Consumer Satisfaction with Speech-Language Pathology Services in University Clinics: Implications for Student Supervision

Monica Gordon Pershey
Sheree Reese

ABSTRACT. This study examined consumer satisfaction with speech-language therapy services in two university clinics as reported by 96 clients and caregivers. Satisfaction was related to student speech-language pathologists' communication with clients and families. Explaining clients' communication problems, discussing session objectives, describing progress, providing home programming, and offering strategies for maintaining skills after discharge contributed to perceptions of effective service. Survey findings hold implications for supervision of student clinicians. Positive feedback confirms that students are providing quality service and supervisors are teaching clinical skills and managing service delivery. Feedback that points out deficiencies can help students and supervisors set goals for improvement.

Monica Gordon Pershey, EdD, CCC-SLP, is Assistant Professor, Department of Speech and Hearing, Cleveland State University, 2121 Euclid Avenue, MC 431B, Cleveland, OH 44115-2214 (E-mail: m.pershey@csuohio.edu).

Sheree Reese, EdD, CCC-SLP, is Associate Professor in Communication Disorders and Deafness, Kean University, 1000 Morris Avenue, Union, NJ 07083 (E-mail: sheree.reese@verizon.net or sh-reese@comcast.net).

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University programs in speech-language pathology have the responsibility of preparing students to provide quality clinical services to the public. Evaluation of student performance and clinical effectiveness is an essential component of this educational process. In addition to the evaluative judgements of qualified clinical supervisors, another way to assess the quality of services provided is by measuring consumer satisfaction with services (Larson & Kallail, 1987). Several authors have noted that clients are often the best source of information on the effectiveness and outcomes of services (American Speech-Language Hearing Association [ASHA], 1997; Frattali, 1991; Nelson, Hayes, Larson, & Batalden, 1989; Waldowski, 2002). Consumer satisfaction conceivably predicts that the habilitative or rehabilitative value of goals, procedures, and activities implemented with a satisfied client will also be of value to other clients (Hawkins, 1991).

Consumers who choose university-based therapy are selecting a unique environment and may be interacting for the first time with conditions that are specific to this setting, e.g., negotiating a large, crowded campus; working with pre-professional clinicians who are providing services in order to earn a grade and university course credit. The consumer's choice of therapy setting may be made due to financial and/or geographic restrictions. Characteristics of the consumer (age, affluence, mobility, familiarity with speech-language therapy, etc.) influence his/her acceptance of the situational variables particular to university clinics (see Schwartz, 1991).

The purpose of this study was to measure consumer satisfaction with speech and language therapy services provided by two university clinics in different regions of the United States. An allied purpose was to discuss the impact of clients' perceptions of therapeutic outcomes on subsequent supervisory practices and program management. The application of clients' perceptions of therapeutic outcomes to ensuing supervisory approaches and program management in university clinics is not yet well-documented (see Pickering, 1987; Dowling, 2001). Research to date has focused on the converse, that is, the impact of supervision on students' clinical performance (Dowling, 1993) and on ensuing therapeutic outcomes (Anderson, 1988). However, where continuous process improvement (Dowling, 2001) is a clinic's organizational goal, supervisors and supervisees must collect outcome data and repeatedly

assess the quality of outcomes. The relationship of supervision of clinicians in training to the assurance of providing quality services at university clinics must be well-defined, data-driven, and well-documented (Dowling, 2001; Shapiro, 1994). This process allows staff to develop an action plan to improve a clinic's performance. This study sought to identify consumer needs and expectations which might be considered by university clinic personnel as they assess their programs and consider approaches for configuring clinic practica that will prepare graduate students well and provide services to clients in the most effective and efficient ways possible. Information obtained from consumer surveys can be directly applied during the supervisory process of clinical teaching, that is, the frequent reflective interaction between students and supervisors which furthers students' development of clinical skills (Anderson, 1988; McLeod, Lincoln, McAllister, Maloney, Purcell, & Eadie, 1995; Shapiro, 1994). Discussion of consumers' views is a learning/teaching strategy that can help students and supervisors find productive ways of promoting therapeutic gains.

CONSUMER SATISFACTION: THREE DECADES OF ASSESSING QUALITY OF CARE

Since the 1970s, the use of consumer satisfaction surveys has helped speech-language pathologists (SLPs) determine how well they meet consumers' expectations (Frattali, 1991; Chapey, 1986; Rao, Goldsmith, Wilkerson, & Hildebrandt, 1992). According to Schwartz and Baer (1991) and Dowling (1987; 2001), using evaluative feedback from consumers is an important tool for program planning, evaluation, and restructuring, as well as for fostering student SLPs' critical thinking and problem-solving abilities. Ideally, program personnel can poll a portion of consumers and use these data to anticipate which features of a program may be accepted and which may be rejected by a greater number of consumers. Consumers who do not accept a program's procedures and personnel may refuse to commence services or may withdraw from the program; therefore, gathering information about potential areas of consumer dissatisfaction before rejection actually occurs could save a university program from undesirable consequences. Supervisees often benefit from understanding how their endeavors actualize both consumers' expectations and organizational goals (Dowling, 2001).

