Significant changes have occurred in the field of communication disorders in recent years as the result of demographic, sociologic, economic, and legislative trends occurring nationally (Blosser, 1991; Huffman, 1995; Logemann, 1994; Montgomery & Herer, 1994). In the near future, statewide and national education and health care reform efforts will potentially have even greater effect on the practice of the profession of speech-language pathology.

In addition to national issues such as these, the role of the speech-language pathologist continues to evolve as the understanding of individuals with communication disorders expands and the impact of communication deficits on learning and living continues to become evident. This requires treatment approaches that are more functional in nature and are provided in contexts that are best suited to the individuals served.

Advances in technology have increased clinicians' and clients' access to information and treatment methodologies, thereby broadening the opportunities for service delivery. Legislation and regulatory agencies continue to define policy for service delivery, calling for (a) more effective consumer involvement in planning and implementing treatment, (b) the documentation of efficacy through outcome-based measures, (c) the expansion of service delivery options, and (d) clarification of the competencies and skills needed to be a qualified service provider.

These changes have resulted in increased discussions of the need to make changes in the way speech-language pathology services are delivered. Unfortunately, distinct explanations of alternative service delivery options and advice on procedures for making desired service delivery changes have been slow in coming.

Although the roles and expectations others hold for speech-language pathologists have changed at an incredible rate, practitioners' understanding, development, and adoption of alternative models for delivering services have not kept up with the pace. As Logemann stated in her Presidential Address at the 1994 American Speech-Language-Hearing Association (ASHA) Convention, “In the last 20 years, we have not greatly expanded our models of service delivery or focused our research on the best forms of service delivery for particular disorders, age groups, settings, and so forth.” (Logemann, 1994).

The purpose of this article is to discuss why there is a need to implement alternative service delivery models (ASDMs) at this time. It proposes a conceptual framework for designing service delivery plans that are most appropriate for meeting clients’ unique needs.
WHY IS IT NECESSARY TO REDEFINE SERVICE DELIVERY AND WHY NOW?

Figure 1 illustrates the evolution of speech-language pathologist service delivery over the past three decades and into the future. For each decade, Row 1 indicates the areas of communication that were the clinicians’ focus for treatment, Row 2 shows the roles clinicians have assumed in service delivery, and Row 3 lists the emerging issues under professional consideration (Blosser & Kratcoski, 1994). This chart demonstrates that changes in service delivery models and the clinicians’ role have paralleled the increased understanding of communication disorders. As new issues emerge and clinical environments change, clinicians have attempted to modify their practices in order to adapt to new challenges.

The profession is at a new turning point in the evolutionary process. In fact, it appears that the field of speech-language pathology is currently undergoing a metamorphosis in service delivery. Currently, significant changes are taking place in education and health care settings that are forcing clinicians to reflect on their approaches to service delivery. In educational forums, public education laws and policies are being rewritten to clarify the meaning and intent of providing services in “least restrictive environments.” Current perspectives propose an expansion of service delivery options based on a commitment to serving all children in the environment that best fits their individual needs.

At present, speech-language pathologists in school settings are moving toward using inclusive models of service delivery that merge speech and language services with educational programming. ASHA defines inclusive practices as intervention services that are based on the unique and specific needs of the individual and are provided in a setting that is least restrictive (ASHA, 1995). States are reevaluating services and acceptable service delivery environments for all children with special needs. Personnel working in education settings must demonstrate that their services will support the student so that he or she can participate to the maximum extent possible in social and learning contexts (Hales & Carlson, 1992). Based on these directions, best practice for speech-language pathologist service delivery within the school setting would indicate that the general education classroom should be considered the first step in the continuum of service delivery to students with communication disabilities (Huffman, 1995).

Concurrently, similar changes are taking place in health care environments. Managed care, reduced financial resources, changes in organizational structure, and changes in philosophy regarding the efficacy of service delivery are forcing practitioners to rethink and redefine their roles and practice patterns. Clinical success is defined in terms of helping clients reach measurable, functional outcomes so they can participate in community, family, work, and learning activities. Service delivery has been expanded to encompass community and home-based settings. Limitations are being set on the frequency and duration of services individuals may receive. These issues are causing
practitioners to critically seek different options for reaching their client population.

WHAT DO CLINICIANS MEAN BY ALTERNATIVE SERVICE DELIVERY MODELS?

