



California State University, Sacramento

Department of Communication Sciences and Disorders

GRADUATE SYLLABUS & COURSE OUTLINE

Semester/Year: Spring 2023	Course: CSAD 243C Practice: Language Disorders III	Section: 1 #165191
Meeting Days: Monday/Wednesday	Weekly Rounds: Wednesdays 12-1 pm	Location: Clinic / Folsom Hall
Instructor: Stephanie Jacobson, M.A., CCC-SLP (she/her)	Email: s.d.jacobson@csus.edu	Phone: 760-685-4414 (personal) 916-278-4777 (office)
Office Location: 2000 Cubicle D	Office Hours/Appointments: Mondays 1-2:30 pm	

DATE OF LAST SYLLABUS REVISION: 1/22/2023

Land Acknowledgement

We are mindful in acknowledging that the land that Sacramento State is located on, was and continues to be stewarded by the indigenous people of this area, the Miwok, Maidu, and Nisenan.

Inclusivity

Students in this course are welcomed and encouraged to be active participants, bringing their **full professional selves** to the clinic. Each of us must show respect for one another. In this course, people of all ethnicities, genders and gender identities, religions, ages, sexual orientations, (dis)abilities, socioeconomic backgrounds, regions, and nationalities are encouraged and welcomed

to share their rich array of perspectives and experiences. Discrimination against minoritized students or clients in any form is **unacceptable**. Please reach out to your instructor if you feel anything less than welcomed in our classroom community, or if you have any specific needs. You will learn best bringing your full professional self to our clinic, and your instructor wishes to support you reaching your potential to be the best clinician you can be.

Catalogue Course Description:

CSAD 243C. Practice: Language Disorders III. 2 Units

Prerequisite: CSAD 243B; instructor permission

Corequisite: CSAD 242C

Term Typically Offered: Fall, Spring

Supervised clinical practice emphasizing adult clients whose speech and language are disordered secondary to neurogenically related problems such as cerebrovascular accident, traumatic brain injury, or other neurological disorders.

Place of Course in Program

Supervised clinical work with adults with acquired cognitive-linguistic communicative disorders.

Sacramento State Graduate Learning Goals (GLG)	Addressed by this course (Y/N)
Disciplinary knowledge: <i>Master, integrate, and apply disciplinary knowledge and skills to current, practical, and important contexts and situations.</i>	Y
Communication: <i>Communicate key knowledge with clarity and purpose both within the discipline and in broader contexts.</i>	Y
Critical thinking/analysis: <i>Demonstrate the ability to be creative, analytical, and critical thinkers.</i>	Y
Information literacy: <i>Demonstrate the ability to obtain, assess, and analyze information from a myriad of sources.</i>	Y
Professionalism: <i>Demonstrate an understanding of professional integrity.</i>	Y
Intercultural/Global Perspectives: <i>Demonstrate relevant knowledge and application of intercultural and/or global perspectives.</i>	Y

Course Learning Outcomes:

Upon completion of this course, students will demonstrate **clinical competency** in the areas of (a) evaluation, (b) intervention, (c) writing and (d) interaction and personal qualities (professional behavior) when working with clients exhibiting acquired cognitive-communication disorders.

Textbooks and Materials:

None

Online Resources:

CANVAS

Course Requirements/Components:

The student clinician will be responsible for:

1. Assessing clients' speech, language, voice, and/or cognitive systems.
2. Conducting, and evaluating language intervention with two (2) clients for a total of four (4) hours/weekly, totaling approximately 30 client contact hours. The clinic therapy begins week #3. *All therapy sessions (including any make-up sessions) must be completed no later than dead week.*
3. Interpreting results of therapy with clients, spouses/partners/family members/significant others and working with them on education/training, compensatory strategies, functional gains, and/or carryover home assignments.
4. Writing daily lesson plans in the form of lesson plans and SOAPS notes. Measurable outcomes must be documented on a daily basis.
5. Documenting progress in daily lesson plans and SOAPS notes in clients' working files.
6. Writing Initial and Final Reports of Therapy. **Late submissions automatically drop your final Writing area clinical competency grade by one grade per week late. No exceptions to this.** As with other practicum experiences, once the student clinician has met with his/her clients, dropping clinical practicum classes by the student clinician is prohibited except for medical reasons or extraordinary circumstances as approved by the Department.
7. Integrating and demonstrating use of the peer review process for editing your ICR and FCR (see specific instructions).
8. Meeting with practicum clinical instructor on a once weekly basis is mandatory. Your clinical instructor will be available to you at other times also, but the weekly meeting should center on specific questions/concerns you have about your clients' programs. Prepare for the weekly meetings: Have specific questions written and ready to discuss. If you are unable to keep your appointment, you must cancel prior to meeting time and reschedule with your clinical instructor.
9. Evaluating your clinical strengths and identifying areas in which you wish to grow. During meetings and evaluations as well as your written clinic documentation, you will discuss your developing areas of strengths and areas you wish to strengthen. You will be asked to be self-evaluative, noting specifically what you need to do better and what you plan to do to strengthen these areas. Your clinical instructor will also commit to what s/he can do to help you in these areas. In keeping with ASHA Standards, we will use formative assessment ("ongoing measurement during educational preparation for the purpose of improving student learning") to evaluate students' critical thinking, decision making, and problem solving skills across oral and written components and in clinical proficiency.