Most surveys of satisfaction with speech-language pathology services have asked clients to consider several dimensions relevant to quality care: access to services, responsiveness of staff, hours of operation, convenience of location, availability of parking or public transportation, adequacy of facilities, costs, professional conduct and competence, family involvement, and information-related issues such as referral to other services and agencies (ASHA, 1989; Chapey, 1986). Both interpersonal and technical aspects of care must be considered (Frattali, 1991; Rao, Goldsmith, Wilkerson, & Hildebrandt, 1992). Chapey (1986) summarized satisfaction issues as relating to access to care, human interactions, clinical expertise, perceived outcomes (therapy perceived as worthwhile and functional; see also Waldowski, 2002), and physical environment.

While all service delivery sites face issues of clinical accountability, the question of whether clients' needs are being met by clinicians is intensified when the service provider is still in training (Anderson, 1988). Supervisors collect data on student performance (Dowling, 1993; Pickering, 1987; Shapiro, 1994) but clients' opinions of the effectiveness of therapy are invaluable. Some consumer survey items may be particularly relevant to university clinics. These considerations include disruption in continuity of services (due primarily to semester breaks and rotation of student clinicians) and considerations of clinician competence, thoroughness, professionalism, and interpersonal sensitivity (Chapey, 1986; Larson & Kallail, 1987).

Consumer feedback may facilitate the process of supervising student clinicians. Anderson (1988) reported that a poll of the supervisory needs of speech-language pathology students revealed that students wanted their supervisors to coach them in becoming procedure-oriented and in providing feedback to clients. Consumer survey data can provide information about areas where students feel less secure–to borrow from the example of the Anderson case, to assess whether particular procedures were successful or whether feedback to clients was sufficient. Consumer data may clarify clients' viewpoints and, accordingly, guide intensive student supervision that is integrated with students' perceived supervisory needs. As Dowling (2001) stated, "[d]ata collection is a key to professional development in the context of supervision. The intent of data collection and analysis is to objectify . . . clinical performance. . . . It . . . makes the testing of assumptions regarding efficacy possible. Most importantly, when actively incorporated into the supervisory process it enhances the clinical problem-solving abilities of both the supervisee and supervisor" (p. 32).

LIMITATIONS OF SURVEY RESEARCH

Methodological concerns that affect validity and/or reliability can arise when distributing a consumer survey. Survey data may not be truthful (valid) due to a lack of confirming or refuting independent evidence. These data may not be reliable (trustworthy), that is, be objectively true over time and not just the momentary opinion of the respondent (Olswang, 1998). In this regard, the value of survey data as feedback to clinicians in training may be slightly compromised. Six potential reliability and validity concerns are enumerated below.

First, surveys can be a retrospective or a concurrent tool (Frattali, 1991; Harper Peterson, 1989). Clients' recollections of past events may be imprecise. Effective feedback to student clinicians should be descriptive and specific (Dowling, 1993; 2001; Dowling & Wittkopp, 1982; Shapiro, 1994). This points to the need to prepare very precise survey items that would obtain, where possible, unequivocal responses.

Second, there is no way of really knowing whether an anonymous survey was filled out by a knowledgeable and truthful party. For example, although a respondent identifies him/herself as a client's parent, the survey may in fact have been completed by someone other than the parent. Third, not all clients are "created equal." An individual with a persistent problem who has had numerous courses of therapy may view satisfaction with treatment outcomes differently than a person who had a short course of therapy that corrected a problem that was amenable to treatment. Shapiro (1994) noted that a valuable aspect of self- or programmatic analysis is gaining familiarity with the strengths and limitations inherent in research procedures and instrumentation. Student clinicians should realize that surveys may yield a certain amount of faulty data that are not likely to expedite development or refinement of clinical management skills, because these data do not offer a solid basis for problem-solving. However, anomalous data may cultivate students' ability to define clinical problems experienced by clients who accomplish varying degrees of success.

A fourth but related concern is that clients may not really be judging quality of care but could actually be reacting to whether services met their preconceived expectations (Frattali, 1991; Rao, Goldsmith, Wilkerson, & Hildebrandt, 1992). A student clinician's adequate understanding of clients' expectations may facilitate the implementation of more appropriate goals and treatment interactions (Reynolds, Ogiba, & Chambliss, 1998). Anderson (1988) stressed the importance of shared expectations. This implies that the client and clinician perceive their

own and each others' behaviors, roles, and responsibilities similarly. Without this convergence of perceptions, the client may view the clinician and the institution she represents unfavorably. No matter how accurately student SLPs view their own behaviors, or how precisely supervisors assess students' areas of strengths and needs, program effectiveness is significantly affected by how student SLPs are viewed by the clients they serve. It is difficult to predict which attributes of service delivery a client will ascribe value to; however, clients frequently identify feeling comfortable, safe, and reassured, being kept informed, and being listened to by staff as important service delivery variables (Harper Petersen, 1989).

Fifth, it may be reasonable to ask whether client satisfaction has anything to do with objective changes in functional speech-language capabilities. The limitations of data based upon self-report of progress must be noted. Consumer satisfaction is most useful when it serves as an indicator of how well the client has achieved functional gains. Hawkins (1991) proposes that the degree of satisfaction that a consumer reports is often a result of the therapeutic goals that were set, the procedures used, the relationship of therapy activities to the client's natural environment, and the outcomes achieved. Rao, Goldsmith, Wilkerson, and Hildebrandt (1992) hypothesize that the satisfied consumer is likely to have experienced improvement, perhaps due to having been cooperative during therapy (Frattali, 1991; Larson & Kallail, 1987). Indeed, in one anecdotal report (Wender, 1990), a client noted preference for a therapist who is personable over a therapist who is technically competent. Information about client satisfaction is indispensable despite its limitations as an indicator of therapeutic progress (Donabedian, 1988).

