

Challenges for Professional Practice in the Next Decade

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ABSTRACT

This article is presented in a question and answer format and shares the thoughts of the 2006 President of the American Speech-Language-Hearing Association (ASHA), Alex Johnson, and current Executive Director of ASHA, Arlene Pietranton, regarding several regulatory issues that the professions of audiology and/or speech-language pathology are likely to have to address over the next decade. Specific topics mentioned include: trends affecting our professions; anticipated service delivery changes; public (i.e., Medicaid and Medicare) and private (i.e., health plans, consumer-driven plans) reimbursement; competing for funding dollars; pay-for-performance; the Individuals with Disabilities Education Act; No Child Left Behind; and ASHA's work with various national organizations and federal agencies in the regulatory arena. Several ASHA resources for further information are listed.

KEYWORDS: Focused Initiatives, funding, reimbursement, service delivery, super trends

Learning Outcomes: As a result of this activity, the reader will be able to (1) identify at least five regulatory issues the professions of audiology and/or speech-language pathology are likely to face in the next decade, (2) describe at least four super trends and their implications for clinical practice, (3) provide at least three examples of ways that the American Speech-Language-Hearing Association's Focused Initiatives are addressing regulatory issues, and (4) identify at least four American Speech-Language-Hearing Association reimbursement resources.

A NOTE FROM THE EDITOR

Academic journals do not usually include interviews. However, we could think of no better way to "pull together" the complicated legal, regu-

latory, and professional practice issues addressed in this publication. Our goal is to apply these concepts and trends in health care to the profession of speech-language pathology. The

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American Speech-Language-Hearing Association (ASHA) activities on behalf of the profession are crucial to our success in a highly regulated and political environment. We asked the following pertinent, challenging questions of our ASHA leader representatives to gauge the “tone at the top,” and to engage our leaders in a conversation about the realities of everyday life within our own version of “all politics is local.”

What do you think are the top regulatory barriers or challenges facing speech-language pathologists (SLPs) and audiologists in the next decade?

It’s important to remember that regulatory matters are driven by federal and state legislative decisions (i.e., “laws”) that precede them, which in turn are subject to the ever-shifting political pendulum of prevailing ideology along a conservative to liberal continuum and an ongoing tug-of-war between federalism and “states’ rights” (i.e., what is decided at the federal level versus deferred to the states). As a result, predicting the future regulatory environment can be compared with looking into a crystal ball! That said, some of the regulatory issues that we believe will continue to be or are likely to become priorities for the professions of audiology and/or speech-language pathology over the next decade are:

- third-party (i.e., Medicaid, Medicare and private health plans) reimbursement guidelines, specifically:
 - (1) Incorporating the professional component (currently restricted to physicians and a few other health-care practitioners) into procedures provided by audiologists and SLPs under the Medicare fee schedule, which could lead to higher reimbursement rates;
 - (2) Implementing outcomes measures under a pay-for-performance system;
 - (3) Moving to electronic record-keeping and transactions (a.k.a. HIPAA) for patient care;
 - (4) Direct access for audiologists under Medicare (i.e., physician referral not necessary); and
 - (5) Supplier status for SLPs for Medicare outpatient Part B services, which would

allow SLPs to apply for and receive a Medicare billing number so they can bill Medicare directly.

- assuring that speech-language-hearing services are provided by qualified practitioners and preempting attempts to remove or undercut professional qualification standards for service providers in schools;
- a heightened demand from payers for scientific evidence demonstrating that services are effective and delivered in cost-effective ways;
- universal licensure that reflects/models ASHA’s standards-based certification requirements to practice in the states and across state lines (i.e., telepractice);
- the growth of Health Saving Accounts (HSAs). As employers see their budgets stretched for health plan premiums, HSAs may create opportunities and challenges for our professions in terms of access to speech-language pathology and audiology services since coverage rules for HSAs are much broader than most health plans and allow the consumer to make choices about where to spend health care dollars; and
- the Medicare outpatient therapy caps, a thorny issue that in all likelihood will be with us for some time to come. The caps were reinstated in 2006 with an exceptions process allowing Medicare patients to receive medically necessary services beyond the financial limitation of \$1740; however, there were many questions about how and when this new exceptions process will be implemented—so we all need to continue to “stay tuned” as the therapy cap saga that began as part of the Balanced Budget Act of 1997 now moves into the ninth year!

