COUNCIL OF ACADEMIC PROGRAMS IN COMMUNICATION SCIENCES AND DISORDERS

White Paper: Preparation of Speech-Language Pathology Clinical Educators

Submitted by: Working Group on the Preparation of Speech-Language Pathology Clinical Educators:

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Background Information

The CAPCSD Board of Directors approved the formation of a working group on the Preparation of Clinical Educators during the summer of 2011. This committee was formed in response to a resolution submitted to CAPCSD from the Northeast Council of Clinic Directors in Communication Sciences and Disorders which identified the need to develop a framework for training and learning outcomes for preparation of clinical educators. CAPCSD's charge to this committee was "to develop a white paper on evidence-based guidelines for individuals to acquire the knowledge and skills necessary for effective clinical supervision and education." The committee was formed with representatives from public and private universities and from all geographic regions of the country. The first conference call was held in November 2011; the committee's work has been conducted via conference calls, e-mails and one face-to-face meeting at the CAPCSD conference in 2012.
The committee members are as follows:

Melissa Bruce; University of Houston, Houston, TX.
Elizabeth Gavett: Boston University, Boston, MA
Pamela Klick: Saint Xavier University, Chicago, IL
Marcella McCollum: San Jose State University, San Jose, CA
Ruth Peaper-Fillyaw: University of New Hampshire, Durham, NH, Committee Chair
Lee Robinson: Brigham Young University, Provo, UT
Lisa Scott: Florida State University, Tallahassee, FL
Michael Flahive: Saint Xavier University was the CAPCSD monitoring vice president for this committee.

Introduction

Clinical supervision has been an integral part of the profession of speech-language pathology since its inception. In ASHA's 1985 Position Statement on Clinical Supervision in Speech-Language Pathology and Audiology, preparation in supervision was identified as "a viable area of specialized study" and clinical supervision as a "distinct area of expertise and practice" (ASHA, 1985). These beliefs were reiterated in the updated 2008 ASHA Position Statement on Clinical Supervision (ASHA, 2008a). The term "clinical supervision" has historically referred to the supervision of graduate or undergraduate students assigned to clinical practicum within a course of study at an institution of higher learning; however, it is important to acknowledge that clinical supervision is practiced in a variety of arenas and with a wide array of supervisees. These supervisees may include speech-language pathologists during their Clinical Fellow experience, speech-language pathology assistants, colleagues in a workplace environment, or professionals in other healthcare fields. Over the span of a career in Communication Sciences and Disorders, all speech-language pathologists will have been a recipient of supervision and many will likely be providers of supervision as well.

Historically, the primary requirement in the professions of Speech-Language Pathology and Audiology for individuals to provide supervision has been to hold the Certificate of Clinical Competence. This requirement implicitly suggests that an individual who is competent to provide clinical services is also competent to provide clinical supervision. More recently, many professions, including our own, emphasize the importance of demonstrating specific knowledge and skills prior to performing any service. The 2008 ASHA supervision documents delineated the specific knowledge and skills required to competently perform the role of clinical supervisor and furthermore stated that "the highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process."(ASHA, 2008a) ASHA's Special Interest Group 11: Administration and Supervision (SIG 11) has also strongly recommended that persons involved in clinical supervision complete some form of training specific to this distinct area of practice. Although ASHA and SIG 11 have indicated the need for training, requirements for the amount of training or the type of training have yet to be developed. A recent ASHA document:

Speech-Language Pathology Assistant Scope of Practice (ASHA, 2013) is the first to include a statement requiring supervisory training. This document specifies that the supervising SLP must have completed or be currently enrolled in at least one course or workshop in supervision for at least 1.0 CEUs (10 clock hours). This requirement applies only to supervisors of Speech-Language Pathology Assistants The Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) also recognizes the need for clinical supervisors of students to have the requisite knowledge and skills in this distinct area of expertise and practice, as evidenced by the inclusion of numerous presentations about supervision issues at the annual conference (Duthie, 2010; Maxwell, (2009); McCrea & Newman (2008); Reuler et al, (2008). The academic community further acknowledges that "clinical supervisor" may not be the most appropriate descriptor for this role; clinical supervision involves much more than "overseeing" the supervisee, which is often the lay interpretation of this term. Effective supervision requires individuals to teach specific skills, clarify conceptual knowledge, facilitate critical thinking, role model professional behavior, develop professional writing, etc., in order for the student to provide proficient speech and language services and to be prepared to enter the workforce. Currently, many professionals involved in the supervisory process recognize that "clinical supervisor" may be an outdated label and have begun referring to this role as "clinical educator/instructor." This label more accurately reflects what clinical supervisors actually do, particularly in the academic setting.

