduate - understanding body systems and knowledge of normal versus abnormal communication-cognition, swallowing and voice.

Incorporate my facial release manual teaching, estim, etc. specific treatment modalities

More hands on training prior to external placement. Programs for SLPAs. They SLPAs we have hired in the past know NOTHING (no artic placement, no child language, no behavior modification, etc.). We have had to stop hiring them because of the amount of education we have to provide up front to make up for what they didn't learn in an undergrad program. They also have a poor work ethic - show up late, call out, don't want a caseload of more than 20 hours per week.

Our scope of practice is vast and often they lack the necessary skill set to address the needs of our clients. For example, children with ASD have more language and speech needs but often feeding aversions, AAC, PECs - they are wholly unprepared based on the current status of the graduate school offerings compared to what we actually do in clinical practice.

Overall, this generation of new graduates want the least amount of work and responsibility for the max amount of pay. All while our reimbursement has declined significantly over the past five years

Proving oromyofunctional treatment knowledge in graduate programs

Soft skills need to be taught at the graduate level. How to interact with people, basic job skills such as following deadlines or communicating if that is not possible. More emphasis on the adult population in graduate school.

Student attitude is of the utmost importance. Approaching a placement with the notion that they may learn something new and be able to apply their knowledge in the real world is welcome. Big egos and a “know it all” attitude are unwelcome, offensive, and why I have not taken a student in many years.

Students are coming unprepared for direct one on one care

Students are not adequately prepared and the time and energy put in is not compensated

Students need more clinical training before their internships start. So many students are unprepared for the amount of time it takes to prepare for sessions, look at the client's information for clinical decision making, and complete administrative paperwork - although that's a bulk of the job. I try to prepare students while I have them, but with such limited time and clinical decision making experience/support in their programs, it feels like taking the time to do those things is considered inconsequential to many programs. I think that's why so many CFs feel overwhelmed and unprepared for the job. I especially think that if programs could start incorporating executive function skills and strategies for clinicians into their programs, including how students can make visual supports for themselves or ways of organizing information they're learning, we'd see less overwhelm and burnout in students and in the field.

Students need more preparation prior to diving in to treat patients. They often times do not have sufficient background knowledge.
Students should have limited active coursework during placement semester to allow for patient planning, prep. Placement supervisors should be more involved in direct evaluation with student, there is little time to be reflective with students in a 90% productivity setting.
We do not accept online graduate training externs, as they have been found to be unprepared, regardless of the program they have come from. We have found graduate trained externs from University in house systems to be better clinicians overall. Online trained graduate students do not have the critical thinking skills to be clinicians, they are trained as technicians. They take too much time as externs for training as clinicians.
We need to require adequate education in the classroom on medical SLP topics dysphagia is most of my caseload and students have only 1 three hour course in dysphagia. Medical SLP topics are not discussed enough in the classroom making many students scared and unprepared
West Coast University should not have a graduate program. It allows students to have 0 clinical experience other than simucase before a full-time placement. Internship coordinator not responsive to concerns
Additional low cost, no cost training from ASHA for supervisors.
ASHA could provide small stipend to supervisors after taking on a certain number of students.
At a minimum, reduced or waived ASHA dues since CCC is required for supervision.
Change by ASHA to provide continuing education credits for providing supervision of students.
If ASHA spent more time preparing universities for to provide real world work education therapy students would be more equipped to enter the work force. The problem is most professors as well as people in roles within ASHA do not understand the real world day to day challenges that consistently make providing services an up hill battle.
More FREE education opportunities on navigating the student experience particularly with challenging students or above average students
No ASHA CEUs
SLPs should receive CEUs or be rewarded with access to free CEUs. PTs and OTs get to count student supervision as part of the hours that go towards their licensure. It would be nice if SLPs could count it, as well.
Supervision requires additional work that therapists aren't paid for. ASHA could offer a stipend for therapist who offer to supervise in smaller clinics to bridge this gap, as private practice clinics typically don't have the extra funds to cover this.
I don’t supervise.
Don’t supervise
I have not supervised any other students.
I have stopped supervising So I am no longer in the loop.
I rarely get graduate students in my practice.
We don’t supervise students.
No suggestions. Very tough situation. Students deserve time to discuss clinical situations, but with high productivity standards, there is not sufficient time
None at this time; I am not able to provide supervision at this time;
Why are all of the questions presented so Negatively?
N/A (*n* = 6)
N/a (*n* = 3)
n/a (*n* = 1)
Na (*n* = 2)
None (*n* = 2)