Perhaps the biggest obstacle to comparison of client satisfaction with objective measures of therapy outcomes is that it is not possible to assure a client that his/her response to a survey will be anonymous if a comparison to his/her therapeutic outcome measures is being made. One possible way around this is to send surveys only to clients who are selected on the basis of having made gains or only to clients who have not shown objective improvement, but this approach would no doubt have its shortcomings. In time, ASHA's collection of national outcome data may assure that a very large number of consumers have been asked the same questions about both their satisfaction with services and their therapeutic success. In the future responses gathered to assess local conditions might be compared to national data on practice patterns and treatment efficacy (Swigert, 1997; Olswang, 1998).

Sixth and finally, survey response rate may be low. Rao and Goldsmith (1991) studied return rates over a five-year period and found that the average response rate for consumer surveys distributed by large institutions, such as hospitals, is 10%. Smaller speech-language therapy departments averaged a response rate of 39%. One state wide effort mailed consumer satisfaction surveys to 1200 clinicians and facilities. A response rate of 16% (188 surveys) was achieved (Pershey, 1997, 1998a, 1998b).

METHODOLOGY

Instrumentation

The survey instrument (see Table 1) was developed after examination of several published surveys that used agreement rating scales, yes-no questions, and open-ended questions (adapted from ASHA, 1989, 1995; Chapey, 1986; Frattali, 1991; Larson & Kallail, 1987; Pershey, 1997, 1998a, 1998b; Rao, Blosser, & Huffman, 1998; Rao, Goldsmith, Wilkerson, & Hildebrandt, 1992, whose efforts serve, effectively, as the piloting of these items). The survey consisted mostly of forced-choice items, a few fill-in-the blank items, and an open-ended request for additional comments. Forty items were arranged under nine main subject headings that addressed client demographics (#1-4A-D), access to care and efficiency of service delivery (#5A-G), communication with the student SLP (#5H-N), clinical expertise of the student SLP (#5O-R), continuity of care (#6A-C), perceived outcomes (self-evaluation of progress, cost of services, overall impression of benefit as compared to cost) (#7A-C, 8A-D), and comments (#9).

Participation

Surveys were mailed to consumers of speech and/or language therapy services at two university speech and hearing clinics in the United States, one on the east coast and one in the Midwest. The participating clinics are both ASHA accredited facilities housed in public universities. Both are located in urban areas and serve mostly low to middle income clientele. The number of clients diagnosed and treated annually averages about 220 at the east coast site and about 110 at the Midwest site.

Consumers were current clients or had attended therapy within the past three years. Two hundred and six surveys were mailed to past and current east coast consumers and 222 were mailed to past and current Midwest consumers. Prepaid return envelopes were included and response within six weeks was required. All responses were anonymous. As such, no reminders could be sent to non-respondents. Cost and employee availability prohibited sending reminders to all 428 clients.

RESULTS

Responses to each of the survey items were compiled and summary statistics, predominantly measures of frequency, were used to analyze results (see Waldowski, 2002). Summary data are reported in Table 1. Results are provided for each clinic and also across both sites in order to show combined trends; as such, no attempt is made to show whether the two sites differ significantly.

East Coast Results

At the east coast clinic, 32.5% (67 surveys) were completed and returned. Of the 67 surveys received, 51 were filled out by the parent of a child receiving therapy and 15 were completed by clients at least 18 years of age. The remaining survey was completed by an "other." Male clients (32) and female clients (35) were nearly equally represented. The age range for clients was 2.6-70 years old. Due to the range and distribution of ages in this sample, all measures of central tendency for this distribution are not representative of the actual ages of clients served.

Sixteen percent (11) of the respondents reported never having therapy prior to attending the university program. Of the 56 consumers who reported having previous therapy, most had attended a university clinic or received therapy in the public schools or as a hospital outpatient. Clinic, private practice, hospital inpatient, and home therapy experiences were all reported. Of those who reported having prior therapy, 15 reported having spent less than six months in therapy prior to survey completion, while 27 had completed more than six months of previous therapy.

Respondents were asked to rate the efficiency of service delivery. Overall findings indicated that clients experienced little difficulty getting through the 'system' to enter the university clinic. The great majority reported that they were scheduled promptly, given convenient appoint-