Although this change in terminology is relatively new, literature examining supervisory models and processes is not. The model most commonly referenced in Communication Sciences and Disorders and referenced in the 2008 ASHA documents is Anderson's Continuum Model (Anderson, 1988). The practice of clinical supervision should be based on a solid theoretical foundation, just as is required in clinical practice. It is important that preparation in supervision be broad enough in scope to address models/frameworks that prepare individuals to supervise persons with varying levels of clinical experience and expertise. For example, one would expect there to be differences between the supervisory expectations required for a novice clinician with little or no experience working in a university clinic and a second-year graduate student clinician with over 350 hours participating in his/her second externship at a hospital rehabilitation unit, or between a speech-language pathology assistant and a Clinical Fellow. Preparation should also accommodate the focus supervisory duties play in one's job. University clinical educators generally view supervision and clinical teaching as all or part of their primary role at the university, so these individuals may benefit from advanced preparation. In contrast, the supervisors of students in externship settings view supervision as an ancillary duty and introductory preparation may be better suited for this group. These differences in the relationship of supervision to one's primary responsibilities, suggest the need for different levels of supervisory preparation.

Furthermore, other professions, including physical therapy, occupational therapy, and athletic training, have acknowledged the need for supervisory training and education and have subsequently developed and implemented more formal programs and requirements for professional preparation of individuals in their fields assuming a supervisory role. Various states have also considered requirements for training in supervision prior to assuming the role of supervisor. Currently, only a small number of states have actually mandated such training for speech-language pathologists; however, it seems likely that other states may be considering requirements for this area of practice.

As previously stated, it is very probable that many speech-language pathologists will assume a supervisory role at some point in their careers. Based on the information cited above, it is becoming increasingly clear that required training for current and future speech-language pathologists and audiologists in the area of clinical supervision is a necessary step to prepare those in the profession who will assume the supervisory role. ASHA's Board of Directors has recently assembled a committee to identify more specific guidelines regarding the clinical preparation of supervisors in a variety of settings, which is further indication of this need.

In summary, supervision practices should be rooted in theory, they should address the already identified knowledge and skills delineated in 2008 by ASHA, and they should be applied differentially for varying levels of supervisees. It is critical to explore ways in which educational programs for supervisors can be developed and made accessible to professionals. Prior to assuming the role of supervisor, all clinical supervisors/clinical educators should have adequate preparation in this area of practice. Additionally, there is a need to identify appropriate means of delivering this training. Finally, given the critical role of clinical supervision in the field of speech language pathology and given the expected requirements for clinical educators, it is also important that graduate programs consider the inclusion of professional preparation for this area of practice.

This paper will address the following key issues:
1) Review current evidence describing preparation of clinical supervisors in Communication Sciences and Disorders.
2) Identify and differentiate between knowledge and skills needed for developmental levels of clinical educators.
3) Present data regarding state requirements for professional preparation of supervisors.
4) Identify the current regulations and preparation programs for clinical educators in related professions.
5) Recommend possible "next steps" in order to move toward the goal of developing accessible and appropriate preparation in the supervisory process.

Preparation of Clinical Supervisors: Available Evidence

In 2008, the *Northeast Council of Clinic Directors* in Communication Sciences and Disorders conducted a study of the perceptions and practices in the supervisory process (Peaper-Fillyaw et al., 2008). A questionnaire was sent to supervisors in on- and off-campus settings used by member institutions with 447 completed surveys returned. Respondents were asked how they had acquired supervisory skills; 31.5% reported they had used self-guided instruction, 26% were mentored in the workplace, 11.2 % had attended professional workshops and 4% had taken graduate coursework or a post-master's course.

Also in 2008, Klick & Schmitt conducted a pilot study that examined how universities prepared clinical faculty who provided clinical supervision for graduate students in Communication Sciences & Disorders Programs. A total of 1000 surveys were randomly distributed to professionals involved in clinical supervision at the university level via graduate program directors; 176 surveys were returned. Results revealed that most speech-language pathologists involved in the supervision of graduate students had little or no formal education in supervision. Supervisors tended to heavily rely on information gleaned from personal experiences during their own education and/or engage in self-teaching. Results affirmed the need for formal preparation in clinical supervision as well as a need for the development of new training tools and strategies to support this preparation. The research also suggested the need to investigate how supervisors in other practice settings are prepared prior to assuming this role.

In 2010, *ASHA's Special Interest Group on Administration and Supervision* (SIG 11) sent an e-mail invitation to 1051 affiliates to respond to a "Supervisor Credential" survey; 406 surveys were returned. The following results were obtained when asked: "What kind of training have you received in supervision?" Respondents were asked to check all that applied.

None	1.5%
Informal Networking	65. 0%
Self-study/readings	85.0 %
Workshops/conferences	75.6%
On the job training	76.8%
College or university courses	18.7%
Other	9.6%

The SIG 11 Survey found a much higher percentage of respondents who had attended some formal workshop, conference or course on supervision than did the Northeast Council survey. This may be explained by the fact that the SIG 11 members completing that survey had supervision as an area of interest by virtue of their membership in this ASHA SIG and may have been more committed to seeking formal training.