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 are 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:

SCORE	GRADE	DESCRIPTION
4.65 - 5.00	A	<u>Exceeds Performance Expectations</u> (Minimum assistance required) <ul style="list-style-type: none"> 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+	<u>Meets Performance Expectations</u> (Minimum to moderate assistance required) <ul style="list-style-type: none"> 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
4.15 – 4.34	B	
4.00 – 4.14	B-	
3.85 – 3.99	C+	<u>Needs Improvement in Performance</u> (Moderate assistance required) <ul style="list-style-type: none"> Inconsistently demonstrates clinical skill/behavior 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
3.65 – 3.84	C	
3.50 – 3.64	C-	

3.35 – 3.49	D+	<u>Needs Significant Improvement in Performance</u> (Maximum assistance required) <ul style="list-style-type: none"> Clinical skill/behavior is beginning to emerge, but is inconsistent or inadequate Student is aware of need to modify behavior, but is unsure of how to do so Maximum amount of direction and support from clinical Supervisor required to perform effectively.
3.15 – 3.34	D	
3.00 – 3.14	D-	
1.00 – 2.99	F	<u>Unacceptable Performance</u> (Maximum assistance is not effective) <ul style="list-style-type: none"> 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

Course Policies/Procedures:

ICR/FCR Peer Review Process

Instructions: You will be required to write your ICR and FCR by engaging in the peer review process that you used during your intensive writing course. Please note the ICR and FCR due dates for this clinic and plan for your peer reviews accordingly. As part of the peer review process, you will be asked to complete the following steps:

1. Complete your ICR for each client as per the guidelines in the LIII Syllabus and the California State University, Sacramento Maryjane Rees Language, Speech and Hearing Center Clinic manual.
2. Identify a partner to work with to complete the Peer Review Project. Your peer will be responsible for editing all of your reports, and you will be responsible for editing all of their reports.
3. Swap reports with your Peer Reviewer.
4. Spend at least a day or two editing the reports. Provide comments on ways your peers might improve their report. Note any typographical errors, grammar concerns, or wording concerns you might have. Provide written feedback regarding areas that may be unclear or incomplete. Note all changes in pen or pencil on your peer report hard copies.
5. Once you have edited the reports, return them to your peer reviewer. Collect copies of your reports.
6. Make revisions to your report following the suggestions of your Peer Reviewer. Please consider that if your Peer Reviewer has taken the time to provide the comment(s) or corrections, they are probably correct in their suggestion(s). Edit your reports liberally.

7. Finalize reports and hand in to your Clinical Instructor along with the Peer Reviewed copy of the report with comments and any additional documentation required by your assigned Clinical Instructor.

ICR/FCR Reports

1. Please follow the standardized ICR/FCR format.
2. Please edit all submitted reports including mechanics (e.g., spelling, grammar) and formatting (e.g., margins, font, etc).
3. Please comply with all HIPAA regulations (e.g., use of initials, remove identifying info)
4. For all edits, please use the software's editing tool (e.g., "track changes" in Microsoft Word) or per the assigned clinical instructor's instructions.

SOAPS Notes and Clinical Instructor Observations

1. Please use SOAPS notes to document each treatment session and provide your lesson plans:
 - (a) Please write objectives for each session. All goals/objectives should be modified in some way every week.
 - (b) Please include documentation about the provision of education for each therapy session.
 - (c) Please place a hard copy of your SOAPS note into your chart **before** the start of clinic on Monday mornings.
2. SOAPS Note modification:
 - (a) Please do not **retype** your SOAPS notes, unless instructed.
 - (b) If the clinical instructor asks a question regarding the SOAPS note, please respond in writing before the next treatment session.
3. Therapy Observation Comments:
 - (a) Be sure to **always** initial the clinical instructor's comments once read.
 - (b) Please be sure to answer any questions that are asked on the lined paper and feel free to ask questions for the clinical instructor.
 - (c) Be sure to bring your assigned client folders to every weekly conference with the clinical instructor.

Therapy Observation Comments:

1. Be sure to **always** initial the clinical instructor's comments once read.

2. Please be sure to answer any questions that are asked on the lined paper and feel free to ask questions for the clinical instructor.
3. Be sure to bring your assigned client folders to every weekly conference with the clinical instructor.

Weekly Conferences

Students will meet with the assigned clinical instructor individually every week. This weekly meeting schedule will be created at the beginning of the semester. Please prepare for each weekly conference with the assigned clinical instructor. Students will receive ongoing written and verbal feedback from the assigned clinical instructor throughout the semester. Students are expected to integrate all clinical recommendations into the intervention. As a result, the midterm and final evaluation reports/conferences should be a reflection of the ongoing collaboration and discussions.

Recordings

[Please see CI for adjusted instructions regarding recordings.] If a student is interested in recording a therapy session, please leave a post-it note on the assigned clinical instructor's computer *before the start* of therapy.

Confidentiality:

- A. Please consult your clinic handbook regarding client confidentiality and client confidentiality as it pertains to video and audio recording. Any violation of these policies will result in the student receiving a failing grade in the clinic
- B. A violation of this policy may result in the student receiving a failing grade in the clinic.

General Policies

Absences: Students are expected to meet all clinic appointments. If a student is ill and cannot attend clinic, please contact your clients and assigned clinical instructor. Any sessions canceled by the student must be offered as a make-up session during dead week (sessions canceled by the clients do not necessarily need to be made up). Please refer to the Clinic Handbook for additional information.