TABLE 1. Summary Statistics of Survey Data

SURVEY RESPONSE VARIABLE	NUMBER OF RESPONSES	EAST COAST UNIVERSITY CLINIC	MIDWEST UNIVERSITY CLINIC	AGGREGATES OF BOTH CLINICS
DISTRIBUTION	SURVEYS MAILED	206	222	428
	SURVEYS RECEIVED	67	29	96
	RESPONSE RATE	32.5%	13%	22.75%
DEMOGRAPHICS	1. SURVEY COMPLETED BY	PARENT 51 CLIENT 15 SPOUSE/OTHER 1	PARENT 21 CLIENT 7 SPOUSE/OTHER 1	PARENT 72 CLIENT 22 SPOUSE/OTHER 2
	2. GENDER OF CLIENTS	MALE 32 FEMALE 35	MALE 16 FEMALE 13	MALE 48 FEMALE 48
	3. AGE OF CLIENTS	RANGE 2.6-70 YRS UNDER 18 N = 51 OVER 18 N = 16	RANGE 3-68 YRS UNDER 18 N = 22 OVER 18 N = 7	RANGE 2.6-70 YRS UNDER 18 N = 73 OVER 18 N = 23
	4. A. FIRST THERAPY	11 (16%)	11 (38%)	22 (23%)
	4. B. PREVIOUS THERAPY	56 (84%)	17 (58%)	73 (76%)
	4. C. LENGTH OF PRIOR THERAPY < 6 MOS. > 6 MOS.	 15 27 NO RESPONSE 14	 9 8	 24 35 NO RESPONSE 14
	4. D. TIME SINCE LAST THERAPY < 3 MOS. 3-6 MOS. > 6 MOS.	 24 8 24	 7 1 9	 31 9 33
EFFICIENCY (ACCESS)	5. A. LOCATE/BEGIN	AGREE 54 DISAGREE 6 DON'T KNOW 5 NO RESPONSE 2	AGREE 25 DISAGREE 1 DON'T KNOW 2 NO RESPONSE 1	AGREE 79 DISAGREE 7 DON'T KNOW 7 NO RESPONSE 3
	5. B. FIRST APPOINTMENT	AGREE 59 DISAGREE 5 DON'T KNOW 2 NO RESPONSE 1	AGREE 25 DISAGREE 2 DON'T KNOW 1 NO RESPONSE 1	AGREE 84 DISAGREE 7 DON'T KNOW 3 NO RESPONSE 2
	5. C. CONVENIENT TIME	AGREE 64 DISAGREE 3 DON'T KNOW 0 NO RESPONSE 0	AGREE 26 DISAGREE 1 DON'T KNOW 1 NO RESPONSE 1	AGREE 90 DISAGREE 4 DON'T KNOW 1 NO RESPONSE 1

TABLE 1 (continued)

SURVEY RESPONSE VARIABLE	NUMBER OF RESPONSES	EAST COAST UNIVERSITY CLINIC		MIDWEST UNIVERSITY CLINIC		AGGREGATES OF BOTH CLINICS	
	5. D. ON TIME	AGREE	62	AGREE	26	AGREE	88
		DISAGREE	4	DISAGREE	1	DISAGREE	5
		DON'T KNOW	1	DON'T KNOW	1	DON'T KNOW	2
		NO RESPONSE	0	NO RESPONSE	1	NO RESPONSE	1
	5. E. NOT CANCELED	AGREE	64	AGREE	26	AGREE	90
		DISAGREE	2	DISAGREE	0	DISAGREE	2
		DON'T KNOW	1	DON'T KNOW	1	DON'T KNOW	2
		NO RESPONSE	0	NO RESPONSE	2	NO RESPONSE	2
	5. F. MET SUPERVISOR	AGREE	52	AGREE	26	AGREE	78
		DISAGREE	14	DISAGREE	0	DISAGREE	14
		DON'T KNOW	0	DON'T KNOW	1	DON'T KNOW	1
		NO RESPONSE	1	NO RESPONSE	2	NO RESPONSE	3
	5. G. ACCESS SUPERVISOR	AGREE	55	AGREE	28	AGREE	83
		DISAGREE	7	DISAGREE	0	DISAGREE	7
		DON'T KNOW	5	DON'T KNOW	0	DON'T KNOW	5
		NO RESPONSE	0	NO RESPONSE	1	NO RESPONSE	1
COMMUNICATION	5. H. SLP LISTENED	AGREE	66	AGREE	28	AGREE	94
		DISAGREE	0	DISAGREE	0	DISAGREE	0
		DON'T KNOW	1	DON'T KNOW	0	DON'T KNOW	1
		NO RESPONSE	0	NO RESPONSE	1	NO RESPONSE	1
	5. I. SLP EXPLAINED PROBLEM	AGREE	61	AGREE	24	AGREE	85
		DISAGREE	4	DISAGREE	2	DISAGREE	6
		DON'T KNOW	1	DON'T KNOW	2	DON'T KNOW	3
		NO RESPONSE	1	NO RESPONSE	1	NO RESPONSE	2
	5. J. RESPECT/COURTESY	YES	66	YES	27	YES	93
		SOMETIMES	1	SOMETIMES	1	SOMETIMES	2
		NO	0	NO	0	NO	0
		DON'T KNOW	0	DON'T KNOW	0	DON'T KNOW	0
		NO RESPONSE	0	NO RESPONSE	1	NO RESPONSE	1
	5. K. SLP EXPLAINED SESSION	YES	54	YES	21	YES	75
		SOMETIMES	10	SOMETIMES	6	SOMETIMES	16
		NO	3	NO	0	NO	3
		DON'T KNOW	0	DON'T KNOW	0	DON'T KNOW	0
		NO RESPONSE	0	NO RESPONSE	2	NO RESPONSE	2
	5. L. TELL SESSION PROGRESS	YES	50	YES	21	YES	71
		SOMETIMES	14	SOMETIMES	6	SOMETIMES	20
		NO	3	NO	0	NO	3
		DON'T KNOW	0	DON'T KNOW	0	DON'T KNOW	0
		NO RESPONSE	0	NO RESPONSE	2	NO RESPONSE	2
	5. M. SLP SENSITIVE	YES	62	YES	28	YES	90
		SOMETIMES	5	SOMETIMES	0	SOMETIMES	5
		NO	0	NO	0	NO	0
		DON'T KNOW	0	DON'T KNOW	0	DON'T KNOW	0
		NO RESPONSE	0	NO RESPONSE	1	NO RESPONSE	1
	5. N. TELL TERM PROGRESS	YES	50	YES	26	YES	76
		SOMETIMES	0	SOMETIMES	1	SOMETIMES	1
		NO	0	NO	0	NO	0
		DON'T KNOW	0	DON'T KNOW	0	DON'T KNOW	0
		NO RESPONSE	17	NO RESPONSE	2	NO RESPONSE	19

