Creating a Capstone Program in Your Setting

Teamwork Makes the Dream Work

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NAU NORTHERN ARIZONA UNIVERSITY
Department of Occupational Therapy

- Learning Objective 1: At the conclusion of this session, participants will understand how the Capstone differs from fieldwork
- Learning Objective 2: At the conclusion of this session, participants will identify key components to partnering with universities to develop a Capstone program within their own practice

ACOTE Standards 2018

Accrediting body for occupational programs is granted by Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association

D.1.0. DOCTORAL CAPSTONE

The doctoral capstone shall be an integral part of the program's curriculum design. The goal of the doctoral capstone is to provide an in-depth exposure to one or more of the following: clinical practice skills, research skills, administration, leadership, program and policy development, advocacy, education, and theory development.

The doctoral capstone consists of two parts:

- **Capstone project**
- **Capstone experience**

The student will complete an individual capstone project to demonstrate synthesis and application of knowledge gained.

The student will complete an individual 14-week capstone experience that must be started after completion of all coursework and Level II fieldwork, and completion of preparatory activities defined in D.1.3.

Different Titles for Different Programs

Required Components

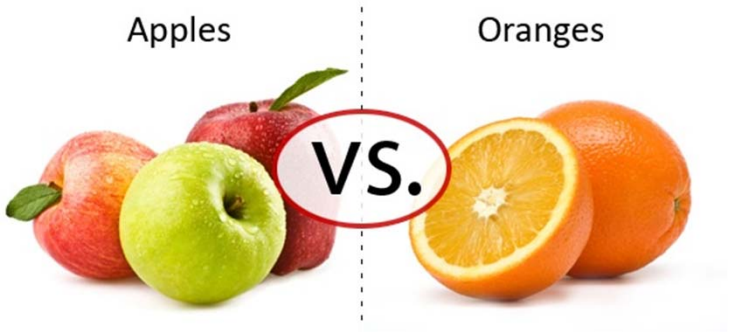
- Memorandum of Understanding with the mentor(s)
- Student affiliation agreement with the mentor and or site
- Goals, objectives, and identified deliverable products
- Literature review and needs assessment
- Mentor with documented experience
- Evaluation of the capstone

Capstone Preparation

Capstone Planning
- Class each spring
- Develop ideas
- Identify mentor

Capstone Experience
- Collaborate on capstone plan
- Carry out capstone plan

Practice-Scholar Culmination
- Campus dissemination
- Presentations and final evaluations



Fieldwork vs Capstone

	Level II Fieldwork	Capstone
Placement in the curriculum	Occurs before DEC	**Occurs after coursework and Level II Fieldwork**
Rotation length	Minimum of 24 Weeks, full time	**14 weeks (540 hours) no more than 20% of hours (112) can be completed outside of the mentored practice setting**
Prerequisites	Academic course work, minimum GPA requirements	**Pass all coursework and Level II Fieldwork**
Goal of the experience	To develop competent, entry-level, generalist occupational therapists	**To provide an in-depth exposure to one or more of the focus areas**
Supervision requirements	OT with at least 1 year of experience who is adequately prepared to serve as a FW educator	**Mentor has expertise consistent with the student's area of focus.** **Mentor does not have to be an OT**

Learning Objectives Focus Area

Gain evidence-based clinical skills in Kinesio Taping with clients who experience neurological impairments

LEARNING ACTIVITY 1:
Kinesio Tape (KT) certification. Incorporate KT in clinical intervention plans, create a student competency checklist for KT

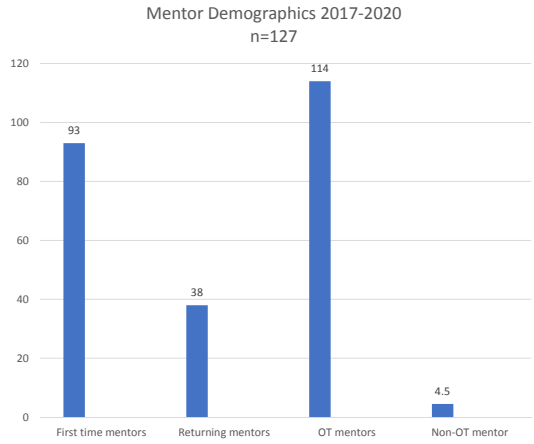
LEARNING ACTIVITY 2:
Literature review for KT and the neurological based impairments. Annotated Bibliography