The SIG 11 survey sought input about the importance of formal training in supervision. Respondents were asked: "How important is formal training in supervision?" Responses were as follows:

Very Important	67.6%

Somewhat important	29.5%
Minimally important	2.0%
Not at all important	0.2%
Do not know/no opinion	0.7%

Other relevant findings from the SIG 11 survey included input about the type of supervisor training in which respondents would participate. Respondents indicated they would participate in the following:

None	1.0%
Self-study/readings	83.9%
Workshops/conferences	96.0%
College or university course for credit	40.1%
Other	11.9%

Respondents were also asked about their potential interest in pursuing a credential in supervision through the question: "If a course of study existed in the area of supervision leading to a credential, how likely is it that you would participate?"

Very likely	53.3%
More likely than unlikely	33.7%
More unlikely than likely	4.5%
Very unlikely	5.5%
Do not know/no opinion	3.0%

This evidence supports our contention that those in supervisory roles often have little preparation for assuming the responsibilities inherent in this role. Additionally, the surveys show that supervisors are interested in more formal preparation and education in the supervisory process.

Knowledge and Skills In Supervision

The *Knowledge and Skills Needed By Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008c) lists 125 separate items reflecting knowledge and skills that clinical educators practicing in the area of speech-language pathology should possess when interacting with students or SLP-As. The items, however, are not classified as introductory, intermediate, or advanced skills.

Although clinical educator training is available via mechanisms such as the ASHA Conventions, state conferences, university-sponsored events, the Special Interest Group 11 (Administration and Supervision) *Perspectives*, and various on-line offerings, the courses vary widely in content and instructional level. It is unknown how closely content of these trainings relates to the knowledge and skills described in the 2008 supervision knowledge and skills document. Additionally, the items listed in the supervision "KASA" document are not categorized as introductory, intermediate, or advanced. Because of the increased attention on clinical educator preparation, it is anticipated that proposals may be developed calling for some sort of standardized, introductory-level training. Therefore, if ASHA or another group were to propose such a voluntary standardized clinical educator training, it would be difficult to know which skills to address in a basic training workshop.

This CAPCSD working group conducted a pilot study (Scott, Bruce, Gavett, Klick, McCollum, Peaper-Fillyaw, & Robinson, 2012), asking 15 experienced clinical educators from a variety of work environments to categorize each skill listed on the supervision KASA as *introductory*, *intermediate*, or *advanced*. Because of the nominal nature of the data, Cohen's Kappa was used to determine the strength of agreement among the categorizations made. Analysis revealed a Kappa value of .44, which represents moderate agreement after chance agreement has been removed.

Inspection of the raw data revealed that 50 items had 100% agreement as being *Introductory* level. [Refer to Appendix A for a listing of these items.] Of the remaining 75 items, only 2 had 100% agreement as *Intermediate* level skills and none had 100% agreement as Advanced level skills. In fact, only 20 of the 125 items were categorized even once as *Advanced*. Although preliminary, these data seem to indicate that there is a fundamental skill set that should be addressed in the development of any uniform supervisory training. Certainly, further exploration of the items and their instructional levels is needed. Attempting to address 125 different aspects of supervision as part of any training would be a daunting task, and a single training course is unlikely to meet the needs of all participants. Thus, creating tiers of learning outcomes would better facilitate course design and offer participants opportunities to advance their skills through multiple courses once they've achieved those that are most basic. Given the small sample size, however, further exploration of the knowledge and skills warranted in speech-language pathology supervision is needed to determine whether the initial 50 skills unanimously identified as *Introductory* would still be viewed as such by a larger pool of experienced clinical supervisors.

State Data on Current Requirement for Supervision Preparation

The CAPCSD working group on the Preparation of Speech-Language Pathology Clinical Educators surveyed clinic directors and department chairs throughout the country to determine which states currently have training requirements imposed by individual state agencies for supervisors of students, clinical fellows (CF), speech-language pathology assistants (SLPA), and those seeking licensure. The following were the findings:

- 41 states currently have no requirements or recommendations for supervision training.
- 13 states have requirements clearly indicated for supervisors (i.e., mandated years of experience, etc.) of non-licensed clinicians (SLPAs, students, CF, etc.)
- 3 states have regulations from their departments of public instruction mandating some sort of requirement (license, training, etc.)
- 9 states require proof of continuing education in the area of supervision
- An increasing number of states are recommending training in the area of supervision

Of those findings, the breakdown in terms of requirements was weighted toward supervisors of SLPAs.

- 2 states require 2+years of clinical experience for supervision of those seeking licensure versus 11 states that required 2+ years of clinical experience for those supervising SLPAs
- 3 states required training/coursework in supervision for those supervising temporary license holders/CFs/students versus 6 states for those supervising SLPAs

In surveying representatives of the various states, it is evident that there is a growing move toward requiring or strongly recommending some sort of training for those responsible for supervising students, clinicians, and SLPAs. In particular, states are increasing their regulation of supervisors of SLPAs.

State-by-state specific requirements are available for review in Appendix B.