Tentative Course Schedule/Outline:

TENTATIVE CLINIC SCHEDULE AND EXPECTATIONS (PLEASE VERIFY SPECIFIC DATES WITH YOUR CLINICAL INSTRUCTOR [CI])		
For additional information, please see the most recent clinic handbook, including special instructions for COVID-19.		
(a) Student Clinic Handbook or the (b) Student Clinic Handbook, Clinical Instructor edition		
DATE:	(a) The student will:	(b) The clinical instructor will:
<u>Week #1</u> <i>Beginning the week of 1/23/23</i>	<p>Clients assigned. Please read/ review client file thoroughly. Create initial draft assessment plan. Create a list of questions & comments to maximize meeting with CI.</p> <p>Make appointment and meet with CI to plan first sessions. Include your rationale as to why you are (a) asking your specific interview questions and (b) selecting the tests/ assessments.</p> <p>Schedule and meet with clinical instructor to finalize assessment plan this week or next.</p>	<p>Meet with each student clinician individually and/or in a group to discuss initial draft assessment plan including interview questions.</p> <p>Provide verbal and/or written instructions/ feedback.</p> <p>Establish a consistent weekly meeting day/time with student this or next week.</p>
<u>Week #2</u> <i>Beginning the week of 1/30/23</i>	<p>Integrate CI's recommendations into assessment plan.</p> <p>Schedule and meet with clinical instructor to finalize assessment plan.</p>	<p>Meet with each student clinician individually and /or in a group to make recommendations/edits and to confirm student's finalized assessment plan.</p> <p>Establish a consistent weekly meeting day/time with student clinicians, if not done during week #1.</p>
<u>Week #3</u>	<p>First week of clinic for L3 clients.</p>	<p>Provide supervision and written feedback.</p>

<p><i>Beginning the week of 2/6/23</i></p>	<p>Conduct interview (be sure to design and use aphasia friendly materials to provide communicative access).</p> <p>Have the client or caretakers (if appropriate) sign all forms required by Clinic Director (i.e., Exchange of Information, Release forms, permission forms, etc.).</p> <p>Prepare for and meet with clinical instructor.</p>	<p>Meet with student clinician.</p>
<p><u>Week #4</u></p> <p><i>Beginning the week of 2/13/23</i></p>	<p>Conduct assessments as scheduled. Develop semester objectives. Chart baseline behaviors as appropriate.</p> <p>Prepare for and meet with clinical instructor.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>
<p><u>Week #5</u></p> <p><i>Beginning the week of 2/20/27</i></p>	<p>Continue assessment; begin therapy.</p> <p>Prepare/plan to integrate peer review process for ICR.</p> <p>Prepare for and meet with clinical instructor.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>
<p><u>Week #6</u></p> <p><i>Beginning the week of 2/27/23</i></p>	<p>Submit first draft of initial case report (ICR).</p> <p>Continue therapy and charting.</p> <p>Prepare for and meet with clinical instructor.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>
<p><u>Week #7</u></p> <p><i>Beginning the week of 3/6/23</i></p>	<p>Continue therapy</p> <p>Submit final draft of ICR; prepare for and meet with clinical instructor.</p>	<p>Provide supervision/written feedback.</p> <p>Meet with student clinician, review mid-semester competencies.</p>

<p><u>Week #8</u></p> <p><i>Beginning the week of 3/13/23</i></p>	<p>Continue therapy</p> <p>MID-SEMESTER COMPETENCIES EVALUATIONS DUE THIS WEEK</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>
<p><u>Week #9</u></p> <p><i>Beginning the week of 3/20/23</i></p>	<p>Spring Break</p>	<p>Spring Break</p>
<p><u>Week #10</u></p> <p><i>Beginning the week of 3/27/23</i></p>	<p>Continue therapy</p> <p>Prepare for and meet with clinical instructor.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>
<p><u>Week #11</u></p> <p><i>Beginning the week of 4/3/23</i></p>	<p>Continue therapy</p> <p>Prepare for and meet with clinical instructor.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>
<p><u>Week #12</u></p> <p><i>Beginning the week of 4/10/23</i></p>	<p>Continue therapy and begin post testing.</p> <p>Prepare for and meet with clinical instructor.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>
<p><u>Week #13</u></p> <p><i>Beginning the week of 4/17/23</i></p>	<p>Continue therapy and begin post testing.</p> <p>Prepare for and meet with clinical instructor.</p> <p>Work on writing final case report drafts.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>

<p><u>Week #14</u></p> <p><i>Beginning the week of 4/24/23</i></p>	<p>Continue therapy.</p> <p>Submit first draft(s) of final case report(s) (FCRs) this week.</p> <p>Plan/conduct end of semester meeting with clients' spouse/ caretakers.</p> <p>Confer with CI and submit forms to clinical instructor regarding continuation of therapy.</p> <p>Conduct end of semester evaluation.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician.</p>
<p><u>Week #15</u></p> <p><i>Beginning the week of 5/1/23</i></p>	<p>Conduct end of semester meeting with clients' spouse/caretakers.</p> <p>Confer with CI and submit forms to clinical instructor regarding continuation of therapy.</p> <p>Submit final draft(s) of final case report(s) (FCRs) this week.</p> <p>Prepare for and meet with clinical instructor.</p>	<p>Provide supervision and written feedback.</p> <p>Meet with student clinician individually and review final competencies report; please follow handbook policy and procedures</p>
<p><u>Week #16</u></p> <p><i>Beginning the week of 5/8/23</i></p>	<p>“DEAD WEEK” / CLINIC MAKE-UP WEEK</p> <p>(Complete any make-up sessions and inform clinical instructor of these sessions)</p>	<p>Meet with student clinician individually and review final competencies report, if not already completed; please follow handbook policy and procedures.</p>
<p><u>Week #17</u></p> <p><i>Beginning the week of 5/15/23</i></p> <p><i>Finals Week</i></p>	<p>All final reports must be completed, signed and ready to go into the client’s file.</p> <p>Release forms for exchange of information should be included with report.</p> <p>Please follow all clinic procedures and policies. See clinic handbook for more information.</p>	<p>Meet with student clinician, if needed.</p>

