PLACE OF COURSE IN PROGRAM:

These courses will generally be taken by students during their second semester of the graduate program and are considered to be the second level clinical practicum courses. The methods course and clinical practicum must be taken concurrently. Each clinician/graduate student will be assigned two clients for a 12-week clinical semester. These may be clients seeking services for transgender voice, voice pathology, laryngectomy, stuttering, or cleft palate. While the practicum's focus is fluency and/or voice, this may be modified to meet the needs of the individual student or client.

SPECIFIC STUDENT LEARNING OUTCOMES:

During the course of this semester the student will:

1. Design, plan, and carry out assessments using standardized tests, informal measures and observations, interviews and conferences, and review of client files, predominantly in the content areas of fluency and voice pathology.
2. Demonstrate the ability to appropriately interpret and apply assessment information to design a treatment program. This program should be sequenced hierarchically and written in a behavioral objective format. This includes:
   3. Long term semester goals
   4. Short term objectives
   5. Treatment methods/procedures
   6. Complete a minimum of 35 total hours of client contact with at least 2 clients. You need to have at least 4 hours in assessment this semester.
   7. Complete a case report for each client which contains a plan for clinical intervention that is tailored specifically for that individual client.
   8. Create a set of pertinent history questions.
   9. Complete a client/caregiver interview utilizing the question set but adjusting as necessary by adding or deleting questions given to the client/caregiver during the interview.
10. Implement the treatment plan in an efficient and effective manner while making the plan and treatment methods interesting and inviting to the client.
11. Discuss with the client/caregiver the assessment findings and the treatment plan in a proactive, compassionate manner.
12. Update the client/caregiver on a regular basis about the progress being made under the treatment plan.
13. Take effective data in a structured and organized manner.
14. Write Initial and Final Case Reports that reflect the work done during the semester for assessment and treatment.
15. Attend weekly conferences with the assigned clinical instructor and assist in the planning and implementation of goals for your work as a clinician.
16. Use professional behavior with the client, caregiver, and clinical instructor.

The above learning outcomes will be assessed through weekly written lesson plans, Initial and Final Case Reports, skill with client assessment, the creation and implementation of therapy techniques, and professional behavior. A midterm and final competency evaluation will be completed by the clinical instructor and presented to you in writing and also in a verbal discussion if requested.

KASA (Knowledge And Skills Acquisition Standards):

Standard III-C: The applicant for certification must demonstrate knowledge of the nature of speech, language, hearing, and communication disorders and differences and swallowing disorders, including their etiologies, characteristics, anatomical/physiological, acoustic, psychological, developmental, and linguistic and cultural correlates. Specific knowledge must be demonstrated in the following areas:

- Fluency – etiologies, characteristics
- Voice and resonance, including respiration and phonation – etiologies, characteristics
- Articulation – etiologies, characteristics
- Receptive and expressive language (phonology, morphology, syntax, semantics, and pragmatics) in speaking, listening, reading, writing, and manual modalities

Standard III-D: The applicant must possess knowledge of the principles and methods of prevention, assessment, and intervention for people with communication and swallowing disorders, including consideration of anatomical/physiological, psychological, developmental, and linguistic and cultural correlates of the disorders.

- Articulation – prevention, assessment, intervention
- Social aspects of communication – prevention, assessment, intervention
- Communication modalities – prevention, assessment, intervention

Standard IV-G: The applicant must complete a program of study that includes supervised clinical experiences sufficient in breadth and depth to achieve the following skills outcomes (in addition to clinical experiences, skills may be demonstrated through successful performance on academic course work and examinations, independent projects, or other appropriate alternative methods):

1. Evaluation (must include all skill outcomes listed in a-g below for each of the 9 major areas) 1. Articulation  2. Fluency  3. Voice and resonance, including respiration and phonation  4. Receptive and expressive language  5. Hearing
   a. Conduct screening and prevention procedures (including prevention activities)
   b. Collect case history information and integrate information from clients/patients, family, caregivers, teachers, relevant others, and other professionals.
   c. Select and administer appropriate evaluation procedures, such as behavioral observations, nonstandardized and standardized tests, and instrumental procedures.
   d. Adapt evaluation procedures to meet client/patient needs.
   e. Interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention.
   f. Complete administrative and reporting functions necessary to support evaluation.
   g. Refer clients/patients for appropriate services.