Preparation of Clinical Educators in Related Professions

The committee surveyed clinical educator preparation in several related professions. Representatives from Physical Therapy, Occupational Therapy, Athletic Training, Audiology, Nursing, Psychology, Social Work and Therapeutic Recreation were interviewed and asked about preparation of clinical educators. The results are presented in the following table.

Clinical Educator Instruction by Profession

Profession	**Standardized Clinical Instructor Education Available**	**Required/ Voluntary**	**Provider**	**Length of training**	**On-line vs. live**	**Credential Offered**
Physical Therapy	YES	Voluntary	APTA	2 day Basic Training; Advanced training also available	Live	Yes
Occupational Therapy	YES	Voluntary	OTA	2 days	Live	Yes
Athletic Training	NO	Required	University Clinical Ed Programs	Variable	Both	No
Speech/Language Pathology	NO					
Audiology	NO					
Nursing	NO					
Psychology	NO					
Social Work	NO					
Therapeutic Recreation	NO					

As noted in the table, Physical Therapy and Occupational Therapy offer formal training programs for clinical educators. Both training programs are managed by the professional association and culminate in a *Clinical Instructor* credential. Although the OT and PT training is not mandated by the respective professional association, individual university and/or clinical programs may impose a requirement that supervisors of their students and/or professional staff hold the Clinical Instructor credential. The Physical Therapy credential has been offered since 1996 with over 35,000 attending the two-day trainings. In response to demand, the American Physical Therapy Association now offers an Advanced Clinical Instructor Training.

Formal preparation for supervisors is required in Athletic Training but unlike Physical Therapy and Occupational Therapy, the training is developed and managed by each academic program rather than by the professional association. Prior to July 2012, individuals who completed the training earned an *Approved Clinical Instructor* credential. Currently, the title has been

changed to Preceptor and no formal credential is offered. Details about the clinical educator preparation programs for the professions of Physical Therapy, Occupational Therapy and Athletic Training, where training is offered or required, are provided in Appendix C.

Recommendations

1. Formal training/preparation of clinical educators is necessary and should be required. Quality clinical experiences supported by clinical educators knowledgeable about the supervisory process are crucial for supervisees at any level. The 2008 ASHA *Position Statement: Clinical Supervision in Speech-Language Pathology* (ASHA, 2008a) stated, "The highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process," but stopped short of making this a requirement. The recently released Speech-Language Pathology Assistant Scope of Practice (ASHA, 2013) is the first ASHA document to require training for supervisors, but this is limited to supervisors of speech-language pathology assistants.
   A mandate for training in supervision is supported by the ASHA Code of Ethics (ASHA, 2010): Principle I, Rule A. "Individuals shall provide all services competently." and Principle II, Rule B. "Individuals shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their level of education, training and experience." ASHA's Code of Ethics expects that clinicians are adequately prepared to treat clients competently. This expectation should also apply to those who provide the professional service of supervision.
   Training for supervisors of certain supervisees has already been mandated by some state license boards and state departments of education, yet there is no national standard. The time has come to require formal education in the supervisory process to ensure that supervisors are prepared to assume this demanding, complex and important role in our profession.

2. In order to ensure consistency of supervisor preparation, the required clinical educator training should follow a standard curriculum with primary focus on the supervisory process which can be adapted to meet the needs of supervisees at all levels. Training content should be structured around the *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision (2008c)* described in the ASHA document which may include:
   - Establishing an effective relationship with the supervisee
   - Utilizing effective interpersonal communication
   - Structuring learning experiences to assure supervisees will develop critical thinking skills and clinical decision making skills appropriate for their level
   - Using questions to develop clinical reasoning skills
   - Using objective observation techniques and sharing feedback with supervisees
   - Understanding the impact on diversity of supervisory interactions

   The training programs developed should be at basic and intermediate/advanced levels. The basic training curriculum would be required of all supervisors with an optional advanced curriculum for clinical educators for whom supervision is their primary professional role or for whom this is an area of high interest. Individual employers could decide whether the advanced training is required for their setting.

3. Criteria for those who present the training workshops must be developed. Trainers should be experienced supervisors with expertise in the supervisory process.

4. The required training workshops must be widely available to supervisors nationwide. Possible hybrid models of face-to-face workshops complemented with an on-line component should be explored.

5. There should be a reasonable phase-in period before the training requirement takes effect. Supervisors will need time to obtain the training. Additionally, college/university programs and employers will need time to plan for and implement the changes imposed by this requirement.

6. This paper described successful Clinical Instructor credential programs that have been implemented by related disciplines. While we believe the Clinical Instructor credential has merit, we recognize the logistics of developing and maintaining a credentialing program are significant and could delay implementing the training requirement. The focus should be in making sure that supervisors receive needed training; the focus should not be on earning a credential. However, the development of a Clinical Educator Credential in Speech-Language Pathology seems a reasonable long-term goal. As supervisors receive and recognize the value of education about the process, it is likely they would support a credentialing program to acknowledge their skills in this area.