Pediatric Hospital

Additional pay or factor in to productivity
Compensation, staffing and extra time
Incentives or compensation Allow student supervision to count toward CEU (as OT and PT does)
Monetary compensation by university programs to allow for a reduction in revenue demands for the supervising/training clinicians because as it stands there is minimal time to talk to students, never mind train them.
More compensation
Some sort of compensation for the therapist or organization to offset impact to efficiency required in training students. More focus on

PEDIATRIC dysphagia in the training programs.

Time or money

Allotted time for student supervision meetings - handbook for students so that the therapist is not collecting articles and resources to provide for reference

Allowing observations and seeing patients for Outpatient follow up to build competency

Offering CEUs for supervising students like OT and PT do. Make sure that graduate programs are fully preparing students to be in a medical setting.

If you work within a specialization and see patients for just evaluations or short bursts of therapy, it is challenging to have a student and give them autonomy.

More staffing and more time

Increase staff to allow for non-direct patient time for mentoring

Hospital administrators having power trips and being over controlling at their discretion

Reducing productivity standard for supervising SLP

There limit the number of students per year

We need proper staffing to make room to do that.

Ensure students have adequate knowledge and skills prior to internships

Graduate programs have become way too large such that SLP students are learning in large lecture classes and have very limited opportunities for in-depth training in their graduate program clinics (this is especially true for 100% online programs.) Our hospital has not increased the number of placements we have (and we cannot) and we need graduate students ready to learn at the next level in the medical setting.

Graduate programs need more pediatric dysphagia or even dysphagia in general training

Setting clear expectations and enforcing the consequences. My hope is that academic programs would better reinforce to students that their time in placements should be viewed like a job. They will be supported to learn, but they must meet the standards of behavior and performance expectations. The consequences will be failure to pass the placement. When we have more than one student from a university with similar concerns, we must then communicate to the school that we cannot continue to take their students.

Improved communication from university settings

More education on medical SLP, especially pediatric Dysphagia. Most clinicians are unprepared through school for this type of position unless we get placements, resulting in us educating ourselves through CEUs which is good but should not be our main source of education.

Increased acute care opportunities/training prior to outplacement opportunities.

Provide basic 101 developmental milestones of all areas SLP provide services for (artic/language/motor speech/feeding/voice/fluency)

Several new SLP graduate programs are not adequately preparing students in the foundations of speech and language disorders.

The graduate students are very unprepared and it adds a lot of work without compensation to get them where they need to be.

Given financial strain of institution, it is difficult to remove staff members from patient care in order to support graduate student education. Students are not well prepared for our setting, and take a significant amount of work from our team to support in their training.

We are located a very significant distance from Universities who offer SLP training.

Better advocacy from ASHA about the need for supervisors and workplace support of additional time for people who do supervise.

I do not offer supervision

I don't provide graduate student supervision as a PRN

I have stopped taking students for awhile because I simply do not have time to supervise and train. We have back to back patients and students slow me down. We do not get any break in productivity for having a student.

I don't have time to take a student. My job in acute care is extremely complex and fast paced. I can't send a student to feed a medically complex infant to treat a child on a vent. I don't have the time ,compensation or motivation to take a student. On rare occasions that I allow a student to supervise,

it greatly affects my daily productivity standard which makes it not worth my time. If I don't see at least 7 patients in an 8 hour day, I'm mandated to float to the adult units, even though I haven't treated, done any continuing education or been updated in adult treatment for 25 years.

n/a

None

None at this time

None I haven't supervised a student at this location yet

Rehabilitation Hospital

Appropriate compensation and increased training

Compensation and/or decreased productivity requirements in order to adequately supervise and teach

Compensation for taking a student or access to CEU subscription?