Many discussions of alternative service delivery models have appeared in the literature in recent years (ASHA, 1991; Crais, 1995; Christensen & Luckett, 1990; Creaghead, Estomin, Freilinger, & Peters-Johnson, 1992; Damico, 1987; Frassinelli, Superior, & Moyers, 1983; Miller, 1989; Neidecker & Blosser, 1993; Nelson, 1989; Prelock, Miller, & Reed, 1995; Shulman, 1987). Traditionally, service delivery models are presented as discreet programs with unique characteristics, often in a hierarchical structure based on factors such as frequency of services, location of services, and amount of direct contact between the speech-language pathologist and client (Neidecker & Blosser, 1993; Ohio Department of Education, 1991).

These programs have been assigned a variety of labels such as direct therapy, traditional pullout, collaboration, consultation, co-teaching, integrated, inclusive, home-based, center-based, transdisciplinary team-based, classroom-based, departmentalized, language laboratory, paraprofessional, consultative, diagnostic, and community-based. The terms are focused on the activities or roles performed by the clinician (consultation) or on the context for delivery of the service (classroom-based or community-based).

There appears to be little consensus concerning the definition of each of these models. For example, one often hears that a clinician is using a “classroom-based model.” However, the specifics of the intervention are not clear. There are multiple ways the term “classroom-based” is being interpreted. For one clinician, the term may imply that the clinician works with the child on classroom-based materials. A second clinician may interpret the term to mean collaborating with the teacher. In a third interpretation, the clinician might work with a small group of children within the classroom structure, whereas a fourth clinician might present a language or listening-based lesson to an entire class.

In addition, the specific factors that should be used to determine which model is most appropriate to meet the needs of a particular individual are not clearly identified. Some interpret the hierarchy as an implication that one service delivery option is better than another, whereas others view the models as more applicable to particular settings (such as schools) than others. This concept of unique and discreet options has in effect limited instead of expanded clinicians’ thinking about how to develop appropriate treatment programs.

THE PAC FRAMEWORK FOR ALTERNATIVE MODELS OF SERVICE DELIVERY

A common conceptual framework for guiding decisions about the selection of appropriate services to meet particular clients’ needs is lacking. In the most basic sense, alternative service delivery models are the unique combination of providers, service activities, and contexts (PACs) necessary to meet the specific needs of the individual with communication disorders (student, patient, client). There are three premises on which such a conceptual framework should be based. These premises apply regardless of the type of setting.

Premise One

There are essential characteristics that define good service delivery. Flower (1984) identified five such characteristics:

- **Efficacy**: Does the service make a difference to the consumer?
- **Coordination**: When multiple professional services are provided to the same individual, are all services coordinated and working toward the same end?
- **Continuity**: Is there an uninterrupted sequence of services, and is each phase staged and integrated?
- **Participation**: Are the individual’s wishes, motivations, and interests considered by incorporating the individual and family members in the decision-making process?
- **Economy**: Are time, energy, funding, and other resources used most efficiently to accomplish the goals?

Premise Two

Service delivery must be creative and flexible and offer clients a variety of options for receiving services that fit their lifestyle and needs. This includes varying key aspects of service delivery, including:

- the type of services provided;
- the amount of direct time the speech-language pathologist spends with the client;
- the location for providing services;
- the provider who delivers the services;
- the mode of service delivery; and
- the materials and techniques used for assessment and intervention.

Premise Three

The provider, activity, and context must be clearly specified in the treatment plan. In this model, the clinician determines the unique PAC for each individual client served. The result is a service delivery model that is relevant to the clients’ presenting communication problem and needs, with clear direction for all team members. Following is a discussion of the PAC concept.

Providers. Providers (P) are those communication partners who can foster meaningful change in an individual’s communication performance by implementing appropriate procedures to elicit, modify, and/or reinforce
communication responses. Traditionally, the speech-language pathologist is viewed as the person who has assumed ultimate responsibility for this role. However, it should not always be assumed that the speech-language pathologist is the best provider. To improve efficacy, both assessment and intervention require shared responsibility among the client’s communication partners. To be successful, numerous providers should be involved in the assessment and treatment process. The selection of providers should be determined by the client’s needs at a given point in time, the activity to be completed, and the context in which the activity is to be conducted. Providers may change over time as intervention needs and goals change. Clearly, this model assumes that there should be several providers for each client.