7. Given the likelihood that Speech-Language Pathology students will assume supervisory roles at some point in their careers, students would benefit from an introduction to the supervisory process while in their graduate program.

8. CAPCSD should play a key role in supporting excellence in clinical education as it is a crucial component of any academic program preparing speech-language pathologists. This may include:
    - Continued inclusion of clinical education topics at the annual national CAPCSD conference
    - Monitoring and supporting standards for formal preparation of clinical educators
    - Including explicit language in responsibilities of a CAPCSD vice president to assume responsibility for monitoring clinical education issues
    - Consideration to fund research in clinical education

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Appendix A: Knowledge and Skills

Supervisory knowledge and skills rated with 100% agreement, organized by item number from the *Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision* (ASHA, 2008c) document.

Item	Text
IA2	Recognize that planning and goal setting are critical components of the supervisory process both for the clinical care provided to the client by the supervisee and for the professional growth of the supervisee.
IA4	Understand the importance of implementing a supervisory style that corresponds to the knowledge and skill level of the supervisee.
IA6	Be familiar with data collection methods and tools for analysis of clinical behaviors.
1B1	Facilitate an understanding of the supervisory process that includes the objectives of supervision, the roles of the participants, the components of the supervisory process, and a clear description of the assigned tasks and responsibilities.
1B2	Assist the supervisee in formulating goals for the clinical and supervisory processes, as needed.
1B3	Assess the supervisee's knowledge, skills, and prior experiences in relationship to the clients served.
1B4	Adapt or develop observational formats that facilitate objective data collection.
1B5	Be able to select and apply a supervisory style based on the needs of the clients served, and the knowledge and skill of the supervisee.
1B7	Be able to analyze the data collected to facilitate the supervisee's clinical skill development and professional growth.
IIA1	Understand the basic principles and dynamics of effective interpersonal communication.
IIA4	Understand the importance of effective listening skills.
IIB1	Demonstrate the use of effective interpersonal skills.
IIB6	Demonstrate behaviors that facilitate effective listening (e.g., silent listening, questioning, paraphrasing, empathizing, and supporting).
IIIA4	Understand the use of self-evaluation to promote supervisee growth.
IIIB2	Assist the supervisee in objectively analyzing and interpreting the data obtained and in understanding how to use it for modification of intervention plans.
IIIB3	Assist the supervisee in identifying salient patterns in either clinician or client behavior that facilitate or hinder learning.
IVA1	Understand and demonstrate best practices, including the application of current research in speech-language pathology, for assessing clients with specific communication and swallowing disorders.
IVA3	Understand assessment tools and techniques specific to the clients served.
IVB1	Facilitate the supervisee's use of best practices in assessment, including the application of current research to the assessment process.
IVB2	Facilitate the supervisee's use of verbal and nonverbal behaviors to establish an effective client–clinician relationship.
IVB3	Assist the supervisee in selecting and using assessment tools and techniques specific to the clients served.
IVB4	Assist the supervisee in providing rationales for the selected procedures.
IVB5	Demonstrate how to integrate assessment findings and observations to diagnose and develop appropriate recommendations for intervention and/or management.

Item	Text
VA1	Understand best practices, including the application of current research in speech-language pathology, for developing a treatment plan for and providing intervention to clients with specific communication and swallowing disorders.
VA2	Be familiar with intervention materials, procedures, and techniques that are evidence based.
VA3	Be familiar with methods of data collection to analyze client behaviors and performance.
VB1	Assist the supervisee in developing and prioritizing appropriate treatment goals.
VB2	Facilitate the supervisee's consideration of evidence in selecting materials, procedures, and techniques, and in providing a rationale for their use.
VB3	Assist the supervisee in selecting and using a variety of clinical materials and techniques appropriate to the clients served, and in providing a rationale for their use.
VB5	Assist the supervisee in analyzing the data collected in order to reformulate goals, treatment plans, procedures, and techniques.
VIA1	Understand the importance of scheduling regular supervisory conferences and/or team meetings.
VIB1	Regularly schedule supervisory conferences and/or team meetings.
VIIA1	Recognize the significance of the supervisory role in clinical accountability to the clients served and to the growth of the supervisee.
VIIB4	Provide verbal and written feedback that is descriptive and objective in a timely manner.
VIIIB1	Create a learning and work environment that uses the strengths and expertise of all participants.
VIIIB2	Demonstrate empathy and concern for others as evidenced by behaviors such as active listening, asking questions, and facilitating open and honest communication.
IXA1	Understand the value of accurate and timely documentation.
IXA2	Understand effective record-keeping systems and practices for clinically related interactions.
IXB1	Facilitate the supervisee's ability to complete clinical documentation accurately and effectively, and in compliance with accrediting and regulatory agencies and third party funding sources.
IXB2	Assist the supervisee in sharing information collaboratively while adhering to requirements for confidentiality (e.g., HIPAA, FERPA).
XA1	Understand current standards for student supervision (Council on Academic Accreditation in Audiology and Speech-Language Pathology, 2004).
XA3	Understand current ASHA Code of Ethics rules, particularly regarding supervision, competence, delegation, representation of credentials, and inter-professional and intra-professional relationships.
XA4	Understand current state licensure board requirements for supervision.
XB1	Adhere to all ASHA, state, and facility standards, regulations, and requirements for supervision.
XB2	Assist the supervisee in adhering to standards, regulations, and setting-specific requirements for documentation, billing, and protection of privacy and confidentiality.
XB3	Demonstrate ethical behaviors in both inter-professional and intra-professional relationships.
XB4	Assist the supervisee in conforming with standards and regulations for professional conduct.
XIB1	Model professional and personal behaviors necessary for maintenance and life-long development of professional competency.
XIB2	Foster a mutually trusting relationship with the supervisee.
XIB3	Communicate in a manner that provides support and encouragement.