For more detailed and current information about billing and reimbursement issues, readers are encouraged to visit “Billing and Reimbursement” in the ASHA and NSSLHA Members section of the ASHA Web site www.asha.org.

Can SLPs and audiologists overcome physician groups’ attempts to “squell” the professions from advancing as independent health professionals?

It is a difficult environment for all health professions and we need to understand that

our colleagues in medicine are also struggling to maintain position. In reality, SLPs and audiologists have seen great progress in the past decade in terms of recognition, independence, and scope of practice. Our professions are in great demand and they continue to grow in health, educational, and private practice settings. With increasing recognition in the health community as well as among consumer groups and individuals, our professions become a concern to those who feel we may be competitors.

What can we do and what should our position be in such an environment? First, we need to stay the course of high quality and excellent value. We need to practice using the highest standards and best evidence. If our services are in demand and continue to be valued because they make a difference, then market forces will continue to drive the need for what we do. On the other hand, if our practices become less than excellent, the “market” (i.e., consumers, referral sources) will go elsewhere. We need to be sure that we are viewing those who would try to “squench” us as customers who benefit from our services as well as adversaries. In reality, the health-care community needs the services provided by members of our professions and we need to be less than shy in partnering in service delivery, demonstrating that what we do makes patients better and saves dollars in the long run.

A second area that we need to be concerned about is communication with our various audiences. We must be eager to communicate at every level about the accomplishments of our professions in service delivery outcomes, with a focus on the benefit to quality of communication and quality of life. We need to stress the value added when our services are coupled with those provided by other health providers. How are services enhanced when a qualified (i.e., certified) audiologist or SLP provides services in conjunction with excellent medical, mental health, or rehabilitative services provided by other disciplines? These stories need to be told over and over again. Additionally, we should to emphasize the *unique* contributions of those in our professions. As health care dollars are guarded jealously by the government, insurers, and consumers we have to be able to communicate in an understandable manner about the essential benefits of our services to those who

need them. We will have difficulty in continuing to market our services unless we explain the unique benefits we offer.

Finally, we need to advocate at every level. Regardless of our intentions to provide high-quality services delivered effectively, we must be attentive to the legislative and reimbursement environment. We also need to be sure that members of our professions understand how to advocate for themselves and for their patients at every level. Communicating with decision makers in the local, state, and national arena should be a high priority for anyone who has a sincere commitment to helping the professions advance from a reimbursement perspective.

Why do SLPs and audiologists always seem to lag behind physical therapists in securing regulatory and public support of our services?

This is certainly a perception that is widely held by ASHA members. The perception is not necessarily a valid one. For example, SLPs and audiologists were the first to require a physician referral for Medicaid rather than a physician prescription. Now both speech-language pathology and physical therapy require a referral rather than a physician prescription. In Medicare, home health reimbursement is better for speech-language pathology services than physical therapy. In 2003 alone, 10 new Current Procedural Terminology (CPT) codes were added for speech-language pathology.

There are, however, some market realities. One must keep in mind that physical therapy is a dominant force in rehabilitation visibility compared with speech-language pathology. The 2004 AdvanceMed study for the Centers for Medicare & Medicaid Services (CMS) found that Medicare physical therapy expenditures represented 75% of Part B while speech-language pathology services were at 7%. Thus, in the governmental health-care system there is much broader utilization of physical therapy services than SLP or audiology services. It is likely that the higher frequency of utilization and larger expenditures for physical therapy contributes to the perception that there is more regulatory support than is seen in audiology and SLP.

Despite far greater utilization of physical therapy services, our advocacy efforts have been

quite successful in obtaining strong support for service to those with communication disorders. Some significant questions for SLPs and audiologists are:

- How can we increase *appropriate* utilization of our services?
- How can we support advocacy efforts to maintain and expand on our history of success in regulatory support?