SOAPS FORMAT

- S:** **Subjective:** What the client or caregiver says to the clinician that relates to the client's medical or speech status. Any observations made by the clinician that pertain to their performance or status.
- O:** **Objective:** The activities/tasks performed during the therapy session, as well as the objective information describing the client's response to the activities/tasks. It is data, factual information.
- A:** **Analysis:** The clinician's analysis of what the client's response indicated, e.g., progress, regression, with effort, etc. It is likely a combination of the S and the O.
- P:** **Plan:** The clinician's abbreviated lesson plan for the upcoming week. This should include your plan for any referrals, consultations, and changes.
- S:** **Self-Reflection:** Write a reflection on your clinical performance. Be sure to include in your response:
- A. What I did well?
 - B. What area(s) to improve along with my strategy for implementation)

Documentation Using the SOAPS Format: Useful Tips

The speech-language pathologist's documentation becomes part of the patient's medical record. It is a legal and confidential document. The patient report serves many purposes. In addition to serving as a medical communication purpose, the report also provides a proof of treatment rendered for insurance purposes or legal purposes. In the event of future legal action, the report may also serve as the only proof of the treatment provided. If it is not written down, it did not happen. Any detail or information which may be important or pertinent to the patient's care should be included.

Key Elements of SOAPS Report Format

SUBJECTIVE – THE PATIENT'S STORY: Observations

1. Patient Description: Anything the patient or family noted. The patient behavior. How they came in. Behavior or emotional issues.
2. Patient statements (I am tired, I had trouble with the home work, I have a new diagnosis, I saw my MD etc.
3. Who was present for the session
4. Chief complaint – Always in an Eval

5. History of the Present Event: What happened? When did it happen? Where did it happen? Who was involved? How did it happen? How long did it occur? What was done to improve or change things?
6. Past Medical History (Pertinent)

OBJECTIVE INFORMATION – THE DATA: Findings (What the Patient did)

1. Goals listed with percentages, data, etc.
2. The Objective part is all about numbers. What did they client actually DO.
3. General Observations: Other noteworthy information such as environmental conditions, patient location upon arrival, patient behavior, etc.
4. Diagnostic Results; level or performance on today's tasks related to the goals
5. This should be clear in terms of how many trials, what was done. It should be written in a way that other therapists of the same discipline should understand it.

ASSESSMENT – THE THERAPIST'S IMPRESSION: Analysis of information from S and O (What do you think the patient's behavior means)

1. Conclusions made based on chief complaint and exam findings
2. Assessment is what the S. and O. mean (was it typical, did it improve, reasons for change, eval performance, fewer cues, did one lead to the other - and where was the breakdown).
3. This should be written in a language that MD, RN, PT, OT and other disciplines should be able to understand

PLAN – THE THERAPIST'S PLAN OF THERAPY: The Plan

1. What you're going to work on short term and long term. Any referrals, assignments etc.
2. Any changes to therapy plan or something to increase or decrease focus on
3. Based on what happened in O/A

S – Self-reflection (this section is specific to documentation at CSUS!): Reflect on your performance as a clinician and identify:

1. What you did well
 2. Areas of improvement in YOUR clinical performance
 3. How you can support YOUR improved performance in future therapy sessions.
- Do not discuss something in the A or P if it was not mentioned in the S. or O.
 - SOAP notes are supposed to be succinct - telegraphic speech is acceptable as long as it's clear.

Provided by and modified from Mission Hospital, California

CSAD 243C Practice: Language Disorders III – Spring 2023

EXAMPLE

SOAPS NOTES

Language III

Spring Semester, 2023

Student name: Sam Student

Client's initials: BA

Age: 78

Session dates: 2/6-5/3/2023

Clinical instructor: Stephanie D. Jacobson

S: Client arrived 10 minutes late due to traffic; he was pleasant but complained of a poor night's sleep last night and appeared very tired. Reported completion of his oral strengthening exercises 3x/day; family reported improved speech.

All information here is either a subjective observation from the clinician or something reported from the client or caregiver. Always use terms like "appeared to," or "reported."

- O:**
1. Client independently recalled 2/3 clear speech strategies.
 2. Client read single/compound CVC words containing alternating front and back phonemes with moderate assistance using learned compensatory strategies (reduced rate of speech and over articulation) with 70% accuracy.
 3. Client read 3-word phrases with moderate assistance to reduce his rate of speech and maximal assistance using a learned compensatory strategy (over articulation) with 50% accuracy.

This defines the tasks that were performed and the client's response in the form of objective data.

A: Client required more assistance to reach the same level of intelligibility at both the CVC and short phrase level. Level of fatigue may have impacted his performance. His level of commitment in performing his exercises at home remains consistent, and he reported success communicating with his family.