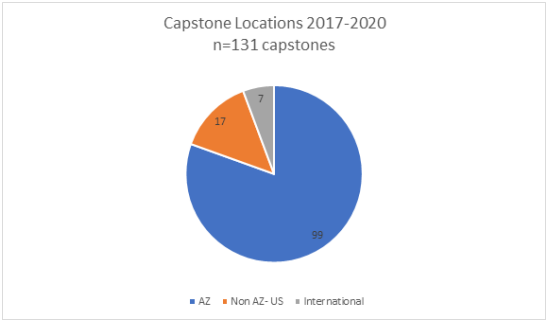
LEARNING ACTIVITY 3:
Develop digital, evidenced-based client education handouts for wear and care

LEARNING ACTIVITY 4:
Develop the research protocol for the XXX KT project and submit to IRB

LEARNING ACTIVITY 5:
Pilot study proposal with article submission, poster presentation development

Demographics





Capstone Experience: View of the Practitioner

Fieldwork Student vs. Capstone Student

- Needs to develop entry level practice skills
- Needs graded guidance to facilitate learning experience
- Supervisor/supervisee or teacher/student relationship
- Supervisor dictates topics for meetings and discussion with goals of improving practice skills
- Supervisor evaluation of skills

- Demonstrated competency in entry level practice
- Ready to build on entry level skills; more independent in therapy and documentation
- Mentor/mentee relationship; facilitator vs. instructor
- Student drives discussion topics based on objectives and areas they want to improve
- Evaluation of performance is performed by both student and mentor

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Why Capstone Students?

- With the option of doctoral degree as entry level, what did I hope this does for practitioners and us as a profession?
  - Advanced training in specialized area- above entry level in at least one area of practice
  - Experience and skills leadership, supervision, or management
  - Evidence-based/evidence contributions- research, quality improvement, program development

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Specialized Area of Practice

- Entry Level Practice- successfully completed program in accredited university; completed 24 weeks of mentored practice experience
  - Able to perform expected duties of occupational therapist
  - General practitioners, not specialized
  - Little to no advanced knowledge of specialized practice areas
- Specialized Practice- advanced knowledge of specific area of practice
  - Builds on entry level knowledge
  - Examples: hand therapy, feeding, sensory integration, neuro., etc.

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What is your specialized area of practice?

- What is unique about this setting?
- What is my advanced area of practice?

- Structure the experience around your expertise
- Discover where your expertise overlaps with the student's goals.

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Moving from Supervisor to Mentor

- Supervisor- teaches a student to acquire knowledge and competency
- Mentor- guided relationship; more experienced person guides a less experienced person
- Students take a self-directed learning approach to accomplish goals- mentor is there to guide them to their goals

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Mentorship

- Develop a mentorship experience- Mix of readings, trainings, and hand-on
- Collaborate on objectives
- Gather information on current abilities and knowledge- pretest assessments, interview (formal or informal), observation
- Provide learning experiences
  - Build their professional library
  - Formal trainings and hands-on learning
  - Discussion times

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Meetings with Capstone Students

- Student driven
- Students should mention topics for discussion based on self-evaluation of skills
- Mentor provides resources and instruction to facilitate learning
- Student track progress and monitor timeline
- Areas of difficulty should be mentioned by student

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Residency Program for Doctoral Level Occupational Therapy Students
Piller Child Development

Objectives:

Part One: Sensory Integration Mentorship
By the conclusion of the residency program students will:
1) demonstrate an understanding of sensory integration theory and practice through verbal, written, and demonstrated means
2) complete a sensory integration treatment mentorship program
3) perform at least 12 independent therapy sessions with using sensory integration theory for 50% or more of the session
4) independently perform at least 5 sensorimotor evaluations
5) perform one parent inservice on sensory-related topic

Part Two: Establishing Manualized Intervention
By the conclusion of the residency program students will:
1) outline a research process for developing a practice-based research study
2) perform a thorough literature review of evidenced-based practice for identified areas of dysfunction
3) follow the guidelines to create a manualized intervention based on theory, research and practice

Part Three: Treatment/Supervision
By the conclusion of the residency program students will:
1) under supervision of OT, independently completed at least 10 hours of treatment per week
2) in conjunction with supervising OT, complete progress reports for on OTA for duration of residency
3) perform at least 5 co-treatment sessions with SLP or SLPA
4) under supervision of OT, independently perform all required documentation including daily notes, progress reports, discharge summaries and evaluations
5) complete one letter of medical necessity
6) demonstrate understanding of ICD-10 and CPT codes and basic guidelines for billing

Required Texts:

Ayres, A.J. (1979). *Sensory integration and the child.* Los Angeles, CA: Western Psychological Services.