When implementing alternative models of service delivery, the speech-language pathologist’s role includes guiding the team as they weigh the following decision: “Who are the most appropriate persons to conduct or provide specific communication-related activities with this client and in what context?” The decision regarding who can be an effective provider is dependent on factors such as the relationship of the individual to the client, the severity of the disability, the partner’s general knowledge and understanding of the disability, the individual’s willingness to participate in the program, and situations and contexts of interactions. In determining providers, the speech-language pathologist and fellow team members should consider the following questions:

1. Who are the key communication partners in this person’s life? (parents, other caregivers, teachers, coworkers, tutors, peers)
2. Are there barriers that would prevent the team from delivering specific assessment and/or treatment procedures? (time constraints, location, motivation, conflicting philosophies, fear, lack of information, inadequate skills)
3. Can these barriers be resolved through training and/or counseling? (in-service meetings, support groups, workshops, written materials, audio and video materials, observation, demonstration)
4. What is the most appropriate provider role for each communication partner considering the outcomes/goals for the client at the specific point in time? (observe and report behaviors, model, question, prompt, correct, reinforce).

Examples of potential providers in addition to the speech-language pathologist are parents, siblings, regular educators, special educators, tutors, intervention specialists, psychologists, administrators, occupational therapists, and physical therapists. Key roles played by individuals such as these will enable services to be integrated into the daily routine.

Activities. Activities (A) are those tasks that comprise total case management for clients with communication disorders. The tasks can be grouped into four major categories: (1) planning to determine courses of action in all aspects of case management; (2) assessing to determine strengths and needs; (3) implementing treatment procedures; and (4) monitoring services to determine the efficacy and outcomes to identify if modifications are necessary. Clearly, the speech-language pathologist is not the only person qualified to perform these activities. Through shared responsibility, we can gain more valuable information and make more efficient use of shrinking resources.

Planning. A significant portion of the speech-language pathologist’s service delivery time involves planning to determine the appropriate course of action needed to meet each client’s needs. Planning includes tasks such as discussing assessment findings, reviewing pertinent data, determining goals and objectives, selecting appropriate intervention procedures, and modifying intervention plans. This planning often takes the form of meetings, where several participants from various disciplines come together to present their perspectives. Within the PAC model, the emphasis during planning efforts is on who the providers will be, what activities each will conduct, and the context in which the activities will be conducted.

Assessment. The purpose of assessment is to identify the communication strengths and needs of the client as well as the extent of services necessary. Unless information is also gathered regarding the priorities and concerns of the client, his or her family, and other important individuals, an appropriate service plan cannot be developed. Within the assessment process, all individuals who can contribute information are considered providers. In the PAC model, the goal of the identification and assessment aspects of service delivery is not to identify what is wrong. Instead, the goal is to identify what works for a particular client in a particular setting when assisted by particular people. Thus, the speech-language pathologist’s role is to provide a framework for obtaining, organizing, and synthesizing the information.

Implementing interventions. A primary activity in service delivery is providing intervention. Within the intervention plan for any given client, different providers will inevitably assume different roles for implementing intervention. For example, one provider (such as the speech-language pathologist) may introduce a new skill to the client while a second provider (the parent) reinforces the targeted behavior and a third provider (the teacher) observes the client’s performance to determine additional skill areas to be targeted in the future.

Clinicians working within the school setting often express confusion about how to work collaboratively with teachers. The following list (Friend, 1992) delineates the diverse roles a team of providers might assume to implement interventions in that service delivery setting:

- There is one primary provider of services to the student.
- One provider (speech-language pathologist) teaches others specific assessment or treatment strategies; other providers (e.g., teacher) implement the strategies.
- One provider provides services; the others assist side-by-side.
- One provider provides services at a learning center within a large group.
• Two providers implement interventions simultaneously during a co-directed lesson (parallel teaching).
• One provider (teacher and curriculum) recommends to other providers suggestions of content and methods to incorporate into intervention; other providers (speech-language pathologists) implement recommendations (supplemental teaching).
• Other roles devised to meet the client’s unique needs.

In the PAC model, the speech-language pathologist will often find it necessary to assume the role of preparing providers for the activities to be conducted. For example, to involve key communication partners in implementing intervention, the speech-language pathologist must prepare them for the role by teaching skills such as: (a) identifying when a communication breakdown has occurred; (b) recognizing that it is related to the individual’s communication disability; and (c) knowing the appropriate procedures to implement to bring about change at that time (Blosser & DePompe, 1994). These skills can be developed in others through informal conversations, in-service meetings, demonstrations, written instructions, audio and visual resources, and the like.