Appendix B: State by State Data

State Specific Requirements for Clinical Educators

State	Accrediting Agency	Requirements for supervising students, temporary license holders, etc.	Requirements for supervising SLPAs
Alabama	Alabama Board of Examiners of SLP & Audiology	no training required	Supervisors must have two years experience in addition to the supervised professional experience and have at least 10 clock hours of training in the supervision of assistants.
Alaska	Department of Commerce	no training required	no training required
Arizona	Division of Licensing Services; Office of Special Licensing	no training required	Supervisors must have two years experience
Arkansas	Board of Examiners for SLP & Aud.	no training required	2 years of full-time professional experience after the completion of the CF
California	CA SLPAB (licensing)	6 hours of CE in the area of supervision prior to supervising temporary license holders	6 hours of CE in the area of supervision prior to supervising SLPAs
Colorado	Colorado Department of Regulatory Agencies	no training required	no training required
Connecticut	Department of Public Health	no training required	no training required
Delaware	Board of SLP, AuD, & Hearing Aid Dispensers	no training required	no training required
Florida	Department of Education	Supervision workshop	no training required
Georgia	Board of Examiners for SLP & Aud.	no training required	no training required
Hawaii	Department of Commerce and Consumer Affairs	no training required	no training required
Idaho	Speech and Hearing Services Licensure Board	no training required	no training required
Illinois	Illinois Dept of Professional Regulation	no training required	Supervisors must have two years experience in addition to the supervised professional experience and have at least 10 clock hours of training in the supervision of assistants.
Indiana	Indiana Professional Licensing Agency	no training required	Supervisor must have at least three years of clinical experience.
Iowa	Bureau of Professional Licensure	no training required	no training required
Kansas	Department of Aging and Disability Services	no training required	no training required
Kentucky	Board of SLP & Aud.	no training required	no training required
Louisiana	Board of Examiners for SLP & Aud.	no training required	no training required
Maine	Board of Examiners in Speech-Language Pathology	no training required	Supervisors must have a minimum of two year post graduate professional experience and complete at least 10 hours of approved training in the area of supervision
Maryland	Board of SLP, AuD, & Hearing Aid Dispensers	2 years exp.	Supervisors must have a minimum of three years of work experience
Massachusetts	Board of Registration in SLP & Aud.	no training required	Supervisors must have been practicing for 2 years and may supervise a maximum of 3 assistants at any given time
Michigan	Board of Speech-Language Pathology	no training required	not licensed by the state
Minnesota	Department of Health	no training required	Supervisors must have completed at least one continuing education unit in supervision.
Mississippi	Department of Health	no training required	no training required
Missouri	Missouri Board of Healing Arts	no training required	no training required
Montana	Department of Labor and Industry	no training required	no training required
Nebraska	Board of Examiners for Aud. & SLP	no training required	no training required
Nevada	Board of Examiners for SLP & Aud.	No postgraduate professional experience is required.	not licensed by the state
New Hampshire	Office of Licensed Allied Health Professionals	no training required	no training required
New Jersey	Department of Law and Public Safety	no training required	not licensed by the state
New Mexico	Regulation and Licensing Board	License and 2 years experience for SLPA, License for CFY	Supervisors must have a minimum of 2 years of experience
New York	Board for SLP & Aud.	no training required	not licensed by the state
North Carolina	Board of Examiners for SLP & Aud.	no training required	no training required
North Dakota	Department of Public Instruction	Recommended - 10 hours of supervision workhshop, course conference if supervising student in school based practicum	no training required
Ohio	Board of SLP & Aud.	no training required	no training required
Oklahoma	Board of Examiners for SLP & Aud.	Supervisors must have been licensed for a minimum of two years	Supervisor has to agree to attend supervision training
Oregon	Board for SLP & Aud.	no training required	Supervisors must have a minimum of two years experience.
Pennsylvania	Board of Examiners for SLP & Aud.	no training required	no training required
Rhode Island	Board of Examiners in Speech-Language and Hearing	no training required	Supervisors must have a minimum of two year experience
South Carolina	Department of Labor, Licensing and Regulation	no training required	no training required
South Dakota	not regulated	no training required	Supervisors must have at least three years of experience
Tennessee	State Board of Communication Disorders and Sciences	no training required	no training required
Texas	Board of Examiners for SLP & Aud.	no training required	no training required
Utah	Division of Occupational and Professional Licensing	no training required	no training required
Vermont	Office of Licensing and Professional Standards	no training required	not licensed by the state
Virginia	Board of Audiology and Speech Pathology	no training required	no training required
Washington	Board of Hearing and Speech	Supervisor must hold license for at least two years	no training required
West Virginia	Board for SLP & Aud.	no training required	Supervisors must have two years post-licensure clinical experience and must complete initial supervision training
Wisconsin	Dept. of Public Instruction	Course or 10 hours of supervision workshop, conference if supervising student in school based practicum	no training required
Wyoming	Board of SLP & Aud.	no training required	no training required