The answers to these questions are challenging and deserve careful consideration. In fact, ASHA and other professional associations concerned with advocacy and regulatory issues are “obsessed” with these questions. At a specific level, audiologists and SLPs can work to be sure that they are using the scope of practice^{1,2} of their respective professions to be confident that they are offering the full range of services of benefit to their patients. Because the scope is broad, individual professionals rarely provide *all* of the services that are part of their field and so SLPs and audiologists should make it a point to refer to colleagues within the profession whenever appropriate. A second approach to the problem includes increased support of national advocacy efforts. Participation on committees in state associations and in ASHA, financial support of the ASHA Political Action Committee, and positive responses to requests for communication with state and national legislative bodies will continue to enhance our position and assure ongoing attempts to address the reality of expanding our services. Information about ASHA’s annual Public Policy Agenda—which guides the Association’s public policy advocacy activities—can be found at <http://www.asha.org/about/legislation-advocacy/briefs-agenda/>.

Describe how ASHA’s Focused Initiatives address regulatory concerns.

ASHA’s Focused Initiatives are determined on an annual basis based on members’ input about issues facing the professions, which are discussed and prioritized by the ASHA Legislative Council during its annual spring meeting. The ASHA Executive Board then determines how many Focused Initiatives the Association will have for a given year, the desired outcomes for each of the Focused Initiatives, and

whether a particular Focused Initiative will be a single or multiyear effort. Here are the 2006 ASHA Focused Initiatives and their associated issues:

- doctoral shortage—(1) There is a critical shortage and continuing attrition of Ph.D.-level faculty in higher education that will affect preparation of professionals as well as the conduct of research in communication sciences and disorders; (2) tradition has limited the role of research instruction in all levels of the curriculum, resulting in a lack of a coordinated academic culture and scientific/research personnel preparation experiences in the discipline that promote careers as teachers/researchers in higher education; and (3) there is no coordinated data collection and dissemination system related to doctoral programs that allows for the exchange of information on research training experiences, funding levels, scholarship activities, and those who enter academia upon completing the Ph.D. degree.
- evidence-based practice—A robust and actively used high-quality basic, applied, and efficacy research base in communication sciences and disorders, related fields of study, and related functions for the discipline and professions is essential to provide evidence-based clinical practice and quality clinical services and is important for the future of the professions;
- health-care reimbursement—Coverage rules and reimbursement rates are increasingly affecting access to, and scope of services provided by, audiologists and SLPs;
- personnel issues—(1) We must improve the acquisition of data and information about the underlying factors that lead to persistent vacancies for qualified SLPs and audiologists in educational and health-care employment settings; and (2) we must examine the issue of persistent vacancies that result in requests to lower state certification/licensure requirements for SLPs and audiologists and employment of less-qualified individuals to provide services.

Several of ASHA’s current Focused Initiatives include strategies that specifically

address legislative and/or regulatory issues. For example, the doctoral shortage led to the pursuit of federal legislation that would recognize Communications Sciences and Disorders (CSD) graduates as shortage specialties that have access to increased federal professional development and training funds, federal student financial aid, federal research funds, and loan forgiveness policies. Evidence-based practice has encouraged the pursuit of increased federal funding for high-quality research to support evidence-based practices. Regarding health-care reimbursement, some ASHA members are developing practice policy documents for school-based SLPs addressing what constitutes “under the direction of” when supervising nonqualified clinicians for Medicaid reimbursement of speech-language services. In terms of personnel issues, strategies include developing and disseminating information to state associations on the impact changes in IDEA may have on personnel qualifications in the states; actions that may be taken by state education agencies to reduce personnel qualifications; teaching others how to deal with state actions to reduce personnel qualifications and to advocate for the use of qualified personnel to provide audiology and speech-language pathology services and maintain the master’s degree requirement for school-based speech-language pathologists.

For more detailed information about ASHA’s current Focused Initiatives, readers are encouraged to visit “Leadership, Awards and Initiatives” in the Members and Professionals section of the ASHA Web site www.asha.org.