Compensation, CEU credits for supervising a student.

Extra duties without compensation

It should be a requirement for increase pay or at least "preceptor pay" as it's a big responsibility. I wish there were guidelines or checklists for precepting / supervising students

More people would likely be willing to supervise students if they got anything for it other than a good feeling. OTs and PTs receive CEU credit for supervising students. That would be a good incentive for a lot of SLPs. Maybe access to free CEUs via ASHA if you are supervising students. Also, actually having time to train and talk to our students would be makes people more likely to take one on. As it stands now, taking in a student likely means I'm just going to have to stay late to actually educate them and possibly pay late fees at daycare because of it.

Offer incentive pay and training Lower productivity expectations

Offer increased pay/incentive for taking on a student, and drop the productivity expectations

Provide monetary incentive or additional blocked time part of the treatment day

More time allotted to provide feedback to students. Reimbursement for time provided

Reimbursement or continuing education credit

We should receive continuing Ed credit like physical therapists do. Would be great for companies to allow an extra 30 minutes a day initially when a student is there for training.

Consistent national plan for incentivizing clinical instructors

Add more programs to nearby schools. Educate h.s. students on what an SLP does. Have better relationships with a variety of outplacement locations.

Communicate regularly with supervisors, ask questions, and document.

Continue to encourage SLPs to take the courses to be able to supervise students

Corporate policy at the sars

Decreasing productivity requirements at least for a period of time when a student is present (to give ample time for feedback and assistance.

Extra support for training students when caseload is high

Guarantee block time more regularly to meet with student

In the same way that there are minimum criteria to be met prior to graduation from a graduate program, there should be minimum criteria to be met prior to medical placements. It is unsafe and wasteful to start from scratch training students on very short placements (8-12 weeks) regarding concepts, skills, and interventions that they should have at least heard of before their externship/internship placements.

More time in the day dedicated to teaching/ educating

Need more staff willing to supervise.

Paperwork requirements can be burdensome.

Continued dialogue between the academic program and our facility to increase student preparedness

Creating better relationships with hospitals and universities and joint development of programs for students to initially come and Engage in serial Observations. And progress the process to the level of a clinical fellow.

For some students their personal difficulties in communication should have been addressed by their undergrad or grad program before internship

Have more standards in dysphagia education. It should be more than 1 semester. Students spend many semesters learning about children. There needs to be courses on functional adults- both swallow and cognition. Otherwise everything looks like a disorders.

Here's a refined version that maintains a professional tone and clearly conveys the challenges you faced: --- The last student I supervised unfortunately failed their placement under my guidance. Not only was he unprepared clinically and lacked the foundational knowledge necessary for success, but his professionalism also fell short. He demonstrated a lack of self-monitoring skills and failed to proactively address his learning gaps. When resources were offered to support his development, he chose to prioritize studying for the Praxis exam over addressing the areas where he needed improvement. Additionally, when I reached out to the university for support, I found their response to be unhelpful, which further complicated the situation. Since his placement, I have chosen to forego student supervision, which as been approximately 3 years. This was the only student I have failed throughout my career.

Improved dysphagia and cognitive education for adults provided by graduate program prior to externship/internship

Improved graduate education to prepare students for working in a fast-paced medical setting; coursework on other conditions that impact our patients (i.e., diabetes, hypertension, etc.); practice reading a medical chart

Increase familiarity of university supervisors who place students with the outplacement sites to assist with appropriate placements.

Lack of professionalism of graduate students, lack of adequate preparation, difficulties with graduate students being open to feedback... we've noticed a significant increase in barriers with our graduate students since COVID. The online modules they take/simucases are no replacement for live experiences.

Medical track graduate programs, increase length of graduate programs so students are adequately trained, provide guidance on productivity requirements when supervising a student.

More education regarding dysphagia in acute setting

More focused curriculum on swallowing and swallowing disorders

Practical training with dysphagia

Standard practice for interviews prior to placement confirmation; Setting expectations for students (from college-level and placement-level) that it will be challenging and involve "after-work" preparation and time.