SURVEY RESPONSE VARIABLE	NUMBER OF RESPONSES	EAST COAST UNIVERSITY CLINIC	MIDWEST UNIVERSITY CLINIC	AGGREGATES OF BOTH CLINICS
EXPERTISE	5. O. HOME INSTRUCTIONS	YES 55 SOMETIMES 10 NO 2 DON'T KNOW 0 NO RESPONSE 0	YES 17 SOMETIMES 6 NO 2 DON'T KNOW 0 NO RESPONSE 4	YES 72 SOMETIMES 16 NO 4 DON'T KNOW 0 NO RESPONSE 4
	5. P. INSTRUCTIONS HELPFUL	YES 51 SOMETIMES 2 NO 1 DON'T KNOW 0 NO RESPONSE 13	YES 18 SOMETIMES 3 NO 0 DON'T KNOW 1 NO RESPONSE 7	YES 69 SOMETIMES 5 NO 1 DON'T KNOW 1 NO RESPONSE 20
	5. Q. EXPERIENCED	YES 53 SOMETIMES 10 NO 3 DON'T KNOW 1 NO RESPONSE 0	YES 20 SOMETIMES 6 NO 0 DON'T KNOW 0 NO RESPONSE 3	YES 73 SOMETIMES 16 NO 3 DON'T KNOW 1 NO RESPONSE 3
	5. R. FUTURE MAINTENANCE	YES 45 SOMETIMES 13 NO 9 DON'T KNOW 0 NO RESPONSE 0	YES 15 SOMETIMES 6 NO 4 DON'T KNOW 1 NO RESPONSE 3	YES 60 SOMETIMES 19 NO 13 DON'T KNOW 1 NO RESPONSE 3
CONTINUITY	6. A. CHANGED SLP PER TERM	YES 43 NO 9 NO RESPONSE 15	YES 20 NO 5 NO RESPONSE 4	YES 63 NO 14 NO RESPONSE 19
	6. B. WORKED WITH SAME SLP FOR _____ TERMS	1 TERM 58 2 TERMS 6 3 TERMS 0 4 TERMS 0 4+ TERMS 0 NO RESPONSE 3	1 TERM 17 2 TERMS 3 3 TERMS 1 4 TERMS 1 4+ TERMS 0 NO RESPONSE 7	1 TERM 75 2 TERMS 9 3 TERMS 1 4 TERMS 1 4+TERMS 0 NO RESPONSE 10
	6.C. WAS AN ADVANTAGE TO CHANGE SLP WAS NOT AN ADVANTAGE TO CHANGE SLP	12 19 NO RESPONSE BY 12/43 POSSIBLE RESPONDENTS (SEE 6A)	9 3 NO RESPONSE BY 8/20 POSSIBLE RESPONDENTS (SEE 6A)	21 22 NO RESPONSE BY 20/63 POSSIBLE RESPONDENTS (SEE 6A)
SELF-EVALUATION	7. A. BEFORE THERAPY EXCELLENT GOOD FAIR POOR DON'T KNOW NO RESPONSE	 2 (3%) 11 (16%) 22 (33%) 31 (46%) 1 (1.5%) 0	 2 (7%) 2 (7%) 5 (17%) 14 (49%) 1 (3%) 5 (17%)	 4 (4%) 13 (14%) 27 (28%) 45 (47%) 2 (2%) 5 (5%)
	7. B. AFTER THERAPY EXCELLENT GOOD FAIR POOR DON'T KNOW NO RESPONSE	 12 (18%) (+15%) 40 (60%) (+44%) 13 (19%) (−14%) 1 (1.5%) (−44.5%) 1 (1.5%) (+/−0%) 0	 6 (20%) (+13%) 7 (24%) (+17%) 10 (35%) (+18%) 2 (7%) (−42%) 1 (3%) (+/−0%) 3 (11%) (−6%)	 18 (19%) (+15%) 47 (49%) (+36%) 23 (24%) (−4%) 3 (3%) (−44%) 2 (2%) (+/−0%) 3 (3%) (−2%)
	7. C. OVERALL BENEFIT EXCELLENT GOOD FAIR POOR DON'T KNOW NO RESPONSE	 17 (25%) 35 (52%) 10 (15%) 0 0 5 (7%)	 12 (41%) 11 (37%) 3 (11%) 0 0 3 (11%)	 29 (30%) 46 (48%) 13 (14%) 0 0 8 (8%)