Appendix C: Clinical Educator Preparation in Related Disciplines

Profession:	Physical Therapy
Program:	APTA Clinical Instructor Education Certification Program
Outcome:	Basic and Advanced credentials offered
Required:	The APTA does not require this preparation of supervisors although many university programs require supervisors of their students to have completed the program.
Program Initiated:	1996
Number completing Training:	35,000 for basic credential, 700 for advanced as of 11/2011
Format of Training:	Live 2 day workshops

Program Development

The initial training materials grew out of a program initiated by the New England Consortium of PT Clinical Education Coordinators. This New England group had designed a supervision training program and was offering this to their own clinical educators. The APTA wanted to develop a similar national offering and offered a RFP which was awarded to three members of the New England Consortium.

Award was for $25,000 in 1994-1996 and covered the time for the principal investigators and support staff needed to assist with project, material development and pilot testing of the assessment component of the program

Goals for the project:

- Easily accessible across the country (reason they have multiple trainers)
- Affordable
- Valued by profession, recognized as a new skill set by administrators
- Result in "credential" - not just a CE product

Currently the training is only available in live workshops. They have discussed on-line offerings, but feel the group learning activities at the workshops and the sharing of information by participants are important components of the live workshops. There have been recent discussion about offering a hybrid model where workshop participants could complete some initial on-line modules and then come together for a live meeting and group activities but no decision about this change have occurred yet.

APTA also offers Advanced Clinical Educator training in response to demand from members.

How Program is Organized and Supported (as of 11/2011)

The individual courses are arranged by a local sponsor who makes all of the logistical arrangements. There is a set fee charged by the APTA ($90 for members), but local sponsors can increase the registration fee to cover additional expenses (room rental, meals, transportation for speakers, honorariums). The APTA does not impose a cap as to what the local sponsor may charge.

Trainers may receive an honorarium of up to $600 for the 2-day workshop. Some trainers will present for less or waive the honorarium as a way of offering service to their profession and/or university or employment facility.

Support provided at the national level by the APTA for the fee charged:

- Course Manuals
- Maintain schedule of courses offered nationally
- Maintain database of certified CIs
- Print and send out certificates
- Certify CEU completion

APTA offers trainer workshops every 2 years. Individuals interested in becoming trainers apply (extensive criteria to be considered as a trainer is posted on APTA website and reviewed by committee). If approved, they are invited to attend the trainer workshop. Demand and the geographical distribution of trainers may influence who to invite to new trainings. For example, the state of California requires the training for anyone working with a PT who has been trained in a foreign country, so there is a high demand in that state. The fee to attend the 2012 trainer workshop is $400.

While the local trainings are supported by the fees charged, the APTA budget does support the staff who manages the CIECP program, marketing, database, printing and other operating expenses.

The CIECP curriculum is reviewed every 5 years and modifications made as needed. The review is conducted by APTA staff as well as by experienced trainers who are recruited to perform this review.

APTA Program Curriculum

As noted above, the APTA CIECP training takes place over two days in a live workshop format. The format includes lecture as well as small group activities and covers the following content:

Section I: The Clinician as Clinical Educator
Roles and Responsibilities
Clinical Instructor Self-Assessment
APTA Guidelines for Clinical Instructors

Section II: Readiness to Learn
Learning Styles
Stages of Learning
Writing Behavioral Objectives for student clinicians

Characteristics of Adult Learners
Educational Objectives Taxonomy

Section III: Facilitating Learning in the Clinical Environment
Expectations of Students
Teaching Methods to Structure Effective Learning Experiences
Teaching/Supervisory Techniques
Guidelines for Providing Feedback

Section IV: Performance Assessment – The Clinical Environment
Formative and Summative Assessments
Anecdotal Record
Critical Incident Report
APTA Clinical Performance Instrument – This is an evaluation tool used by most APTA DPT programs to assess student clinical performance. Practical exercises addressing how to use this instrument are included in the workshop.