How will service delivery change over the next decade for SLPs? For audiologists?

The American Society of Association Executives (ASAE) & The Center for Association Leadership³ has identified eight strategic trends that will affect professional associations over the next decade. These trends have significant implications for service delivery in our professions and we can benefit from considering our work and our plans in the context of these trends. The trends, as outlined in the ASAE report, are described below with our interpre-

tation as to what they might mean to service delivery.

Demassification refers to the breaking up of mass markets into smaller, more focused segments. It is likely that consumers will want specific services tailored to their own situations and delivered in settings and locations that are comfortable and convenient. Services will have to be provided in a way that does not appear to be “adapted” to the consumer; rather the service will be designed specifically for the consumer’s communication and health needs. For example, there will continue to be increased demand for service delivery in the consumer’s primary language by an individual fluent in that language.

Consider this scenario: You are a service provider in a geographic location with many individuals whose primary language is not English. Although you are fluent in Spanish and English, you are not fluent in many of the languages spoken by your consumers. How will you focus services to meet the expectations of consumers? What skills, technologies, resource persons, and information will you need to accomplish this expectation?

Unbundling refers to the loss of appeal of “one size fits all” products and services. Consumers will continue to want more and more choice in the services being offered. Patients are likely to desire an opportunity to decide among treatment options. Clinicians will probably have to be able to provide reasonable choices to the patient.

Consider this scenario: Your audiology practice has decided to provide an array of services to adults with hearing impairment. Although you have typically provided basic evaluations, hearing aid services, and brief follow-up, you have decided to add to the menu of services that you provide. You add “quality of communication” services to your population, ones that impact social goals and improved “hearing” ability. How will you do this?

Scrimping. As individuals expect a greater return for their money, personal and social payoffs will be increasingly important to consumers of the future. Clinical service providers will need to be able to speak to specific, not general, benefits to meet these expectations.

Moreover, SLPs and audiologists will have to be able to articulate the expected outcomes of a procedure to secure the patient's agreement to proceed. Clearly, the trends being set forward in our evidence-based practice initiatives will be invaluable to clinical service providers in demonstrating outcomes.

Consider this scenario: The SLP program in a large university hospital is asked to outline the benefits of services provided to patients with dysphagia. The SLP's first draft list provides the predictable examples associated with improved nutrition, timely hospital discharge, and avoidance of a feeding tube. The hospital director indicates that the list is a "good start" but wants information included about specific social, personal, and health benefits associated with improved swallowing for patients with various conditions. You decide to organize the benefits around the categories of acute, chronic, and degenerative conditions and to write the list exclusively from the perspective of quality of life and quality of communication issues. How would the list look? What justification would be needed to support the claims made on the list? How might existing information be used (National Outcomes Measures [NOMS] data, outcomes measures, other tools) to guide the listing?

Wave 3.1. This refers to Alvin Toffler's "Third Wave" concept.⁴ Toffler was referring to a shift toward societies that rely heavily on information to generate knowledge. It is this use of knowledge that becomes important in the "Third Wave." Data and other information, while serving as the basis for decision-making, is not the need. The need is to shift attention to the decisions and knowledge that are generated based on the information. Therefore, clinicians will need to use the data available to them to support their decisions, and will need to be able to *know* the best test, best product, or most successful treatment choice for their patients. Patients will want to *know* that their clinician has considered the best information to make the best decision possible.

Consider this scenario: The Director of Rehabilitation has asked you to provide a list of hard facts, with supporting evidence, for your treatment practices. She wants proof that

what you do with your caseload works efficiently and effectively. How would you proceed?

Virtualization. Virtual "communities" are important to consumers now and this is likely to increase in the future. It is likely that service programs of the future will offer a variety of online services and that clinicians will have to develop, as part of their service delivery model, skills in facilitating communication among various constituencies.