This is an assessment of how all of the information contained in the O and if pertinent, the S, translates to functional performance. Are we seeing improvement? Decline? This sums up what is in the S and O.

- P:**
1. Review of clear speech strategies and rationale.
 2. Oral motor exercises.
 3. Reading 3-4 word sentences while tape recording.
 4. Mr. A. will perform self-assessment of intelligibility.
- S:** My treatment plan was well organized but my use of professional jargon negatively impacted the client's understanding of the task objectives.

LESSON PLAN TEMPLATE

<p>S.M.A.R.T. Weekly Objectives</p>	<p>Method/Approach with Rationale <i>(include independent and EB information in discussion; cite literature, if applicable)</i></p>	<p>Materials Rationale</p>	<p>Results <i>(Objective data with accuracy levels)</i></p>	<p>Next week's Plan <i>(S.M.A.R.T. therapy objectives Discuss cueing hierarchy & appropriate levels of complexity demonstrating your task analysis)</i></p>	<p>Self-Reflection <i>(Be sure to answer: [a] What I did well? and [b] What area(s) to improve along with my strategy for implementation)</i></p>
<p>Given moderate visual and verbal cues, client will decode written single syllable words of up to 4 graphemes containing 4 common rimes with 80% accuracy over two consecutive therapy sessions.</p>	<p>Expose the client to rime and onsets in order to increase her ability to decode words containing these units rapidly and automatically. Extension activities may include increasing the difficulty of decoding activities by adding a fourth grapheme to target words (e.g. adding / t/ to “can” = “can’t”) and highlighting the word family within the word.</p>	<p>Use letter tiles, onset/rime cards, and word family cards, to help client blend onsets with rimes in words of up to 4 graphemes. BOB Books as this series is right at her level and provides illustrations that correspond to each word read.</p>	<p>Client blended onsets and rimes in words of up to 4 graphemes with 80% accuracy when given moderate verbal phonemic cues over two consecutive therapy sessions.</p>	<p>Given moderate visual and verbal cues, client will decode written single syllable words of up to 4 graphemes containing 6 common rimes with 80% accuracy over two consecutive therapy sessions.</p>	<p>Consistent verbal encouragement is judged to positively impact this client’s increased willingness to engage in reading activities. Intermittent physical activities and the inclusion of games continues to provide an outlet for her high level of energy. As I increase the complexity of the reading tasks, I need to make sure I am scaffolding the strategies I use to support her continued success. For example, I need to attempt to decrease the level of phonemic cuing I am giving.</p>

Note: Student clinicians are required to use this standardized clinic format for ICR:



Maryjane Rees Language, Speech and Hearing Center
Department of Communication Sciences and Disorders
California State University, Sacramento
6000 J Street
Sacramento, CA 95819-6071
T:(916) 278-6601 F:(916) 278-7730

Initial Case Report (ICR)

Spring Semester 2023

Client name:	File #:
Date of birth:	Age:
Address:	Date of report:
Phone:	Caregiver(s):
Graduate clinician:	Clinical Instructor: Stephanie Jacobson

Sample Report Format (may be modified per clinical instructor discretion):

Diagnoses

- **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 History and Information

This section includes chief complaint, referral source, prior speech therapy, diagnosis and onset date, past medical history, prior level of function (e.g., employment, educational level, communication

abilities, languages spoken), and current status (e.g., living environment, employment, physical abilities, medications). If client is returning, comment on any interval change since last seen.

Subjective

This will be a statement describing the testing environment (including attendees), dates of testing, and overall performance_(attention, cooperation, etc.).

Objective

Oral-Mechanism Examination

Comment on the structure and function of the oral periphery. Include results of formal tests, and description of the quality of speech (e.g., spastic dysarthria, oral and verbal dyspraxia).

Motor Speech Production

Include patient reported measures and deficit-based measures here. When commenting on intelligibility, be sure to include at what level (e.g., monosyllabic words, phrases, in conversation), in what context (i.e., known vs. unknown), and to what kind of listener (e.g., familiar vs. unfamiliar).

Receptive Language

Auditory Comprehension

Include results of patient reported measures, formal tests (please follow the appropriate format), as well as informal impressions (e.g., ability to follow conversation, ability to understand depending on length and complexity, etc.).

Reading Comprehension

Include results of formal tests, as well as clinician-derived reading tasks. Be sure to discuss visual neglect and vision correction, if applicable. Comment on comprehension of gestures and other non-verbal cues.

Expressive Language

Verbal Expression

Include results of patient reported measures, formal tests, as well as spontaneous productions. Describe the quality of utterances (e.g., fluent, non-fluent, jargon, phonemic paraphasic errors) and provide examples. Also include spontaneous use of gestures, or ability to use an alternative or augmentative communication device (which could be as simple as pointing to a word from a choice of three).

Written Expression

This section includes writing, which may be as minimal as a signature, or as complex as a consumer complaint letter.

Cognition

This section should include any/all areas of cognition that were assessed. Remember to use both patient reported measures and deficit measures. Be sure to distinguish the different types of memory, attention, etc...

Memory

Attention

Executive Functioning

Problem-Solving

Judgement

Orientation

Assessment

This section should be *brief*. Format as below.

[Client name] presents with [severity] [chronicity] [type] [disorder] characterized by [specific deficits]. Also include client perception and overall communicative abilities. You should then follow with a brief *analysis* that discusses the functional problems and quality of life impact that are a result of the speech/language/cognitive-communication deficit.