2. Intervention (must include all skill outcomes listed in a-g below for each of the 9 major areas):
   a. Develop setting-appropriate intervention plans with measurable and achievable goals that meet clients'/patients' needs. Collaborate with clients/patients and relevant others in the planning process.
   b. Implement intervention plans (involve clients/patients and relevant others in the intervention process).
   c. Select or develop and use appropriate materials and instrumentation for prevention and intervention.
   d. Measure and evaluate clients'/patients' performance and progress.
   e. Modify intervention plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients/patients.
   f. Complete administrative and reporting functions necessary to support intervention.
   g. Identify and refer clients/patients for services as appropriate.

3. Interaction and Personal Qualities
   a. Communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others.
   b. Collaborate with other professionals in case management.
   c. Provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others.
   d. Adhere to the ASHA Code of Ethics and behave professionally.
Specifically, this course is designed to examine the etiologies and characteristics of the disorders of fluency; the etiologies and characteristics for disorders of voice and resonance, including respiration and phonation; and the social aspects of communication (challenging behavior, ineffective social skills, lack of communication opportunities, etc.).

COURSE POLICIES:

Attendance:
Prompt attendance at clinic treatment sessions is required at all times. Any missed assessment or treatment sessions must be made up during the week between the end of clinic and finals week and with the approval and knowledge of your clinical instructor. A clinical instructor must be supervising your sessions at all times.

Clinical Instructors:
Your clinical instructor and your therapy times have been assigned to you based on the schedule that you provided to the scheduling office. No changes to your schedule may be made without the approval of the Clinic Coordinator.
Your clinical instructors are required to meet with you on a weekly basis. Those meetings may be individual conferences to discuss your clients and your assessment/treatment plans or group conferences at the discretion of the clinical instructor. Attendance at these conferences is mandatory. If you have concerns that your clinical issues are not being adequately addressed, you should first talk with your clinical instructor. If your concerns are not addressed, speak with the Clinic Coordinator.

SCHEDULE:

Week 1: Methods class meets and students prepare for clients. Clients are assigned. Read client files. Make appointment with clinical instructor to plan first sessions if needed.

Week 2: Interview questions due to clinical instructors, if required. Review tests/Shipley. Decide on tests and practice prior to first client meeting.

Week 3: First day of clinic for most clients. Conduct interviews. Have client sign Client Permission Form and the Send Release Form. Play with child clients. Get a language & speech sample from adult clients; begin testing with adult clients. Review policies and Agreement Form.

Week 4: Conduct further evaluations as needed. Voice and fluency clients should not require more than 2 sessions of assessment. Set up semester objectives. Chart baseline behaviors if appropriate. Score all formal/informal tests administered to date. Begin treatment objectives, especially with your adult client. At the end of this week or the beginning of the next week, meet with your client/caregiver to discuss your assessment findings and your semester treatment plan.
Week 5: Analyze test results in preparation for Initial Case Report. If you have spent 2 weeks in assessment, begin treatment objectives this week. At the end of this week, meet with your client/caregiver to discuss your assessment findings and your semester treatment plan.

Week 6: Submit first draft of initial case reports, including demographics, history, evaluation information and semester objectives to clinical instructor. This first draft is graded so edit your work carefully. A required report format has been supplied to the clinical instructor and provided to you in SPHP 228A. Continue your treatment plan.

Weeks 7&8: The final draft (printed copy with full identifying information and all revisions) should be submitted to your clinical instructor. Continue treatment plan. Update your client/caregiver about progress in therapy.

Week 8&9: Midterm performance evaluations/conferences occur in these weeks.

Week 12: Submit first draft of Final Case Report to your clinical instructor. This first draft is graded. Be sure you have edited your work.

Week 13: Submit final form of Final Case Report to your clinical instructor for signature. Submit forms to clinical instructor regarding continuation of therapy.

Week 14: Last week of Clinic: Conduct Final Conference with client/caregiver. All final reports must be completed, signed and ready to go into the client's file. Release Forms for exchange of information should be included with report. Submit client contact hours form to Clinical Instructor for signature. Meet with Clinical instructor for final evaluation in this week or the next.

Week 15: Dead week - Possible clinic hours if you had to cancel therapy during semester.