Bundy, A. C., Lane, S. J., & Murray, E. A. (2002). *Sensory integration theory and practice* (2nd ed.). Philadelphia, PA: F. A. Davis Company.

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Leadership/Management

- What opportunities are there for leadership/management?
  - Supervision of OTAs
  - Collaboration with other professionals
  - Presentations to other professionals or consumers of services
  - Shadowing or assisting management

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Clinical Research

- Practice-based research- What questions do you have about your practice?
- Retrospective outcome studies- Are you interested in effectiveness of interventions?
- Quality improvement projects- Evaluation of current information to determine quality of programs; Are you interested in if you are adhering to practice guidelines? Are you interested in quality of interventions or programs?

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Clinical Research

- Goal: Practical application of evidence-based practitioner and gathering of evidence in practice
- What questions do you have as the practitioner?
- What are the student's questions?

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More than Research

- In clinic research/quality improvement
- Formulating a question
- Methods of gathering data
- Evaluating results

What are your ideas?

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University Partnership

- Access to IRB
- Access to faculty to assist with research methodology and design
- Access to university resources
- Students have experience in research and can guide the process
- Students have time

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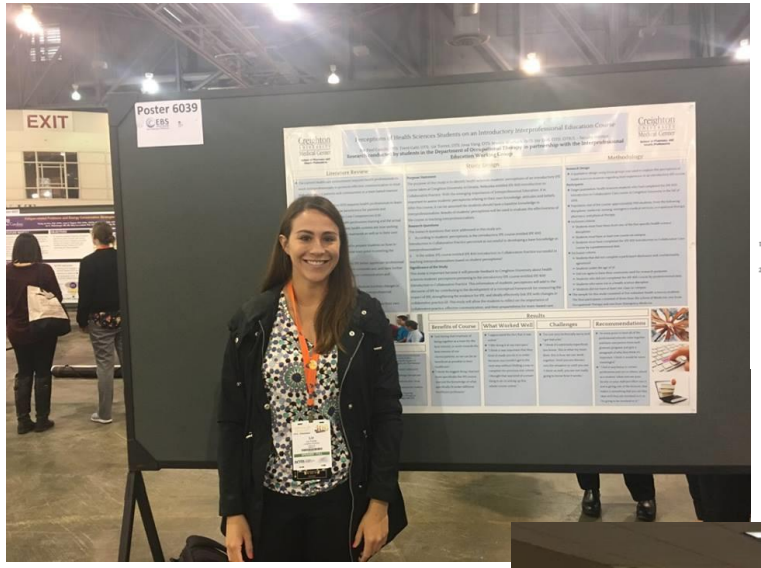
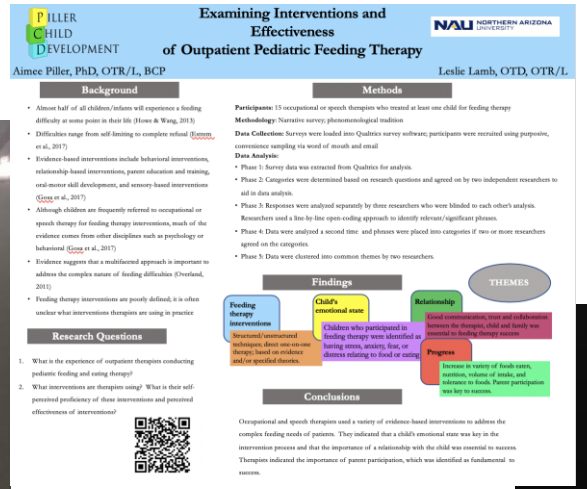
Capstone Example

- Identify your own area of expertise
- Identify your practice questions or practice questions of other therapists in your office
- Make connections with managers and other administrators

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Examining Interventions and Effectiveness of Outpatient Pediatric Feeding Therapy

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Background

- Almost half of all children/infants will experience a feeding difficulty at some point in their life (Howe & Wang, 2013)
- Difficulties range from self-limiting to complete refusal (Esmon et al., 2017)
- Evidence-based interventions include behavioral interventions, relationship-based interventions, parent education and training, oral-motor skill development, and sensory-based interventions (Goday et al., 2017)
- Although children are frequently referred to occupational or speech therapy for feeding therapy interventions, much of the evidence comes from other disciplines such as psychology or behavioral (Goday et al., 2017)
- Evidence suggests that a multifaceted approach is important to address the complex nature of feeding difficulties (Overland, 2011)
- Feeding therapy interventions are poorly defined; it is often unclear what interventions therapists are using in practice

Research Questions

1. What is the experience of outpatient therapists conducting pediatric feeding and eating therapy?
2. What interventions are therapists using? What is their self-perceived proficiency of these interventions and perceived effectiveness of interventions?