Evaluating efficacy and outcomes. Intervention is effective when the client’s performance is appropriate for the contexts in which he or she participates. This can only be determined by reports provided by the astute providers in the client’s various communication environments. The speech-language pathologist’s role is to solicit information, analyze it, and work with other providers to make appropriate modifications.

In deciding those activities that are necessary to address the client’s needs, teams should contemplate the following activity-related questions:

• What are the tasks that need to be completed with this client at this particular point in time? (identify needs, design interventions, teach others to implement interventions, and evaluate progress)
• What providers would be most appropriate for performing each activity? (Consider such factors as the relationship of the individual to the client, the frequency of contact of the provider to the client, and the individual’s level of understanding, experience, and training relative to the disorder and the necessary intervention.)
• What steps should be taken to prepare the providers to perform these activities and who should take the steps? (in-service meetings, demonstrations, written materials, audio- or videotapes).
• What materials do the providers need to conduct the activity? (observation and data collection forms, assessment checklists and materials, surveys and questionnaires, resource lists, stimulus materials, and augmentative or assistive devices.)

Contexts. Contexts (C) are those situations, conditions, environments, or interactions where communication is required. During planning opportunities, providers should jointly determine the most appropriate contexts for conducting specific activities necessary for case management. The range of contexts and conditions for each client is extensive. In determining contexts, the speech-language pathologist should consider demands and expectations for communication required in the context. Specifically, the team must consider:

• What are the primary contexts in which the client communicates or must transfer newly learned behaviors? (home, school, learning activities, curriculum, community, work)
• What contexts provide natural opportunities for communication or for practicing the targeted behaviors? (instruction, play, large group activities, recreation and leisure, routines, vocational settings)
• What contexts provide valid and reliable opportunities for observing and evaluating communication performance and progress?
• Does the environment restrict or promote communication skills for this individual?

Appropriate contexts include the regular education classroom, resource room, classroom assignments, cafeteria, recess, home, community, and vocational settings.

Figure 2 summarizes the providers, activities, and contexts that are applicable to a school setting.

APPLICATION OF THE PAC MODEL

The PAC model can be used by planning teams to devise the course of assessment or treatment in many different types of settings. Preschool personnel can use it for developing a child’s individualized family service plan (IFSP). School-based teams can use it when formulating a child’s individualized education program (IEP) or individual transition plan (ITP). It can also be applied in private practice or in rehabilitation, clinical, or hospital settings on a broad or limited basis.

The PAC model provides a useful format for discussing the client’s needs, promoting joint decision-making, and encouraging full participation in implementation of the plan. The framework helps clarify the roles teachers, parents, and others can play in the service delivery process. It can be used at any point in time in the service delivery process—at the beginning to plan the goals and direction of treatment or at any point along the way to refine or expand intervention options.

The PAC model offers a creative process for exploring key aspects and questions that should be contemplated when developing programs for clients. It provides a very useful organizational tool for teams that have not worked together previously or teams that are trying to determine strategies for how they can work together more effectively. The PAC model is especially valuable for educating practitioners, family members, educators, and others (such as students in pre-service training) about important considerations that must be made in order to provide clients with the best services possible. It would be beneficial for teams to spend some time discussing the team process to be used to work together and provide services to a client. The PAC
Figure 2. Alternative models of service delivery.

<table>
<thead>
<tr>
<th>PROVIDERS are those individuals who can foster meaningful change in an individual's communication performance by eliciting, modifying, reinforcing, and/or supporting the student's use of language/communication.</th>
<th>ACTIVITIES are those tasks that comprise total case management for meeting the needs of students who have communication disorders. The tasks can be grouped into four major areas: planning assessment/intervention activities, assessment of student needs, implementing interventions, and evaluating student progress.</th>
<th>CONTEXTS/CONDITIONS are those environments, circumstances, materials, or interactions where effective communication by the student is necessary for the student's participation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech-language pathologist</td>
<td>Planning</td>
<td>Therapy room</td>
</tr>
<tr>
<td>Special education teacher</td>
<td>Assessment</td>
<td>Classroom</td>
</tr>
<tr>
<td>Tutor</td>
<td>Implementing</td>
<td>Home</td>
</tr>
<tr>
<td>Assistant</td>
<td>Evaluating</td>
<td>Community</td>
</tr>
<tr>
<td>Regular education teacher</td>
<td></td>
<td>Curricular materials</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td>Peer interactions</td>
</tr>
<tr>
<td>Friends</td>
<td></td>
<td>Teacher–student interactions</td>
</tr>
<tr>
<td>Relatives</td>
<td></td>
<td>Gym</td>
</tr>
<tr>
<td>Physical therapist</td>
<td></td>
<td>Playground</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td></td>
<td>Church</td>
</tr>
<tr>
<td>Principal</td>
<td></td>
<td>Scout meetings</td>
</tr>
<tr>
<td>Scout leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coach</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The framework would be a good focus for this type of discussion and for in-service training for team members.