TABLE 1(continued)

COSTS	8. A. FAIR BILLING	AGREE 59 DISAGREE 2 DON'T KNOW 2 NO RESPONSE 4	AGREE 22 DISAGREE 1 DON'T KNOW 3 NO RESPONSE 3	AGREE 81 DISAGREE 3 DON'T KNOW 5 NO RESPONSE 7
	8. B. INSURANCE COVERAGE	YES 1 NO 57 NO RESPONSE 9	YES 6 NO 19 NO RESPONSE 4	YES 7 NO 76 NO RESPONSE 13
	8. C. INSURANCE COVERS 80-100% 50-80% < 50% DOES INSURANCE PAY FOR SESSIONS YOU NEED	 1 0 0 YES 1 NO 0 DON'T KNOW 0	 5 1 0 YES 4 NO 1 DON'T KNOW 1	 6 1 0 YES 5 NO 1 DON'T KNOW 1
OVERALL IMPRESSION OF BENEFIT	8. D. BENEFIT, WORTH COST BENEFIT, NOT WORTH COST NO BENEFIT, WORTH COST NO BENEFIT, NOT WORTH COST NO RESPONSE	53 (79%) 5 (7.5%) 3 (4.5%) 0 6 (9%)	23 (80%) 0 0 1 (3%) 5 (17%)	76 (79%) 5 (5%) 3 (3%) 1 (1%) 11 (12%)

ment times, found their clinicians to be on time and reliable, and found the clinic supervisor to be accessible. A small number of respondents reported that they had not met or could not access a clinic supervisor.

Student SLPs attained essentially positive ratings for their communication abilities. Parents and clients were mostly satisfied with both the interpersonal and technical aspects of clinicians' communications: listening skills, explanations of therapy and progress, respectful behavior, strategies for use at home, post-therapy maintenance suggestions, and overall level of knowledge.

Forty-three clients changed therapists every term (academic semester) while nine did not. Fifty-eight respondents reported that they worked with a therapist for only one term; six reported that they worked with the same therapist for two semesters. Twelve reported that it was an advantage to change therapists, while 19 reported that it was not an advantage.

Respondents were asked to give a rough self-evaluation of progress in their program of therapy at this site. Prior to beginning therapy, 31 (46%) of the respondents rated the client's communication skills as poor, 22 (33%) rated skills as fair, 11 (16%) rated skills as good, 2 (3%) rated skills as excellent. Following therapy, 1 (1.5%) rated the client's communication skills as poor (a decrease of 44.5%), 13 (19%) rated skills as fair (a decrease on 14%), 40 (60%) rated skills as good (an increase of 44%) and 12 (18%) rated skills as excellent (an increase of 15%). Clearly, the overall trend is that respondents perceived that clients' communication skills had improved. Seventeen consumers (25%) reported that their overall benefit from therapy was excellent; 35 (52%)

reported that the overall benefit was good, and 10 (15%) reported that the overall benefit was fair.

Cost of service was generally thought to be reasonable. Clients sampled were mostly uninsured (57 of 67 individuals reported no coverage). Fifty-three clients reported having benefitted from speech therapy and that it was worth the financial cost; five felt that they had benefitted but it was not worth the financial cost. Three felt that they had not benefitted from therapy but it was worth the cost.

Comments described the student clinicians as caring, helpful, experienced, knowledgeable, respectful, courteous and offering a variety of strategies and techniques. Positive comments focused on the professionalism of faculty and the administration of the clinic. Respondents were generally satisfied with the quantity and quality of the information provided by the student clinicians and the clinical supervisors. Parents were satisfied with the support that they received in order to facilitate their role in the therapy program. Some expressed dissatisfaction with the need to change clinicians from one semester to the next and noted negative changes in therapeutic progress as a result. Written comments indicated that satisfaction with the SLP was related to two factors: whether the client and/or family liked the SLP or not and whether or not they perceived that progress was attained. Clients also voiced concerns about clinicians' specific areas of knowledge (e.g., English as a second language), and about assignment of therapy times, breaks in therapy due to semester changes and holidays, difficulty reaching the clinic by phone, limited clinic hours, difficulty parking, and poor waiting room atmosphere.

Midwest Results

A response rate of 13% (29 surveys) was obtained at the midwest university. Parents completed 21 of the surveys, clients completed seven, and one was completed by an "other." Sixteen male and 13 female clients were represented. Clients ranged in age from three to 68 years. There were 22 clients under 18 years and seven over 18 years of age. Again, measures of central tendency for this distribution are not representative of the actual ages of clients served; however, the modal client age was five.

Thirty-eight percent of clients (11) had not had previous therapy while 58% (17) had prior therapy either at a university setting, at school, or as hospital outpatients. Nine reported a prior course of therapy of less than six months while 12 respondents had prior therapy for more than six months.

The great majority of clients gave positive ratings to the efficiency of service delivery. No difficulty in accessing services was reported. The communication abilities of the student clinicians were also highly rated, although there are areas where the SLPs might need to provide better interventions, i.e., explaining therapy and progress, offering strategies to use at home, and preparing clients for post-therapy maintenance of skills.