Student needs to be trained and ready to be on site - online students tend to not have in person experience which we don't have time to train them on how to do therapy like it is day one in clinic. Online students are not prepared to do a clinical in the hospital setting,

Students are coming in with lower expectations/less or poor carryover of clinical information that was supposed to be learned during graduate school or graduate clinic

The students university liaison needs to be communicating with our team before, during and after the placement.

They should first see adult outpatients at a university clinic prior to a hospital setting.

Training before hand

Unfortunately, it is a shift in culture with the current age demographic of many of the students that is a barrier to their success in an intensive medical setting.

Universities not supportive of additional student needs or preparing them appropriately, no time to mentor students given productivity requirements

Working with schools and administrators of the hospital to make sure things run smoothly

N/A

NA

none

Skilled Nursing Facility

Additional compensation or continuing education units for supervision.

Compensation for the additional work would be nice.

Incentives for supervisor. It's hard to go the extra mile when the demands on your time are

already overwhelming. It's easier not to in the real world.
Lobby for companies to adjust compensation structures and productivity accordingly!
Provide stipend and lower productivity standards
Provide continuing education credits or some other compensation
There needs to be compensation and CEUs provided like the other therapists get
Decrease expected productivity when they begin, our facility posts our productivity publicly and you get “called out” in rehab meetings if you do not meet. There is no additional compensation, and to avoid the productivity dilemma, most work with students would be off the clock
We deserve extra compensation.
Encourage graduate programs to compensate supervisors.
My company has to make money to survive, our productivity requirement is reasonable, but there is no extra time for having a student who will require teaching/supervision within the current productivity standard. If the facility could be reimbursed for this non billable time, maybe from the teaching University, government, ASHA, my company might be willing to have students.
Productivity demands remain the same despite need for extra time for training. Additionally, lack of compensation affects supervision. The schools pay for students to be in settings however companies pocket the money rather than giving it to the supervisors doing the training
Reduce productivity standard and compensation
Time and compensation
Time
Increased time to supervise; significantly reduced productivity standards to allow that extra time and reduce pressure/stress. Increased training for supervision and support during the process.
We need additional compensation and additional time to teach students. Companies should not expect unrealistic productivity standards and groups/concurrents when the SLP has a student.
Change productivity demands.
Company or productivity incentives to allow students, as well as to allow time/space to learn
Continuing Education
Ease productivity standards when student is being supervised
Eliminate productivity requirements if taking students
Eliminating or reducing productivity standards when supervising students. Hiring appropriate staff to support caseload to allow more time for education/training while supervising
If having a student was considered in my productivity. To improve time for education.
Need admin support and more time to allow for proper supervision.
Need reduced productivity to accurately be able to train a student without working on supervision tasks off the clock
Provisional licensure will help. Provisional licensure will soon be allowed for CFs in Massachusetts.
Reduced productivity standards in the setting. Actually being given time to thoroughly explain and teach
Requirement for supervision class
Supervision requires extra time for planning and coaching with the student. Extra time is not provided by my employer. Caseloads should decrease and additional time should be allotted during the day 30 minutes to 1 hour. Supervision requires additional skills, time and expertise. I need to be paid for my skills, time and expertise. Universities could shift tuition dollars to cover and augment a portion of the SLP’s salary. If I had dedicated time and compensation for supervision, I could commit to taking students regularly. I enjoy it. But I can’t work for free or donate additional time.
This would not be possible within current productivity standards. The contract rehab. company I work for will hire CFY's but does not allow graduate student supervision.
Training a student should not count against productivity initially.
When I was working at 90% productivity, there was no way for me to supervise. At my current facility, with 65%, I actually have the time to supervise students and attempt to complete my other tasks needed.

Create universal requirements for setting education. Some students have never heard of interventions for certain settings

Encourage schools to finish classes in earlier semesters so students have time and focus in externships

Ensure adequate training of graduate students even when classes may be presented remotely or via zoom. Especially in pivotal areas such as dysphagia.