Consider this scenario: Working in an outpatient rehabilitation setting, an SLP's caseload consists of many patients who have sustained a traumatic brain injury as a result of motor vehicle accidents. Many of the patients' families are having difficulty participating in the treatment because of scheduling issues, so the SLP decides to form an "online community" to provide information, support, and interaction about how best to assist with generalization issues and adapting skills learned in therapy to home settings. How would this be accomplished? What would be included in the online community?

Cyber-mobbing refers to directing the power of the Web for information. It is closely related to the virtualization trend. It is likely that the Web will provide highly individualized and customized marketing and information-sharing opportunities for service providers. When one considers the opportunities for directing specific communications and information to subgroups of consumers in a convenient and affordable manner, the trends regarding demassification and unbundling are also addressed.

Scrutiny. Consumers will be able to track legal and ethical standards and behavior and will be able to compare outcomes data and pricing to determine true value of services. Clinicians will want to be sure that they meet the highest standards of practice, conform to rules for continuing education and specialization requirements, and indicate that they aspire and conform to high ethical standards. It is likely that more so than in previous generations consumers will want "proof" of qualifications and quality.

Consider this scenario: How would you provide evidence that you meet all of the

qualifications desired by your consumers/patients? How will membership in professional associations help you meet this goal? What role will certification play? What about specialty recognition? How will you communicate “quality” to your consumer audience?

Counter Americanism. According to the super trends report, the long-standing dominance of American styles, values, and products is diminishing as Asian and European economic and political values change. While the impact on direct service delivery is likely to be minimally affected by this trend, there are some considerations to be made. For example, clinicians who live in sections of the country with large bilingual populations or communities where English is a second language are likely to face increased demand for development of skills in additional languages. Similarly, it is more important than ever to embrace opportunities to learn about multicultural issues in service delivery.

In addition to these “macro” trends, there are many other factors that we believe will impact service delivery provided by SLPs and audiologists over the next decade. These include technology, genetics, adult learning styles, more culturally diverse populations, and a need for evidence to validate clinical practice. A few specific examples of these trends are as follows:

- in the area of technology, facilitating the remote delivery of services using various methods of telepractice, and the ongoing improvement of software and hardware to accommodate the needs of persons with disabilities;
- families who are increasingly involved in management of problems and who need, and expect, information presented in clear, culturally appropriate ways;
- the stimuli and strategies that clinicians use to facilitate communication will be more patiently shared with clients, their families, and other professionals.
- the increased use of scientific evidence to support clinical decisions about which treatment approaches are effective and the duration of treatment needed for individuals throughout the life cycle and across all types of communication disorders;
- clinicians who offer SLP services may be in their second careers. These individuals will bring with them new and different ideas and experiences from a variety of disciplines and venues;
- the business aspects of clinical practice will be viewed more readily as integral components of a successful clinical practice;
- the populations treated will include more newborns and infants as well as older geriatric patients with communication, feeding, and swallowing problems;
- there will be increased competition for funding and reimbursement dollars.

How will the transition to a doctoral-level profession change the practice of audiology in the next decade?

We think it is important to remember that audiology’s transition to doctoral-entry is a standards-driven change based on the knowledge and skills required for practice of the profession. In considering the history of other professions that have made that transition for similar reasons (i.e., not solely or primarily for the “status”—real or perceived), our belief is that the key changes are likely to be:

- the profession will become better known for its knowledge, expertise, and high ethical conduct;
- audiologists will use support personnel (e.g., audiologic assistants) more regularly as part of cost-effective models of service delivery;
- there will be an increase in the number of audiologists in private practice as a result of increased autonomy and reimbursement for audiology services;
- the impact of evidence-based practice will foster greater collaboration between practitioners and researchers.

What progress has been made in securing public and private health plan payment for speech-language pathology services in the last 5 years, and what is likely to be achieved in the next 5 to 10 years?

Due to double-digit increases in health insurance premiums, ASHA’s advocacy efforts with private health plans over the past 5 years have

focused first on maintaining current coverage levels for speech and language services—to help assure that the profession and those who need our services don't "lose ground." Most private health plans provide a speech and language benefit; however, coverage varies considerably from plan to plan. Many plans provide coverage for speech-language services only when necessitated by accident or illness and exclude coverage for the pediatric population.