Twenty clients worked with a new therapist each semester. Seventeen worked with a therapist for only one term. Nine individuals reported that it was an advantage to change therapists while three reported that it was not an advantage.

Regarding self-evaluation of progress in therapy at this site, 14 respondents (49%) perceived that clients began therapy with poor communication abilities. Five respondents (17%) rated clients' skills as fair, two (7%) as good, and two (7%) as excellent. The number of respondents who rated clients' post-therapy skills as poor fell by 42% (two respondents, or 7%, reporting poor skills after therapy). Ten respondents (35%) reported fair skills (an increase of 18%), seven (24%) reported good skills (an increase of 17%), and six (20%) reported excellent skills (an increase of 13%). Overall benefit was rated as excellent by 12 respondents (41%), as good by 11 respondents (37%), and as fair by three persons (11%).

Costs were perceived as fair by the great majority of consumers. Those without insurance coverage for speech-language therapy (19 clients) outnumbered those with insurance (6) by more than three to one. Among insureds, coverage was usually 80 to 100% of the cost of therapy. Twenty-three clients (80%) indicated that they had benefitted from therapy and it was worth its cost. Only one client indicated no benefit and the belief that therapy was not worth its cost.

Comments often had an affective component. Respondents praised university personnel and students and repeatedly cited that they (or their children) had benefitted from therapy. A few negative comments were made about lack of continuity of therapists and limited parking.

Comparison Across Sites

Table 1 provides comparative and aggregate figures for both university clinics. Many commonalities were shared. Consumer responses were overwhelmingly positive for both current and retrospective impressions of both sites. Respondents had a very high degree of satisfaction with services and costs and indicated that clients had improved their communica-

tion skills. Seventy-three consumers stated that their student clinician was experienced and knowledgeable (item 5Q); 30% reported an excellent overall benefit from therapy and 48% reported that overall benefit was good (item 7C). Seventy-nine percent benefitted from therapy and found it to be worth the cost (item 8D). However, examination of the aggregate data reveals that some student clinicians might not have given clients explicit explanations of session purposes and objectives and sometimes did not deliver clear feedback on progress attained during given therapy sessions. Clients sometimes noted that home programming was not provided; however, lack of home programming may not be a shortcoming, i.e., a client who voiced this concern may have not been judged by the student SLP and clinic supervisor to be a candidate for home programming. Another area where consumers noted concern is future maintenance of therapy skills. One-third (32 of 96) of the respondents did not have a sense of how they would work to maintain their skills after therapy ends (or did not know if they had been given this sort of instruction). However, clients were not asked whether they were nearing the end of their course of treatment and if it was time to be concerned about future planning; therefore, absence of planning may not be an immediate concern for all who expressed concern.

In terms of differences across sites, the east cost site had a much higher survey response rate and included more responses that reflected the views of adult clients. It appears that the greatest difference between the two sites pertains to the issue of continuity of care. Student clinicians at both sites most often worked with a client for only one semester. It should be noted that only 43 of 63 possible respondents answered question 6C, which asked whether it was an advantage to change clinicians each term. (Response is possible if the consumer's answer to 6A was "yes.") Perhaps some non-respondents were first-term clients or had not changed SLPs. Twenty-one felt that changing SLPs was an advantage and 22 felt that it was not an advantage. However, 19 of the 22 who did not feel that it was an advantage were respondents at the east coast site.

DISCUSSION

The Trend Toward Positive Responses

Self-perceptions of therapeutic progress, affordable costs, efficient service, and rapport with service providers were nearly universally re-

ported in this study. Perhaps the current level of satisfaction reflects a generally acceptable level of student preparedness and clinical supervision. This trend toward positive responses to services provided at a variety of university and non-university sites was also reported by ASHA (1995), Frazier (1995), Grela and Illerbrun (1998), Larson and Kallail (1987), Pershey (1997, 1998a, 1998b), Rao (1991), and Rao, Goldsmith, Wilkerson, and Hildebrandt (1992). In the ASHA (1995) report of more than 800 consumers of speech-language pathology and audiology services in hospitals, rehabilitation centers, and university clinics, at least 90% of the speech-language pathology consumers agreed or strongly agreed with 18 of the 21 satisfaction statements. Typically, there were almost twice as many 'strongly agree' responses as 'agree' responses. Pershey (1997, 1998a, 1998b) stated that all respondents reported gains and no respondents reported that communication abilities were the same or worse after therapy.

Positive responses potentially have the effect of allowing student clinicians to feel valued. Dowling (1987; 1993; 2001) and Dowling and Wittkopp (1982) asserted that a constructive supervisory relationship reinforces the student's sense of being held in the supervisor's and the program's positive regard.