Prognosis is [excellent/good/fair/poor/guarded], due to [positive prognostic indicators], and [barriers to progression].

Recommendations & Plan

Make recommendations for frequency and duration of therapy, as well as participants (spouse, children), and any applicable home program. You can also discuss recommendations for outside of therapy, such as whether or not your client should manage his/her own checkbook, and community referrals (e.g., support groups, audiological evaluation).

Goals

Patient Stated Goal

This should be a statement indicating the overarching goal that a client would ultimately want to achieve.

End of Semester Goals

These should be written in the format of a SMART goal and should be achievable by the end of the semester. Recommend focussing on 2-3 goals.

Signatures

First/Last Name, B.A./S.

Graduate Clinician

Stephanie Jacobson, M.A., CCC-SLP

Supervising Clinical Instructor

CA License # SP24137

Student clinicians are required to use this standardized clinic format for FCR:



Maryjane Rees Language, Speech and Hearing Center
Department of Communication Sciences and Disorders
California State University, Sacramento
6000 J Street
Sacramento, CA 95819-6071
T:(916) 278-6601 F:(916) 278-7730

Final Case Report (FCR)

Spring/Fall Semester (year)

Client name: _____ **File #:** _____
Date of birth: _____ **Age:** _____
Address: _____ **Date of report:** _____
Phone: _____ **Caregiver(s):** _____
Graduate clinician: _____ **Clinical Instructor:** Stephanie Jacobson

Therapy Report:

CLIENT NAME was enrolled for speech therapy during the FALL/SPRING semester of YEAR. HE/SHE was seen between MONTH DATE, YEAR and MONTH DATE, YEAR for XX of XX scheduled sessions.

Medical Diagnosis:

Impressions (Diagnostic) Statement:

Prior Level of Function:

Current Level of Functioning:

Current Medications:

Client goals:

Pain:

Barrier(s) to Progress:

THERAPEUTIC FOCUS:

1. LIST GOAL #1 as written in ICR (**Goal Met/Partially Met/Not Met**)

[**Example:** Using learned compensatory strategies, XXX. will use three-to-five word phrases using appropriate prosody and increase speech intelligibility during simple/basic conversation with a familiar communication partners given minimal assistance with 80% accuracy across three consecutive sessions. (Goal Met)]

Write another statement describing the patient's current ability in terms of this goal OR progress towards this goal.

[**Example:** During three separate conversations about various topics with familiar and unfamiliar conversational partners, XXX used appropriate prosody and demonstrated increased speech intelligibility while independently using scripted introductory and closing phrases 100% of the time (three out of three trials) across three consecutive sessions.]

Continue listing all goals from ICR, following example listed above.

PROGRESS AND PROCEDURES: [Example, listed below]

Upon initially meeting XXX on MONTH DATE YEAR, XX presented with DIAGNOSTIC STATEMENT HERE. The client and/or significant others were educated regarding specific areas of education and training including X, Y, and Z. XXX continues to present with but has made progress Due to his increased independence with using compensatory strategies, XX became a regular member of XXX social group which has provided him with additional opportunities to use his strategies in a communicatively supportive environment and to significantly increase his social networks. XX regularly completed homework assignments and demonstrated high motivation in accurately using strategies taught, which had a positive impact in decreasing the amount of speech fillers used in conversation due to word-finding difficulties and increasing the intelligibility of multisyllabic words.

RECOMMENDATIONS: [Example, listed below]

Therapy at this center is recommended during the Fall/Spring semester of YEAR. Future goals may include, but are not limited to:

1. List your recommended **therapy goals** here...

Recommendations for XXX.: (**see examples below**)

- A. Increase participation in activities and groups that will increase XXX.'s potential for increased social networks (ex. joining programs within CSUS NeuroService Alliance, UC Davis Conversational Group for Aphasia, attending art classes, golf lessons, wine clubs, etc).

- B. Increase metacognition of conversational skills through the use of a journal where XXX will take notes of successful conversations and skills that need to be improved when attending social activities and/or groups.
- C. Continue using strategies of circumlocution and pacing while conversing with familiar and unfamiliar conversational partners.
- D. Continue using scripted phrases to increase self-confidence when greeting unfamiliar conversational partners.

First/Last Name, B.A./S.

Graduate Clinician

Stephanie Jacobson, M.A., CCC-SLP

Supervising Clinical Instructor

CA License # SP24137

Additional Information

Commitment to Integrity:

Sac State's Academic Honesty Policy & Procedures:

“The principles of truth and honesty are recognized as fundamental to a community of scholars and teachers. California State University, Sacramento expects that both faculty and students will honor these principles, and in so doing, will protect the integrity of academic work and student grades.” Read more about Sac State's Academic Honesty Policy & Procedures at the following website: <https://www.csus.edu/umannual/student/stu-100.htm>

Definitions: At Sac State, “cheating is the act of obtaining or attempting to obtain credit for academic work through the use of any dishonest, deceptive, or fraudulent means.” **Plagiarism** is a form of cheating. At Sac State, “plagiarism is the use of distinctive ideas or works belonging to another person without providing adequate acknowledgement of that person's contribution.” Source: Sacramento State University Library Note: Any form of academic dishonesty, including cheating and plagiarism, shall be reported to the [Office of Student Conduct](#).

Department Policy on Use of APA Format

The Department of Communication Sciences and Disorders requires the use of the APA format and style. All students are required to reference the APA manual. All assignments are to be composed using APA format and style unless otherwise noted.