I do not feel the students are well prepared for the medical setting and are taught more from a research standpoint point vs. real life situations. I think university faculty need to have more recent experience working out in the field.

If any barriers ever arise I go directly to the graduate school director.

Increased education in school related to insurance practices and regulations. Adult focused medical education and EBP driven treatments for adults. Increased support for supervisors in additional leadership training and compensation. Increased ASHA requirements- 6/6hr is minimal and with many contract companies productivity these times are over pressured and under scheduled to benefit the CF

Academic preparation, hands-on training/experience with live clients/patients

More training with students regarding realistic demands of SLP and time constraints.

Need better prepared students who understand professional expectations

Schools need to prepare them better and ensure that they have a medical externship.

SLP students don’t understand setting and are ill equipped for the demands of skilled nursing.

Student come with insufficient knowledge of dementia, dysphasia and caseload development

Students need to have better problem solving skills when it comes to working with nurses, CNA, activities, and etc. in Nursing home.

The students I've supervised have reported not having ample courses available and the courses available have offered very limited information.

ASHA needs to create a productivity statement to include non-patient facing but required duties, productivity of 70%

ASHA needs to step in and provide guidance to medical companies about reasonable productivity expectations!!!

I supervise students and I do not have any barriers. Most students have not worked with brain injured patients. I see my patients each for an hour a day. This is good for students as they are able to get to know the patients better and able to plan for the patients. All my students wish they could stay with us at Pathways because they become very attached. Our program is unique. We have a contract with Medicaid. We sometimes get an insurance or work related case. Our patients tend to stay longer providing for a greater outcome.

I supervise each semester if I am able.

My place of work is very supportive of student supervision.

I am not willing to take on students with efficiency standards

Did not supervise

Do not have students

I am the only SLP and do not currently have the qualifications to supervise

I do not supervise students

I have not started supervising students so I am unsure of any barriers.

Difficult as extra responsibility of clinical supervision adds additional pressure

I'm honestly not sure

No full time SLP available for supervision

No students

No suggestions as I do not supervise students on a consistent basis

No suggestions. I am not sure how the reimbursement piece works so if that could be easier so things don’t have to get redone that would be my only suggestion.

Only had one grad student experience

No Barriers

N/A (*n* = 4)

N/a (*n* = 2)

Na

N/A I have not supervised a student.

None (*n* = 2)

none

None at this time

Other Facility

Reimbursement for time. Often I would work at home to prep.

I've never experienced those kinds of barriers. I've had 2 questionable students out of 10 or 12. I believe it's my responsibility to recognize and resolve barriers without any outside involvement. Otherwise, students should not be placed in a setting with barriers.