The following case examples illustrate the PACs that were developed by school-based teams for two children in a local school district in Northeastern Ohio. The PACs were developed during the IEP planning process and formed the basis for the IEPs written for these children. These PACs represent the types of PACs speech-language pathologists can consider for students on their caseload. Similar case descriptions and scenarios could also be created for other clinical populations and age groups served in other types of treatment settings.

**Case #1**

R is a 12-year-old boy with cerebral palsy. His speech and language skills are severely impaired as a result of motor dysfunction. Attempts to communicate verbally are unintelligible. He has been enrolled in speech-language pathology treatment programs within the school setting since the age of five. In that time, he has not acquired appropriate verbal communication skills. At the age of 10, the school-based team determined that his overall performance and ability to function in the classroom and home settings would be greatly improved with the use of an augmentative communication system. The speech-language pathologist incorporated these recommendations into her plan and subsequently introduced R to a simple augmentative communication device. All intervention was conducted in a pullout service delivery framework, working individually or in a small group. Within the confines of the therapy room, R learned to activate the device, select vocabulary, and respond to the clinician's comments and questions. Generalization of skills for using the device for learning and interacting with others was not evident. Therefore, the team developed the goal for R as described in Table 1.

To implement this IEP, the team developed the PAC shown in Table 2 to determine the appropriate providers, desired activities, and targeted contexts for facilitating attainment of the goal.

**Case #2**

T, age 5, is in kindergarten. Her speech and language skills are characteristic of a 3-year-old child. Because this child's communication needs are so great, the school-based

| Table 1. R's Goals. |
| --- | --- | --- |
| Goal | Criteria | Evaluation |
| R will use an augmentative communication device to communicate during classroom activities and daily activities at home to request information or comment to teacher, parents, and peers. | Request or comment at least three times per day. | Teacher will observe R during small group activities and document incidences of requests and comments on a chart. |
Table 2. R's PAC.

<table>
<thead>
<tr>
<th>Providers</th>
<th>Activities</th>
<th>Contexts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech-language pathologist</td>
<td><strong>Assessment</strong>&lt;br&gt;Determine communication needs for increased interaction and participation in the classroom setting.&lt;br&gt;Identify modifications needed on the device and in the classroom to increase use of the device in that context.&lt;br&gt;Monitor teacher’s use of recommended strategies.</td>
<td>Speech-language pathologist room&lt;br&gt;Classroom&lt;br&gt;Teacher lunchroom and conference room</td>
</tr>
<tr>
<td><strong>Intervention</strong>&lt;br&gt;Program the device.</td>
<td>Add/Delete vocabulary and messages to increase appropriateness.&lt;br&gt;Conduct teacher and peer training.</td>
<td></td>
</tr>
<tr>
<td>Teacher</td>
<td><strong>Intervention</strong>&lt;br&gt;Devise opportunities throughout the school day that promote communication via the device.&lt;br&gt;Require student to respond to all teacher questions using the device.&lt;br&gt;Request that the student use the device at least three times per school day to request information or comment to teacher or peers.&lt;br&gt;Report progress and problems to the clinician.</td>
<td>Classroom&lt;br&gt;Other applicable areas of the school</td>
</tr>
<tr>
<td>Peer</td>
<td><strong>Intervention</strong>&lt;br&gt;Learn to use the device (teacher and speech-language pathologist must facilitate initial exposure).&lt;br&gt;Assist speech-language pathologist when programming the device by providing voice for recordings.&lt;br&gt;Engage student in interactions and encourage him to use the device for response (teacher can facilitate by pairing student and peer during classroom learning and fun activities).</td>
<td>Classroom&lt;br&gt;Cafeteria&lt;br&gt;Recreation areas</td>
</tr>
</tbody>
</table>

IEP team decided to focus on the two goals identified in Table 3.

The team divided responsibility for accomplishing the two goals between multiple providers. The speech-language pathologist agreed to work on improving functional communication skills and increasing intelligibility and the teacher targeted establishing the basic concepts needed for successful performance in the classroom. More specifically, the PAC shown in Table 4 was developed to delineate the activities of each provider in the targeted contexts.