Understand When You May Drop This Course:

It is the student's responsibility to understand when he/she need to consider disenrolling from a course. Refer to the Sac State Course Schedule for dates and deadlines for registration. After this period, a serious and compelling reason is required to drop from the course. Serious and compelling reasons include: (a) documented and significant change in work hours, leaving student unable to attend class, or (b) documented and severe physical/mental illness/injury to the student or student's family. Under emergency/special circumstances, students may petition for an incomplete grade. An incomplete will only be assigned if there is a compelling extenuating circumstance. All incomplete course assignments must be completed by the department's policy.

Equal Access:

California State University-Sacramento, Department of Communication Sciences and Disorders, seeks to provide equal access to its programs, services, and activities for people with disabilities. If you have a documented disability and verification from the Office of Services to Students with Disabilities (SSWD), and wish to discuss academic accommodations, please contact your instructor as soon as possible. It is the student's responsibility to provide documentation of disability to SSWD and meet with a SSWD counselor to request special accommodation before classes start. **Sacramento State Services to Students with Disabilities (SSWD)** offers a wide range of support services and accommodations for students in order to ensure students with disabilities have equal access and opportunity to pursue their educational goals. Working collaboratively with students, faculty, staff and administrators, SSWD provides consultation and serves as the information resource

on disability related issues to the campus community. SSWD is located in Lassen Hall 1008 and can be contacted by phone at (916) 278-6955 (Voice) or (916) 278-7239 (TDD only) or via email at sswd@csus.edu.

Sacramento State is committed to ensuring an accessible learning environment where course or instructional content are usable by all students and faculty. If you believe that you require disability-related academic adjustments for this class (including pregnancy-related disabilities), please immediately contact Services for Students with Disabilities (SSWD) to discuss eligibility. A current accommodation letter from SSWD is required before any modifications, above and beyond what is otherwise available for all other students in this class will be provided. Please be advised that disability-related academic adjustments are not retroactive. SSWD is located on the first floor of Lassen Hall 1008. Phone is 916-278-6955 and e-mail is sswd@csus.edu. For a complete listing of services and current business hours visit <https://www.csus.edu/student-affairs/centers-programs/services-students-disabilities/>

Basic Needs Support

If you are experiencing challenges with food, housing, financial or other unique circumstances that are impacting your education, help is just a phone call or email away! The CARES office provides case management support for any enrolled student. Email the CARES office at cares@csus.edu to speak with a case manager about the resources available to you. Check out the [CARES website](#).

Title IX

The University requires faculty and staff to report any personal disclosures of sexual misconduct including rape, dating/domestic violence and stalking to the Title IX Coordinator. Students who do not wish to report their experience to me or the Title IX Coordinator may speak to someone confidentially by contacting Student Health and Counseling Services.

Sac State is committed to supporting students and fostering a campus environment free of sexual misconduct and gender-based discrimination. If a student chooses to disclose to a faculty or staff member an experience related to sexual misconduct which includes rape, relationship violence, or stalking, all faculty and staff are obligated to report this disclosure to the university's Title IX Coordinator. Sac State's Title IX Coordinator is Mary Lee Vance. Please email equalopportunity@csus.edu or (916) 278-5770. Upon receipt of the report, the Title IX Coordinator will contact you to inform you of your rights and options as a survivor and connect you with support resources, including resolution options for holding accountable the person who harmed you. Students who elect not to discuss their experience with the Title IX Coordinator can speak confidentially to the following confidential resources:

Student Health & Counseling Services at The WELL On Campus

Your physical and mental health are important to your success as a college student. Student Health and Counseling Services (SHCS) in The WELL offers medical, counseling, and wellness services to help you get and stay healthy during your time at Sac State. SHCS offers: Primary Care medical services, including sexual and reproductive healthcare, transgender care, and immunizations; urgent care for acute illness, injuries, and urgent counseling needs; pharmacy for prescriptions and over-the-counter products; mental health counseling, including individual sessions, group counseling, support

groups, mindfulness training, and peer counseling; athletic training for sports injury rehabilitation; wellness services, including nutrition counseling, peer led health education and wellness workshops, and free safer sex supplies; violence and sexual assault support services. Most services are covered by the Health Services fee and available at no additional cost.

Phone Number: 916-278-6461

Website: www.csus.edu/shcs, <https://www.csus.edu/student-life/health-counseling/>

Campus Confidential Advocate – Laura Swartzen

Email: weave@csus.edu

On Campus Phone Number: 916-278-5850 (during business hours)

WEAVE 24/7 Hotline: 916-920-2952

CSUS Grading Policy

Information for students regarding grading is provided here:

<https://www.csus.edu/umannual/acad/umg05150.htm>

Other Resources

- The Office of Student Affairs maintains a list of campus resources/centers: <https://www.csus.edu/center/>
- Testing Center: <https://www.csus.edu/student-affairs/centers-programs/testing-center/>
- Library: <https://library.csus.edu/> for consultation : Rachel Stark, MS, AHIP, stark@csus.edu
- Student Academic Success and Education Equity Programs: <https://www.csus.edu/student-affairs/retention-academic-success/>
- Crisis Assistance and Resource Education Support (CARES): If you are experiencing challenges with food, housing, financial or other unique circumstances that are impacting your education, help is just a phone call or email away. The CARES office provides case management support for any enrolled student. <https://www.csus.edu/student-affairs/crisis-assistance-resource-education-support/>
- CHHS Student Success Center: <https://www.csus.edu/college/health-human-services/student-success/>
- Reading & Writing Center: <https://www.csus.edu/undergraduate-studies/writing-program/reading-writing-center.html>
- Peer & Academic Resource Center: <https://www.csus.edu/student-affairs/centers-programs/peer-academic-resource/>
- SMART Thinking (tutoring resource): <https://www.csus.edu/student-affairs/centers-programs/degrees-project/internal/documents/smarthinking.pdf>