Methods

Participants: 15 occupational or speech therapists who treated at least one child for feeding therapy
Methodology: Narrative survey; phenomenological tradition
Data Collection: Surveys were loaded into Qualtrics survey software; participants were recruited using purposive, convenience sampling via word of mouth and email
Data Analysis:

- Phase 1: Survey data was extracted from Qualtrics for analysis.
- Phase 2: Categories were determined based on research questions and agreed on by two independent researchers to aid in data analysis.
- Phase 3: Responses were analyzed separately by three researchers who were blinded to each other's analysis. Researchers used a line-by-line open-coding approach to identify relevant/significant phrases.
- Phase 4: Data were analyzed a second time and phrases were placed into categories if two or more researchers agreed on the categories.
- Phase 5: Data were clustered into common themes by two researchers.

Findings

THEMES

Feeding therapy interventions
Structured/unstructured techniques; direct one-on-one therapy; based on evidence and/or specified theories.

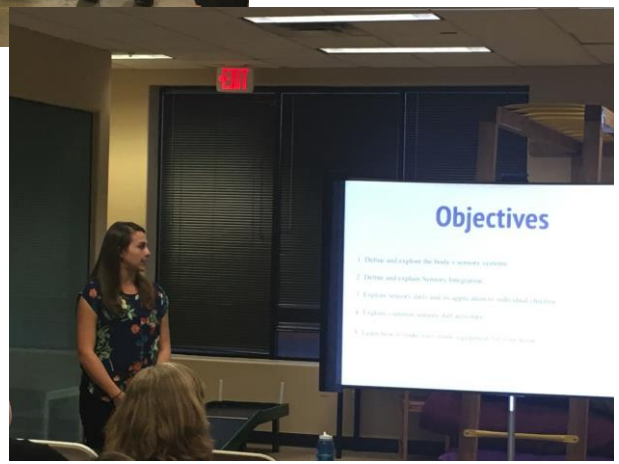
Child's emotional state
Children who participated in feeding therapy were identified as having stress, anxiety, fear, or distress relating to food or eating

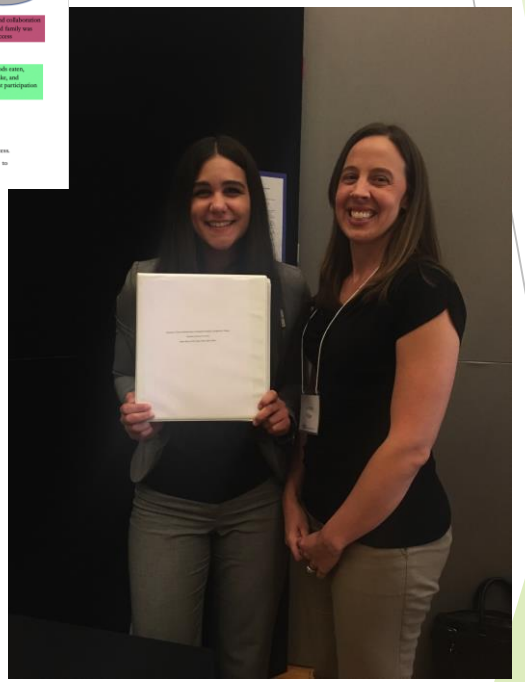
Relationship
Good communication, trust and collaboration between the therapist, child and family was essential to feeding therapy success

Progress
Increase in variety of foods eaten, nutrition, volume of intake, and tolerance to foods. Parent participation was key to success.

Conclusions

Occupational and speech therapists used a variety of evidence-based interventions to address the complex feeding needs of patients. They indicated that a child's emotional state was key in the intervention process and that the importance of a relationship with the child was essential to success. Therapists indicated the importance of parent participation, which was identified as fundamental to success.





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