**SUMMARY**

As a result of demographic and economic trends, as well as reforms in health care and education, speech-language pathologists are being challenged to expand the service delivery options offered to consumers. In response, practitioners are seeking alternative ways of meeting client needs. They are searching for service delivery models that promote clients’ functional skills, are cost-effective, and reflect accountability and efficacy. There is an increasing demand for models that incorporate team decision-making and participation.
Table 4. *T's PAC.*

<table>
<thead>
<tr>
<th>Providers</th>
<th>Activities</th>
<th>Contexts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech-language pathologist</td>
<td><strong>Assessment</strong>&lt;br&gt;Develop a concise profile of the communication strengths and needs.&lt;br&gt;Recommend specific targets for intervention for each team member.&lt;br&gt;<strong>Intervention</strong>&lt;br&gt;Initiate intervention for increasing intelligibility and functional language use.&lt;br&gt;Conduct parent and teacher training to develop awareness of problems and intervention strategies.&lt;br&gt;Conduct intervention within the classroom setting twice per month.&lt;br&gt;<strong>Determining Outcomes</strong>&lt;br&gt;Monitor performance on an ongoing basis.</td>
<td>Therapy room&lt;br&gt;School and home environments&lt;br&gt;Classroom-based activities</td>
</tr>
<tr>
<td>Classroom teacher</td>
<td><strong>Assessment</strong>&lt;br&gt;Gather work samples.&lt;br&gt;Describe communication demands and needs for classroom success.&lt;br&gt;Complete teacher checklist to profile students’ needs.&lt;br&gt;<strong>Intervention</strong>&lt;br&gt;Teach basic concepts.&lt;br&gt;Introduce key vocabulary.&lt;br&gt;Modify personal communication manner and style to elicit and correct unintelligible responses.&lt;br&gt;Alert speech-language pathologist and team when changes or problems occur.</td>
<td>Classroom and social activities in the school setting</td>
</tr>
<tr>
<td>Parents</td>
<td><strong>Assessment</strong>&lt;br&gt;Complete parent interview to describe communication skills and needs at home.&lt;br&gt;Suggest strategies team members may want to try based on personal knowledge of child.&lt;br&gt;<strong>Intervention</strong>&lt;br&gt;Modify personal communication manner and style to elicit and correct unintelligible responses.&lt;br&gt;Alert speech-language pathologist and team when changes or problems occur.</td>
<td>Interview in home, at school, via written communication or by phone&lt;br&gt;Home routines (meals, bath, play, bedtime)&lt;br&gt;Excursions in the community (store, church)&lt;br&gt;Periodic phone conferences</td>
</tr>
</tbody>
</table>

The PAC model presented in this article provides clinicians with a framework for decision-making and service delivery by encouraging speech-language pathologists and their colleagues to consider the unique combination of providers, activities, and contexts necessary to meet the specific needs of each individual with a communication disorder. *Providers* are those individuals who can foster meaningful change in an individual’s communication performance. *Activities* are those tasks that comprise total case management for meeting the needs of clients, including planning, assessment, implementing interventions, and evaluating progress. *Contexts* are those environments or conditions where effective communication is required and can be practiced.

The PAC model demonstrates essential characteristics that define good service delivery, including efficacy, coordination,
continuity, participation, and economy. It promotes creativity and flexibility in program design by encouraging teams to match key aspects of service delivery such as type, length, duration, frequency, and mode of service delivery with the client’s needs and circumstance.

As demonstrated in the PAC examples provided, expanding the number of providers, specifying the activities to be performed, and extending the number of contexts for service delivery will result in increased opportunities for stimulating the development of communication skills and implementing intervention procedures. Thus, the potential for accomplishing identified goals is increased.

Application of the PAC framework to service delivery also facilitates a collaborative team approach as all team members gain insight into the client’s program. Teams that are transitioning to alternative service delivery models will find the PAC framework helpful in guiding case management decisions. Most important, this model provides a format for clearly delineating each team member’s specific roles and activities—again expanding the potential for accomplishing the identified goals. Whenever a different service delivery approach is initiated, it is wise for team members to undergo in-service training. This will ensure that team members gain a common base of understanding and perspective.

REFERENCES


Received November 3, 1995
Accepted July 8, 1996

Contact author: Jean Blosser, EdD, The University of Akron, The School of Communicative Disorders, Akron, OH 44325-3001.