GRADING POLICY:

1. Grading Policy: A passing grade for clinic performance is based on the Final Clinical Competency Form. You should review this form BEFORE clinic starts so that you aware of all items that will become part of your formative and summative assessment for this clinic. The Clinical Competency form will be completed by your clinical instructor at midterm and at final, but it is the final Clinical Competency Report on which your clinic grade is based. The Clinical Competency Form is separated into four (4) general competency categories: Writing, Assessment, Treatment, and Professional Behavior. Each general competency area consists of numerous individual line items.

A passing grade for each clinic is a B- or higher. A passing grade is obtained by achieving a rating of 4.0 or better on the average combined score of the 4 general competency categories, provided that the student achieves; (a) an average rating of 4.0 or better for each of the 4 general competency categories and (b) a minimum score of 3.0 on all individual competency line items. Therefore, any student receiving (a) a rating of 2.99 or less on any one (or more) specific line item or (b) a rating of 3.99 or less for a competency category will not pass the clinic, even if their average combined score of the 4 general competency categories is a B- or higher. In such cases, a grade of C+ will be given for the clinic.
Letter grades will be based upon the following:

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<tr>
<th>SCORE</th>
<th>GRADE</th>
<th>DESCRIPTION</th>
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| 4.65 - 5.00 | A     | **Exceeds Performance Expectations** (Minimum assistance required)  
|           |       | • Clinical skill/behavior well-developed, consistently        |
|           |       | demonstrated, and effectively implemented                     |
|           |       | • Demonstrates creative problem solving                       |
|           |       | • Clinical Instructor consults and provides guidance on ideas |
|           |       | initiated by student                                          |
| 4.50 - 4.64 | A-    |                                                               |
| 4.35 - 4.49 | B+    | **Meets Performance Expectations** (Minimum to moderate assistance required) |
| 4.15 - 4.34 | B     | • Clinical skill/behavior is developed/implemented most of the |
|           |       | time, but needs continued refinement or consistency          |
|           |       | • Student can problem solve and self-evaluate adequately      |
|           |       | in-session                                                    |
|           |       | • Clinical Instructor acts as a collaborator to plan and      |
|           |       | suggest possible alternatives                                 |
| 4.00 - 4.14 | B-    |                                                               |
| 3.85 - 3.99 | C+    | **Needs Improvement in Performance** (Moderate assistance required) |
| 3.65 - 3.84 | C     | • Inconsistently demonstrates clinical skill/behavior        |
| 3.50 - 3.64 | C-    | • Student’s efforts to modify performance result in varying  |
|           |       | degrees of success                                           |
|           |       | • Moderate and ongoing direction and/or support from Clinical |
|           |       | Instructor required to perform effectively                    |
| 3.35 - 3.49 | D+    | **Needs Significant Improvement in Performance** (Maximum assistance required) |
| 3.15 - 3.34 | D     | • Clinical skill/behavior is beginning to emerge, but is     |
| 3.00 - 3.14 | D-    | inconsistent or inadequate                                    |
| 1.00 – 2.99 | F     | **Unacceptable Performance** (Maximum assistance is not effective) |
|           |       | • Clinical skill/behavior is not evident most of the time     |
|           |       | • Student is unaware of need to modify behavior and requires  |
|           |       | ongoing direct instruction from Clinical Instructor to do so |
|           |       | • Specific direction from Clinical Instructor does not alter  |
|           |       | unsatisfactory performance                                    |
Read the Clinical Competency Form carefully and be sure you know on what you will be graded.

PROCEDURES:

- Provide name, current phone numbers, and email address.
- Attend weekly meetings. Be prepared with questions.
- Plan and conduct initial interviews and assessments. Have client or parent sign permission forms and/or agreement forms and submit these forms to the supervisor for signature. Carefully consider your need for any information release forms. Audio record the interview and save the recording until the end of the semester when it is destroyed. Be sure parent or client knows how to cancel a session. Combine assessment and trial therapy (assessment probes) so you will be ready to do therapy when you have finished assessing.
- SOAP notes for Blanton are expected Thursdays for the first two weeks then as needed. Put session notes in the working file with the supervisor notes and therapy plan. Other clinical instructors will have other requirements regarding SOAP notes.
- Maintain therapy logs for each client. These are kept in your working client file.
- Before placing any test protocols in a client’s file, be sure your supervisor has reviewed the test protocol.
- Review supervisor's observation notes and place in your working file. You may make comments on these notes. Be sure to initial them after each session.
- Prepare the initial case report draft for clients after the 6th session. All drafts will be graded. Initial drafts must be double spaced.
  - Prepare homework for client and family to do outside of therapy.
  - Prepare a final case report (13th week of clinic). All drafts will be graded. The final case report will be signed and placed in the client's file. See final evaluation form.
  - After your final report has been accepted, signed, and submitted, destroy previous printed and electronic copies of the reports. If you want to keep a template, be sure to completely remove all identifying information: name of client, parents, family members, physicians, therapists, and other service providers; addresses; phone numbers; birthdates; file numbers; etc.
- Conduct final conference with client/caregiver.
- Complete any make-up sessions during dead week.
- Submit final material for each client. These materials include the signed final drafts of the reports, therapy log, client continuation form, parent or client request for copy of report, report disposition form, and two copies of the client clock hour forms to be signed by your supervisor.
- Participate in end-of-semester evaluation with supervisor during dead week or during finals week as requested.
METHODS CLASS

Methods class requires attendance and participation in discussions of therapy hierarchies and methods, client learning and behaviors, clinician learning and behaviors, what ‘worked’ as a therapy technique, what didn’t, discussions of cause and effect, of KASA points, research studies, clinic deadlines and requirements, etc.

COURSE POLICIES:

Attendance:
Prompt attendance at class meetings is required. Any missed class will result in a loss of 10 points each occurrence. Tardiness will result in a loss of 5 points each occurrence. This is not the time where you may schedule other meetings and activities. This is a required course and professional standards will be applied and upheld.

Week 2: Turn in a single sheet of paper that includes a brief description of each client (demographic, disorder, past therapy, potential therapy plans) so that the methods instructor has information on clients being discussed.

Weeks 2-16: Participation in instruction and discussions:
Maintain professional behavior at all times.
Be certain that all comments are constructive, and that discourse is respectful – of each other, of clients, of clinical personnel at all times.

Enjoy the learning process. Stressful as it is, this is the time you learn and refine how to do your job really well. And that’s a remarkable thing.

POINTS:
1. You begin the semester in Methods class with 100 points, which is an A. Infractions will result in loss of points.
2. Infractions –
   i. Missing class.
   ii. Tardiness.
   iii. Inappropriate behaviors – specific warnings will be given regarding behavior and possible loss of points, then points will be deducted if behavior continues.
   iv. Missing assignment.
3. Points:

   A = 100-90   B = 89-85   B- = 84-80   F = 79-
Initial Case/Final Case/Assessment Report
Spring/Fall Semester (year)

Client Name: 
Date of Birth: 
Age: 
Parents: 
Address: 
Phone: 
Graduate Clinician: 
Clinical Instructor: 
Diagnosis (-es): 

File#: 
Date of Report: 
- **Fonts**: Please use Garamond as this is a Sac State authorized font.

- **Footer**: You must have a footer which indicates STUDENT REPORT (centered).

- **Header**: You must have a header which indicates File # and page x of y (right alignment).

- **Margins**:
  - Left and top @ 1”
  - Right @ 0.7”
  - Bottom @ 0.5”

### Background

Demographic info

Referral info

History: For adult clients – medical (including medications), current health status, work, family, other pertinent information for treatment.

For children – include birth history and developmental information. As above (except for work!).

### Assessment

Voice: Clinician perception of voice. Instrumental assessment data.

Fluency: Percent disfluent. Description of disfluencies and concomitant behaviors, if any.

### Therapy Goals and Progress

Describe previous therapy and progress, if applicable.

More or fewer goals and objectives as needed (Duh).
**Baseline:** Baseline for the following goal. That way where you started is part of your report.

**Goal 1:**

**Objective 1:**

**Objective 2:**

**Objective 3:**

**Progress and Procedures (FCR)**

**Baseline:**

**Goal 2:**

**Objective 1:**

**Objective 2:**

**Objective 3:**

**Progress and Procedures (FCR)**

**Etc.**

**Recommendations**

It is recommended that ... Future goals may include, but are not limited to the following:

1. XYZ
2. XYZ
3. XYZ, etc.

_________________________________           ______________________________
XXXXXXX, B.S.                                 XXXXXXX, CCC-SLP
Graduate Clinician                                    Clinical Instructor