Knowledge And Skills Acquisition (KASA) For Certification in Speech-Language Pathology

CSAD 243C Practice: Language Disorders III

Student Knowledge & Behavior

Standard IV-B: Basic Human Communication Processes

- The student will demonstrate the ability to analyze, synthesize and evaluate knowledge re: **biological** bases of human communication.
- The student will demonstrate the ability to analyze, synthesize and evaluate knowledge re: **neurological** bases of human communication.
- The student will demonstrate the ability to analyze, synthesize and evaluate knowledge re: **psychological** bases of human communication.
- The student will demonstrate the ability to analyze, synthesize and evaluate knowledge re: **linguistic** bases of human communication.
- The student will demonstrate the ability to analyze, synthesize and evaluate knowledge re: **cultural** bases of human communication differences.

Standard IV-F: Research

- The student will demonstrate the ability to analyze, synthesize and evaluate knowledge re: processes used in research and integration of research principles into evidence-based clinical practice

Standard IV-E, IV-G, IV-H: Contemporary Professional Issues

- The student will demonstrate the ability to analyze, synthesize and evaluate knowledge re: standards of ethical conduct.
- The student will demonstrate the ability to analyze, synthesize and evaluate knowledge re: contemporary professional issues and advocacy.

Standard V-A: Oral and Written Communication

- The student will demonstrate skill in oral and written or other forms of communication sufficient for entry into professional practice.

Standard V-B 3d. Adhere to the ASHA Code of Ethics and behave professionally.

- The student will demonstrate the ability to adhere to the ASHA Code of Ethics and behave professionally.

Screening/Prevention

Standard V-B 1a. Conduct screening and prevention procedures (including prevention activities)

- The student will demonstrate the ability to conduct screening and prevention procedures in the area of receptive and expressive language.

Evaluation

Standard V-B 1b. Collect case history information and integrate information from clients/patients, family, caregivers, teachers, relevant others, and other professionals

- The student will demonstrate the ability to collect case history information and integrate information from clients/patients, family, caregivers, teachers, relevant others, and other professionals in the area of receptive and expressive language.

Standard V-B 1c. Select and administer appropriate evaluation procedures, such as behavioral observations nonstandardized and standardized tests, and instrumental procedures

- The student will demonstrate the ability to select and administer appropriate evaluation procedures, such as behavioral observations, nonstandardized and standardized tests, and instrumental procedures in the area of receptive and expressive language.

Standard V-B 1d. Adapt evaluation procedures to meet client/patient needs

- The student will demonstrate the ability to adapt evaluation procedures to meet client/patient needs in the area of receptive and expressive language.

Standard V-B 1e. Interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention

- The student will demonstrate the ability to interpret, integrate, and synthesize all information to develop diagnoses and make appropriate recommendations for intervention in the area of receptive and expressive language.

Standard V-B 1f. Complete administrative and reporting functions necessary to support evaluation

- The student will demonstrate the ability to complete administrative and reporting functions necessary to support evaluation in the area of receptive and expressive language.

Treatment

Standard V-B 2a. 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

- The student will demonstrate the ability to 1) develop setting-appropriate intervention plans with measurable and achievable goals that meet clients'/patients' needs and 2) collaborate with clients/patients and relevant others in the planning process in the area of receptive and expressive language.

Standard V-B 2b. Implement intervention plans (involve clients/patients and relevant others in the intervention process)

- The student will demonstrate the ability to implement intervention plans (involves clients/patients and relevant others in the intervention process) in the area of receptive and expressive language.

Standard V-B 2c. Select or develop and use appropriate materials and instrumentation for prevention and intervention

- The student will demonstrate the ability to select or develop and use appropriate materials and instrumentation for prevention and intervention in the area of receptive and expressive language.

Standard V-B 2d. Measure and evaluate clients'/patients' performance and progress

- The student will demonstrate the ability to measure and evaluate clients'/patients' performance and progress in the area of receptive and expressive language.

Standard V-B 2e. Modify intervention plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients/patients

- The student will demonstrate the ability to modify intervention plans, strategies, materials, or instrumentation as appropriate to meet the needs of clients/patients in the area of receptive and expressive language.

Counseling & Interprofessional Communication

Standard V-B 2f. Complete administrative and reporting functions necessary to support intervention

- The student will demonstrate the ability to complete administrative and reporting functions necessary to support intervention in the area of receptive and expressive language.

Standard V-B 2g. Identify and refer clients/patients for services as appropriate

- The student will demonstrate the ability to identify and refer clients/patients for services as appropriate in the area of receptive and expressive language.

Standard V-B 3a. Communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others.

- The student will demonstrate the ability to communicate effectively, recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others.

Standard V-B 3b. Collaborate with other professionals in case management.

- The student will demonstrate the ability to collaborate with other professionals in case management.

Standard V-B 3c. Provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others.

- The student will demonstrate the ability to provide counseling regarding communication and swallowing disorders to clients/patients, family, caregivers, and relevant others.