Section V: Legal, Regulatory and ADA Issues in Clinical Education
Clinical Affiliation Agreements
Student Dismissal
Students with Disabilities
Student Supervision and Medicare

Section VI: Managing the Exception Student and the Student with Problems in Clinical Education
Identification of the Exceptional Student
Negotiation/Confrontation Form
Learning Contract

Section VII: Answer Keys and Recommended Resources

Profession:	Occupational Therapy
Program:	American Occupational Therapy Association, Inc. (AOTA) Fieldwork Educator Certificate Workshops
Outcome:	15 hours of CE credit toward licensure renewal and a Clinical Instructor credential upon successful completion of the training
Required	No
Size of Training Workshops:	Minimum of 20 participants enrolled in each 2-day workshop
Format of Training:	Live 2-day workshop

Program Description

The clinical (aka. fieldwork) educator training is conducted only in live workshops. The trainers who conduct the workshops have each participated in a 3-day course. The trainer team is composed of one clinician and one fieldwork coordinator from a university OT program. The AOTA determines the frequency of the trainer course based on regional need for training. For example, if the CE 2-day workshops are oversubscribed, plans to offer another trainer course are considered. There have been 3 trainer courses conducted since the AOTA began offering trainer courses approximately five years ago. The fee for the trainer course is approximately $295 for AOTA members and $395 for nonmembers. Trainers sign a contract agreeing to conduct three 2-day workshops over three years. Trainers receive $750 for conducting the 2-day workshop and the host facility receives a $500 stipend for hosting, plus two free seats in the workshop. The curriculum for the 2-day workshop has undergone revision once in the past 5 years.

Goals of the 2-day training for fieldwork educators and academic placement coordinators

- Deeper understanding of the role of fieldwork educator
- Effective strategies to integrate learning theories and supervision models
- Increased skills to provide high-quality educational opportunities during fieldwork experiences
- Interaction with trainers through dialogue and reflections about fieldwork
- Engagement in 4 curricular modules: administration, education, supervision, and evaluation
- Analysis of strategies to support best practice in fieldwork education
- Continuing education credit (15 contact hours) toward licensure renewal

The AOTA offers a *Self-Assessment Tool for Fieldwork Educator Competency*. This document identifies the skills necessary to be an effective fieldwork educator (aka. Clinical Educator in an off-site setting) "whose role is to facilitate the progression from student to entry-level practitioner." This tool enables OTs in the field to assess their own level of competence and identify areas for further development/improvement of their mentoring skills. The use of this tool guides self-reflection for professional growth.

How Program is Organized and Supported

The CE training across the United States is set up by geographic region. For example, Texas/Oklahoma is one region. Qualified trainer teams are designated to serve a given region. The individual 2-day workshops are arranged by a local sponsor at a fieldwork site with a minimum enrollment of 20 participants. Clinical Instructors, OTs, OTAs and Field Work Coordinators are the target registrants. The training is voluntary, but highly recommended by the association. Some settings, such as Methodist Hospital in Houston, encourage all OTs to become certified as fieldwork clinical educators. Following successful completion of the 2-day on-site training, an OT fieldwork clinical educator credential is awarded. The fee for these 2-day workshops ranges from $202.50 to $323.10, depending on whether the registrant is an AOTA member or nonmember, and the number of OTs from the same facility who are registering for the workshop.

Workshop participants receive a fieldwork clinical educator manual that provides extensive detail and guidance regarding such topics as how to establish a student clinical education program in the facility that meets certification requirements, OT student performance expectations, student evaluation procedures, ADA accommodations, various models of supervision and implementation, how to manage challenging students, and how to communicate with university program coordinators.

Profession:	Athletic Training
Program:	Administered by each educational institution
Outcome:	Preceptor
Program Initiated:	Early 2000's
Number completing training:	Over 300 accredited programs in Athletic Training, most at Baccalaureate level
Format of training:	Program autonomy to develop training and evaluation methods

Program Development

Old Standards (effective until July 1, 2012): Accreditation standards for Athletic Training programs require academic programs to develop and deliver preparation in clinical education to all preceptors used in clinical practicum assignments. Programs are free to develop their own training modules; individuals who complete this training are awarded Approved Clinical Instructor (ACI) recognition. ACI's are required to renew/attend another training every 3 years. Required content includes information on learning styles, specifics about a program's curriculum, etc. Training may be online, live or a combination of both. Programs are given flexibility in developing these trainings; training programs are reviewed as part of the accreditation site visit process.

New Standards (effective July 1, 2012): Accreditation Standards for Athletic Training programs continue to require academic programs to develop and deliver preparation in clinical education to preceptors used in clinical practicum assignments; however, some changes have been made to provide programs with greater flexibility. There is no longer an awarding of the credential of Approved Clinical Instructor. The general guidelines for training content in the previous standards have been eliminated, giving programs maximum flexibility to develop training modules specific to the objectives of their program. The requirement to have preceptors (formerly ACIs) attend training every 3 years has been removed. Programs may now send a student to work with a preceptor who has not attended training but this preceptor serves only in a supervisory capacity and is not allowed to assess the student for the purposes of meeting program requirements. This flexibility allows programs to send students to specific sites for a very limited experience (e.g., student health service, emergency room).