I'm in private practice, do not supervise

n/a

None

None at this time

Q. 33. Other Doctorate, Specified

General/VA/Military/LTAC/University Hospital

DMA, Doctor of Musical Arts
EdD
MD

Home Health/Client's Home

Non-related field

Outpatient clinic/office

DHA (*n* = 2)
EdD

Skilled Nursing Facility

Divinity

Q. 35. Other Reasons for Completing Survey

General/VA/Military/LTAC/University Hospital

Appreciation for interest in the medical SLP role
I refer to survey results and appreciate the data that is presented particularly in my administrative role in a health care system
I take survey results to my annual review to ask for increase in wages.
Using the previous 2023 survey to advocate for wage increases recently
Want to know if my compensation is competitive
Trying to help
Appreciation for interest in the medical SLP role
ASHA needs to provide more help to s.
Hoping ASHA will step it up to make a difference in our field. We spend slots of dues and honestly you do not do much for acute care medical speech language pathologist to set standards. Hospitals just do what they want (I have worked for several) and I constantly feel like I am trying to protect my own licensed all the time.
I feel ASHA could be more supportive on guidelines which our employers would then take seriously.
I hope ASHA will hear how we are doing in the trenches and do something
I hope ASHA will use the results of this survey to revamp graduate programs/requirements. Students spend a lot of money and time for a degree only to graduate and discover they don't have to knowledge to work in that area in which they want to work- namely in acute care.
I hope ASHA will use the survey to help SLPs in health care settings
I hope ASHA will use this survey to help SLP's in health care
I HOPE ASHA will use this survey to help SLPs in the health care setting
I hope ASHA will begin supporting healthcare SLP's better with this information
I hope that ASHA will use the information to drive better preparation and education of the Medical SLP track and change its practices to support and advocate for medical SLPs' recognition, compensation, and respect.
I think ASHA needs to make changes and advocate for Medicare and Medicaid reimbursement to not be cut
I think ASHA should attempt to improve the support and advocacy efforts for their members.
I want to make sure med SLPs are represented by ASHA
I'm hopeful ASHA will use this survey to help SLPs
I'm hoping ASHA will step up and provide a two track program and support for acute care SLPs and educational SLPs.
To have a format to let ASHA know I stand with Fix SLP and find their behavior reprehensible.
To get ASHA to listen to real people.
I don't think ASHA truly understands what SLPs do day-to-day, and the MANY challenges we face.
I want ASHA to know how I feel about paying money every year to an organization which I do not feel benefits me.
I wanted to stop getting emails to complete the survey.
Would like ASHA to know how they are NOT supporting us
ASHA sucks

Home Health/Client's Home

I was hoping to give ASHA feedback about ASHA
ASHA needs to help advocate our salaries
Curious what they wanted to know
Desire for increased support from ASHA
Hope ASHA will address healthcare setting
Need for support for therapist with unrealistic productivity
Hoping you will help us and realize we are not happy with your unsuccessful attempts to support us even with us having to pay you EVERY year into infinity.
I am hopeful that ASHA will advocate and accomplish increasing reimbursement for our services so that employers find it beneficial to hire the SLPs that they need (rather than looking at SLPs as a charity cause -- after

paying wages, there is minimal left to cover benefits, overhead, etc.).
I HOPE this will lead to positive change
I want more support from ASHA
I was hoping this would help inform ASHA that our reimbursement rates are way too low and lobby for increase not spend time lobbying states to require the ccc.
I was hoping ASHA would ask about what is actually bothering SLPs with the association
I would like ASHA to be more relevant to me for the dues I pay I receive nothing in return
With ASHA dues increasing and the word in the field for limited support for medical SLPs as a whole is frequently discussed in the field. I've worked for three major health systems in two different states and have experienced issues highlighted in this survey at all three campuses
When I have called ASHA for guidance on billing or reimbursement issues you guys have proven to be severely out of touch.
ASHA has been useless in my opinion and many of my colleague's opinions. I do not believe this will actually make a difference, just wanted to say [expletive] ASHA for pocketing our money and telling us to go cry in the car.
To increase ASHA's motivation to help SLPs working outside of pediatrics / in geriatrics
Participation is an important part of democracy!

Outpatient clinic/office

I have used these stats in my research and feel motivated to pay it forward
If we don't answer surveys, ASHA will not have accurate information.
ASHA needs to actually hear us and take real action. Note how many "fair" and "poor" responses you get to the first question and LISTEN to your members about what to do to improve that!
ASHA needs to get a clue
ASHA needs to hear that their lack of effective activism is directly impacting SLPs across the nation. Effective advocacy now- reduce caseloads for school-based SLPs, increase expectation of working SLPs to supervise graduate students and CFs, and increase insurance and Medicare/caid reimbursement for patients!
Frustration with ASHA lack of support for SLPs
Hope ASHA will improve support for healthcare SLPs
Hopeful it will be used to help
Hoping ASHA will address the unacceptable reimbursement rates. Our rates in OK have gone DOWN these last several years and are now back to what they were 10 years ago. We cannot sustain a business with these rates. Something MUST be done to advocate for adequate reimbursement.
Hoping for better advocacy, toward improved, increased wage standards. This is a female-dominant field, and we are undervalued, overworked, underpaid. We are paying substantially more than our other allied health counterparts to our professional certifying board but with seemingly little to show for it in those areas. In order to further our field, we need to make it lucrative, with obvious return on the educational investment and rigors. Talented clinicians are leaving the field for other work that better rewards and honors their investment.
Hoping that ASHA will do better job supporting its therapists with reimbursement issues from insurance
I hope ASHA does hear the concerns from us clinical SLPs who are struggling with too much work and too little pay.
I HOPE ASHA uses our input to continue improving the profession
I'm hopeful my responses will make an impact on the significant challenges facing our field.
I hope ASHA will advocate for increases in reimbursement rates to reflect our education and the value of the services we provide.
I hope ASHA will use this survey to help SLPs
I hope my responses will be acted on to better our field
I hope that ASHA cares to enforce change for fellow SLPs who are struggling in the workplace. Not enough is being done in regards to reimbursement and advocacy for what we do.
I HOPE that ASHA will use survey results to help SLPs in health care settings.
I HOPE that ASHA will use it to help SLPs in healthcare settings.