Although clients offer important feedback in any therapy setting, clients' perceptions of satisfaction in the university clinic setting cannot be interpreted as judgements of a student SLP's clinical competence (Larson & Kallail, 1987). Clinic supervisors might be pleased with positive consumer response but cannot allow these data to obscure their observations and evaluations of student performance. Positive consumer feedback may be earned by students whose skills are not up to par; conversely, negative consumer feedback may not point to a student whose skills are deficient. The supervisor can participate in students' assessments of the validity and adequacy of consumers' judgements and help students realistically incorporate these views into more comprehensive self-assessments of the quality of their clinical services (McLeod et al., 1995). This process is sometimes known as an "asset inventory" (Dowling, 2001). Supervision conferences may explore the degree of match or mismatch between consumers' perceptions and students' own perceptions of their successes and weaknesses. Consumer feedback might improve students' ability to problem-solve, self-observe and self-analyze (Dowling, 1993), develop flexibility in modifying their own behavior to adapt to individuals' needs, goal-set (Dowling, 1987; 1993), and utilize the findings of descriptive supervisory research (Strike & Gillam, 1988). ASHA (2002) has identified

these supervisory tasks as necessary for promoting students' attainment of clinical independence (Anderson, 1988; Dowling, 2001), with consumer surveys functioning as one of several devices for gathering information.

Continuity of Care

Clients who choose to use university clinics must realize that frequent clinician turn-over assures that student SLPs will experience varied caseloads and diverse clinical experiences (see Lubinski & Masters, 1994). Considering an earlier report (Larson & Kallail, 1987) which suggested that about half of university clinic clients were dissatisfied with changing student SLPs each semester, it was not surprising that about half of this sample also found SLP rotation to be a potentially negative aspect of university clinic service. Given the findings of this study, clinic practica may sometimes need to be configured so that some clients have a continuous program of therapy with one student SLP when the supervisor, student, and client all agree upon the need. An important supervisory issue, then, is developing students' competencies so that, at the end of each term, departing student SLPs adequately prepare clients for transitioning to new clinicians and incoming clinicians provide an appropriate level of continuity in their approach to service.

Parental Satisfaction vs. Client Satisfaction

When respondents are parents of children under the age of 18 years, parental satisfaction has actually been measured more than client satisfaction. This may be reasonable if the parent is viewed as the consumer or stakeholder (Rao, Blosser, & Huffman, 1998). When judged in comparison, responses by adult clients (over 18 years of age) were similar in all areas to those of parents of children attending the two clinics.

Costs

Cost of service was generally thought to be reasonable. Decreasing insurance coverage for speech-language therapy may be leading consumers to look for lower-cost, community-based services. Both university clinics in this study serve predominantly low and middle income clients. The results, therefore, may not be representative of all university clinics and generalizability of these findings may be limited. Some

respondents expressed gratitude that affordable speech therapy was available to them and so were perhaps less critical than more affluent clients might be. Approximately eight out of 10 consumers indicated that therapy was worth its cost. This stands in contrast with the university clinic study by Larson and Kallail (1987) which reported that only 73% of clients agreed that the cost of services was reasonable. In the time that has passed since the Larson and Kallail (1987) study, consumers may have become aware that therapy can be very expensive and that university clinics offer a more modestly priced alternative.

IMPLICATIONS FOR SERVICE DELIVERY AT UNIVERSITY CLINICS

Overall, client satisfaction with therapeutic services provided by students was shown to be at a very high level. Clinical supervisors may want to be sure that student clinicians clearly convey session purposes and objectives and present explicit feedback on how progress was or was not attained during a given therapy session. Also, clients should know why home programming is or is not being provided and should be assured at the beginning of a course of therapy that future maintenance of therapy skills will be addressed as they near the end of their treatment.

IMPLICATIONS FOR SUPERVISION

ASHA's Position Statement (2002) delineated that supervision involves two tasks, clinical teaching and program management. It may be possible to extrapolate the effectiveness of supervision (Anderson, 1988) by researching consumer satisfaction. Positive feedback may confirm that student SLPs are providing quality service, which may confirm that supervisors are successfully teaching clinical skills and coordinating productive mechanisms for service delivery. Feedback that points out deficiencies in services can help students and supervisors set goals and objectives for improvement. Importantly, supervisors and student clinicians should jointly select a small, manageable number of behaviors or conditions to target for change. As Dowling (2001) counseled, attempts to modify too many factors at once can lead to feeling overwhelmed and consequently to frustration, discouragement, and withdrawal of commitment to the process.

FUTURE DIRECTIONS

The positive results of this survey may be used to inform consumers that obtaining speech-language therapy services at a university clinic may be rewarding as well as affordable. The findings of consumer surveys can be distributed in many ways, including brochures mailed to referring practitioners and agencies, web site postings, presentations to community groups, radio and television public service announcements or advertisements, newspaper press releases, etc., to help educate the public about the quality speech-language therapy services available at university clinics.

Future surveys, focus groups, or client interviews might ask consumers for suggestions on how to improve service delivery rather than to describe their degree of satisfaction and may also compare consumers' perceptions to objective measures of therapeutic success. Importantly, consumer satisfaction is not synonymous with habilitative or rehabilitative progress (Hawkins, 1991). Comparison of client satisfaction measures with other measures, such as (a) ASHA's national speech-language therapy outcome measures (Swigert, 1997; Olswang, 1998), (b) individual and aggregate program evaluation data, (c) supervisors' reports of student progress, and (d) supervisees' peer-study can help the university clinic round out its self-examination of service delivery and pre-professional preparation of SLPs. More detailed research of the supervision process itself and of its relationship to accountability for client outcomes and satisfaction is also warranted (Dowling, 2001; Pickering, 1987; Shapiro, 1994; Strike & Gillam, 1988).

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