In 2004, ASHA developed a long-term strategic plan for addressing private health plan reimbursement issues. The plan identified (1) unique actions, approaches, and messages to penetrate the markets for various specific target groups/buyers (e.g., employers, human resource benefit specialists, unions, government, health-care plans); and (2) numerous possible actions ASHA could initiate to add speech, language, and hearing services as a separate benefit (similar to dental and vision) to health plans.

The specific strategies or action items were incorporated into ASHA's Focused Initiative on Health Care Reimbursement work plans beginning in 2005 to further focus and define ASHA's advocacy efforts in the area of private insurance advocacy. They are already yielding a positive impact. Two recent examples are (1) a meeting of the Michigan Speech-Language-Hearing Association Provider Liaison Group with the Director of Medical Affairs, Clinical Applications at Blue Cross Blue Shield of Michigan (BCBS-MI). This resulted in a commitment from BCBS-MI to re-examine their benefit options for BCBS-MI enrollees using ASHA's model speech, language, and hearing benefits as the framework; (2) the clinical coverage guideline recommendations provided by ASHA to assist with the development and administration of a speech-language pathology benefit for Wellpoint and Anthem (which merged recently to form one of the largest private health plans in the United States).

On the other hand, SLPs are also experiencing heightened challenges in certain coverage areas such as cognitive rehabilitation and auditory processing because some health plans regard these services as investigational or consider the available data to be insufficient as to whether these services result in beneficial health outcomes. Legislative efforts have resulted in

some gains, such as coverage for autism-related speech-language services, but they are increasingly difficult to achieve in the current political climate. Individual appeals sometimes yield positive outcomes. For example, the BCBS-MI was recently required by the Michigan State Department of Insurance to overturn a denial and cover speech and language treatment for a child with verbal apraxia. In addition, after a 20-year effort, SLPs in Michigan also were successful in getting BCBS-MI to cover voice treatment.

The Medicare Fee Schedule heavily influences reimbursement rates for all payers. Fortunately, reimbursement rates for speech-language services have been comparatively well-maintained due in large part to the advocacy efforts in the public arena of ASHA's Health Care Economics Committee (HCEC) with the American Medical Association's CPT coding system and the CMS (see Swigert,⁵ this issue).

We also should keep an eye toward group health plan changes that are on the horizon, which will give consumers considerable freedom in deciding how their health care dollars are spent—and should create more access to speech-language pathology and audiology services.

- **HSAs.** HSAs were authorized by the Medicare Modernization Act of 2003. HSAs allow employer contributions, employee contributions, and tax-free rollovers of a portion of the unused flexible spending account. The HSA is also combined with a major medical insurance policy. The unused portion can be rolled over from year to year. With an HSA, if the medical expense is recognized by the IRS, it is recognized by the HSA.
- **Flexible savings accounts.** This option, which many employers have adopted, has been available since the late 1970s, and there is a definite niche for these plans. Pretax dollars can be contributed by the employee in an account to pay for health-care services not covered by the employer's health plan and can be used to pay the employee's share of the health-plan premium. In the beginning of every year, the employee must predict how much money will be needed for additional health-care expenses. However, any money

left in the account on December 31st is forfeited.

As the economy, labor market, and health-care benefit industry remain in constant flux, we believe that SLPs will never be able to stop advocating for coverage of services. As a profession, we need to continuously adapt and change our insurance advocacy strategies to meet—and successfully compete in—a constantly changing environment.

What is ASHA going to do to work with CMS, the Agency for Healthcare Research and Quality, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the National Quality Forum, and others to ensure an important place for SLPs and audiologist in the patient safety and quality indicators arena?

One of ASHA's constant themes to these groups is the critical importance of including hearing, speech-language, cognitive, and swallowing evaluation and intervention for patients to provide appropriate patient care. ASHA provides these recommendations as written comments or in public meetings when CMS solicits feedback for developing quality indicators. ASHA members have been invited as experts to contribute to discussions of quality indicators for both long-term care and home health. ASHA has attended preconference meetings and participated in the 2005 White House Conference on Aging to develop recommendations for additional research and action in the field of aging. Other organizations such as the Alzheimer's Association have sought ASHA's participation and input in their Campaign for Quality Residential Care.