I HOPE that ASHA will use the info to help improve
I HOPE that ASHA will use this survey to help the CDS profession.
I hope this survey helps ASHA find a way to better support SLPs in healthcare settings.
I want ASHA to do better for their members
I want ASHA to know that members want more advocacy and assistance from ASHA. We're not satisfied with the current level of advocacy and support currently provided, especially for the amount we pay for CCCs and membership.
I want ASHA to start making a difference in our workplaces. I feel as if ASHA does not support us appropriately. I only feel like I have to pay dues for a certification. The organization does not advocate for adequate pay and caseload caps.
I want my voice heard about significantly absurd undervaluing of our profession despite demand that is in no way declining - DO BETTER FOR US
I wanted to voice an opinion on the duties of ASHA and the lack of support across the board and I don't feel that ASHA is doing enough to improve reimbursement rates, especially for pediatric private practice. This is the consensus of, literally, EVERY SLP I talk to and I am a member of a large group. I hope the new officers will do more before all pediatric private practices who take insurance are driven out of business due to extremely low reimbursement, the salary demands of CFs and SLPs, and cost of running a business.
I would like ASHA to demonstrate its worth as an organization. At this point many of us are maintaining certification simply so that we are able to continue to take grad students. We believe in the importance of providing grad students with a high quality experience however we do not feel our ASHA membership is value added for our career. Our employer no longer requires it.
Last hope for ASHA to maybe improve their listening to SLPs concerns. I left SNF because they’re unethical and ASHA does nothing.
My colleagues and I are burnt out and need change
I actually saw the email in my in box. I never check my email.
I have little to no respect do ASHA as an entity and find The cost for the service absolutely laughable. No other Therapy discipline is be holding two groups like this outside of their state licensure. Honestly, I have no clue what this organization actually does that provides real world benefit to its members at the patient we trying to serve. Every state becomes more restrictive in the ability to provide services.
I don’t believe ASHA will actually use these survey results to help, but I sure hope they do. There are widespread issues in this profession and our governing body should be working to fix them, instead they appear concerned about getting a very large paycheck in their pocket rather than helping SLPs in the field or advocating for caseload caps, proper payment, and insurance reimbursement.
I was curious about what it would be and hopeful that information gathered could be useful.
I thought it would give us an opportunity to say that our annual dues are too expensive. We do not need printed copies of the Leader.
I'm unhappy with ASHA and hope they will change.
I've been talking to recent graduates and current students who feel they're not receiving enough experience because there aren't enough clients in their graduate program clinics, yet there also aren't enough supervisors in the programs to allow for more clients, either.
Waiting for a patient

Pediatric Hospital

I have referenced previous ASHA workforce surveys.
I noticed on the salary results from the previous survey that there were not enough ped med SLP responses to generate sufficient data analysis
Not sure I've had direct feedback from past healthcare surveys summarizing aggregate results and how ASHA specifically uses that data for advocacy

Hopefulness that ASHA will finally begin advocating for us. We are overworked, underpaid and burnt out. This is no longer a desirable profession and having to pay Asha dues yearly and feeling as if we get nothing in return as far as advocacy adds insult to injury.

I typically feel like ASHA excludes rural practitioners, glad to provide a bit of information

Wanting ASHA to actually advocate for SLPs. We are underpaid, overworked, and I do not see any evidence of ASHA actually acting on our behalf or advocating for us. I truly hope something comes from this survey. Currently, I do not have any hope or belief in ASHA doing anything to improve quality of work and pay for SLPs. Seems that ASHA is just over-charging and ripping off SLPs. The fees are ludicrous.

I do not have hope that ASHA can improve the broken medical system or support SLPs in hospitals.

I don't think ASHA will advocate on our behalf or do anything useful other than waste my time on surveys. We already know what you're really like. Always super quiet with high title individuals sleeping good at night funded by our dues that we pay and never reap the benefits from other than some letters behind our name on a business card.

Rehabilitation Hospital

The survey results have helped me get an increase in pay in the past

There are a lot of recruitment companies that place SLP's in a variety settings. The pay is fixed creating the maximum profit for the companies at the expense of the providers. All Allied health professionals, which would include not only SLP's, but PT's OT's need to unionize so they can earn a decent reasonable fair wage. The same wage is basically offered by many companies and states or the cost of living exceeds the wage being earned. It only makes profit for the company well basically abusing the expertise of the provider.

I hope things change.

Hoping ASHA will do more for SLPs.

I hope ASHA will use the survey to help SLPs in health care settings but I have not see a change since the last survey

I HOPE ASHA will use this surgery to help the CSD profession.

I hope ASHA will create positive change, however I am doubtful given the current lack of support for medical based SLPs

How this pushed this company to do something for us your work hard for a career we are passionate for. Sincerely a burnt out SLP

I believe ASHA is out of touch with the working class SLP

Saw on Facebook medical SLP page

Had time and received the email

I have been around for a long time and have a lot of experience and opinions.

Skilled Nursing Facility

I've used the results from the survey in the past.

Results of surveys are often quite interesting, comparing my situation to others.

I appreciate that ASHA is finally acknowledging the healthcare aspect of our field

We don't usually get asked about adult/rehab settings. Usually the material is school based

Because I think it's important to share the failures of our healthcare system

Frustration in the system has inspired me to voice my concerns

I am hoping ASHA will increase its presence in healthcare setting

Hoping ASHA will do something to help members

Hopeful that ASHA will increase advocacy for SLPs due to responses to survey

Hope that ASHA will see the extreme need for support from this organizer that us SLPs currently are not getting.

I hope ASHA will use this to help our profession

I hope that ASHA will use this survey to help SLPs in the healthcare settings.

So ASHA is aware of how unsupported SLPs feel

ASHA needs to know the struggles we, SLPs, face and should really start doing something to help us.

ASHA needs to put our dues to work for the SLP profession. What is ASHA actually doing??

I am fed up with diminishing reimbursement, pay, and patient care while productivity and demands continues to climb and hope that by speaking to it, something might change one day.

I think ASHA needs to do something for our profession. Alot of clinicians are choosing to drop ASHA because of lack of input

The plight of SLP in medical settings is quite poor due to poor remuneration and high productive standards. Hoping ASHA finally steps up and does something about it.

I want ASHA to address productivity and to advertise/promote understanding of role of a SLP

To express my frustration with productivity standards and feeling little to no support from ASHA with helping to lower productivity standards

I would love for ASHA to advocate for patients who need more therapy than their payers allow currently

Please consider lowering the annual ASHA dues. It's ridiculous and most of us do not make a lot of money. So we have to supplement our income with several jobs. If I had my choice, I would not be affiliated with ASHA because I don't really know what you are doing for us.

I want to encourage ASHA to be much less woke (no "gender affirming care" no diversity, equity, inclusion nonsense. Things should be done on merit.

Let ASHA know they are doing a terrible job

Sometimes it feels better to scream into the void.

Based on the wording and assumed tone of the email ASHA sent, it felt like I had to.

Other Facility

I believe that ASHA needs to do better for SLPs and that current circumstances are unacceptable.

AHSA needs to be aggressive with SLP salaries and make necessary improvements in ASHA's organization with handling monies.