ASHA and other professional associations participate on JCAHO's Professional Technical Advisory Committees (PTAC) for their accreditation programs for hospitals, home care, ambulatory care, long-term care, and behavioral health programs. This allows ASHA to monitor JCAHO's activities and to collaborate with other groups in the development of safety and quality initiatives. Through ASHA's role on the PTACs, we provide comments on proposed standards and participate in discussions about trends and new initiatives, including the National Patient Safety Goals. ASHA has also

participated in joint meetings of government agencies involved in emergency preparedness. Reports of disaster relief efforts for victims of Hurricane Katrina demonstrated the critical importance of understanding how to address the needs of individuals with impairments in communication, cognition, or literacy.

Now that JCAHO is no longer announcing surveys, and instead is focusing on continuous survey readiness, how can SLPs and audiologists play integral roles in helping their employer health-care organizations achieve excellence?

Anyone who has worked in a JCAHO-accredited facility has experienced the intense focused effort and expenditure of resources that preceded a scheduled survey. One impetus for JCAHO to move to unannounced surveys was to ensure the continuity of quality and safety throughout the 3-year accreditation period. JCAHO's survey process has evolved from a focus on individual departments to an examination of facility-wide processes, including the "tracer methodology," in which surveyors randomly select patient charts to evaluate patient safety measures and quality of care.

Several years ago, JCAHO began requiring accredited facilities to select outcome measures and report the data they gathered. ASHA's NOMS system using Functional Communication Measures was included by JCAHO as one of their accepted reportable measures. Facilities that have adopted NOMS to meet JCAHO standards are "ahead of the curve" in anticipating the CMS's projected move to pay-for-performance. They also have a source of data that is more sensitive than Functional Independence Measures for tracking their patients' functional progress.

SLPs and audiologists must continue to document compliance with JCAHO's standards for providers (e.g., that they are properly credentialed and have written competencies) and collaborate with other clinical areas to ensure that other JCAHO standards for patient care are met (e.g., patient education, pain management). In addition, SLPs and audiologists should participate in ongoing performance improvement activities to continuously evaluate and improve care processes, quality indicators, and treatment outcomes.

What successes have SLPs realized in promoting their professionalism in public education? Conversely, are some SLPs still practicing in broom closets?

SLPs' professional status in schools varies greatly across buildings, districts, and states. While this may in part reflect the breadth and quality of services provided by individual SLPs, it is also related to the level of awareness of other educators regarding the critical role that SLPs play in students' academic and social success. ASHA is addressing this directly at the national level through liaisons with key national organizations representing education groups such as principals, special education directors, special education and general education teachers, school psychologists, and reading specialists. The focus of this work has been on SLPs' expanded roles and responsibilities in the schools, particularly related to literacy, prevention, classroom-based services, and early intervening services.

Much of this work must also be done at the local and state levels. ASHA has developed policy documents and other resources to assist members in advocacy efforts. These include: documents on workload, literacy, facilities, and school-based roles and responsibilities; pages on ASHA's Web site regarding salary supplements, workload, IDEA, NCLB, and Medicaid; information on state and local advocacy; and several member forums and group e-mail lists to encourage networking and support among school-based colleagues. Information about these and other resources for school-based SLPs can be found at <http://www.asha.org/members/slp/schools/>.

The success of these efforts has been realized in various ways. A few examples include the following:

- more SLPs report being involved in state and local literacy initiatives, district-wide curriculum committees, and innovative classroom-based programs;
- members also report gaining administrative support for improved working conditions such as appropriate facilities, laptop computers, and other needed equipment, and financial support for continuing education and/or license and certification fees;
- state and local education agencies in over a dozen states have adopted ASHA's workload approach to caseloads, which incorporates SLPs' expanded roles and responsibilities both with and on behalf of students with and without disabilities; and
- salary supplements have been won in over 50 districts nation-wide.

How has the Bush administration's NCLB initiative affected the practice of speech-language pathology in the schools? What is your advice to school-based practitioners in dealing with so many politically-based efforts in public schools?

NCLB has broadened SLPs' roles in the schools, moving our services into the regular education setting in several ways. SLPs are now more involved in literacy initiatives—both with students with disabilities as well as with those who are not identified as having a disability, but are struggling academically. SLPs make important contributions to determinations regarding test accommodations, alternate assessments, and alternate standards. Service delivery options now include more opportunities for consultation and classroom-based services.

ASHA's 2004 Schools Survey included a question on the impact of NCLB. Over 20% of respondents indicated increased paperwork (41%), increased time in prereferral activities (37%), increased literacy activities (36%), increased role in implementing test accommodations (26%), and increased caseload size (21%).

It is essential that school-based SLPs be well-informed about federal and state mandates and policies (see the article by Whitmire and colleagues⁶ in this issue). ASHA has developed several resources to help members find information at the state and federal levels and has advocacy resources to support members in influencing and shaping policy decisions. Information about these resources is available on the ASHA Web site at www.asha.org or by calling the ASHA Action Center at 1-800-498-2071.

What are the issues related to Medicaid-covered services in schools?

Clinical practitioners must be careful not to commit fraud, even unintentionally. This requires knowledge of state and federal policies regarding Medicaid, as well as compliance with ASHA's Code of Ethics. School-based practitioners must be diligent about documentation, while making it as streamlined as possible according to state guidelines. If asked to "sign off" for services provided by unqualified personnel, they must provide a level of direction and supervision that they can justify as adequate to ensure that services were provided in a safe and efficient manner in accordance with accepted standards of practice. It is also important to keep in mind and comply with the ASHA Code of Ethics. For example, Principle I requires that we hold paramount the welfare of the client being served when making decisions.

School-based SLPs should continue to advocate for release time and fair compensation for Medicaid billing and for a percentage of funds to be allocated to speech-language programs. Several resources are available on ASHA's Web site at <http://www.asha.org/members/issues/reimbursement/medicaid/>, including four policy documents with "under the direction of" guidance as previously mentioned, and through technical assistance with staff by calling the Action Center.

In 2004 ASHA established a School Finance Committee, whose charge includes developing strategies for appropriate coverage and reimbursement and to help members better identify and understand complex funding processes. The Committee has developed a Web page on the ASHA Web site at www.asha.org/about/legislation-advocacy/schoolfundadv to help members understand and access funds at the federal, state, and local levels; this includes a comprehensive directory of resources and a section devoted to Medicaid. The Committee is also preparing resource materials (expected to be ready later this year) to address questions such as: What state agency monitors local education agency (LEA) participation and billing? What are the state requirements for how LEAs can use Medicaid reimbursement? Who keeps track of the provider qualifications? and Who in the district office is responsible for Medicaid claims?

Understanding Medicaid funding processes will become increasingly important for school-based ASHA members, as Medicaid funds become less available due to state budget cutbacks. Simply put, those who are well informed will be in the best position to access funds for their programs and services.

What is your best advice to SLPs and audiologists for successful clinical practice in the next 10 years?

This is an easy—and fun—question!! Our "top 10" suggestions are:

- continue to develop professionally as new information appears in the literature—keep your knowledge and skills on the cutting edge;
- meet your patients' needs—take time to listen to your patients and their families/caregivers and be dynamic yet sincere in your interactions;
- be knowledgeable of evidence available to support clinical practice and decision-making and actively engage in research and clinical practitioner partnerships;
- find ways to apply technology to clinical practice and data management that will save time and enhance the quality of services;
- mentor a student or colleague on a regular basis;
- be entrepreneurial;
- use dynamic marketing strategies;
- volunteer with national (ASHA) and state speech-language-hearing associations—you will "get back" as much as you "give";
- be an advocate on behalf of the speech-language pathology profession—speak up and influence those in decision-making positions;
- let people know that you love what you do!

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