Development of a Level I Fieldwork Evaluation

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The Wisconsin Council on Education (Wiscouncil) developed and pilot tested an evaluation of student performance for Level I fieldwork to be used for both occupational therapy and occupational therapy assistant students. Data were gathered from 259 students, fieldwork supervisors, and faculty who rated the form on a number of variables. The majority of students and clinical faculty believed the form was good to excellent in meeting their needs, in being useful in a variety of settings, in being applicable for both occupational therapy and occupational therapy assistant students, and in overall efficiency. On the basis of the results of the 1-year pilot study, short (23-item) and long (38-item) versions of the form were developed. Implications for use and the importance of future research to determine reliability and validity are discussed.

Level I fieldwork is a required component of both occupational therapy and occupational therapy assistant education programs. However, the American Occupational Therapy Association's (AOTA's) Essentials (1983a, 1983b) do not delineate specific standards—They only list the requirements. In 1982, clinical and academic educators in Wisconsin expressed concerns regarding Level I fieldwork, including scheduling problems, the lack of fieldwork sites, cost-effectiveness, the lack of consensus on objectives, and the diversity of evaluation forms required by each school.

The Wisconsin Council on Education (Wiscouncil), representing the six occupational therapy programs in Wisconsin (Mt. Mary College, the University of Wisconsin–Madison, the University of Wisconsin–Milwaukee, Madison Area Technical College, Fox Valley Technical College, and Milwaukee Area Technical College) and fieldwork supervisors from each program, studied these concerns. A survey showed that 78% of the Wisconsin respondents wanted an evaluation with uniform objectives that could be used for both occupational therapy and occupational therapy assistant students in different settings (Leonardelli & Caruso, 1986).

In reviewing the occupational therapy literature, we found that the Wiscouncil's concerns have been raised by others. Bell (1986) identified a number of fieldwork issues on the basis of a national survey. These included (a) time to adequately supervise students, (b) shortages of quality fieldwork sites, and (c) standardization of fieldwork programs. Leonardelli and Caruso (1986) reported survey results indicating serious concerns about the proportions of time and resources expended in the provision of Level I fieldwork. Kautzmann (1987) reported agreement in perceptions between academic and fieldwork educators on the purpose of Level I fieldwork. Six studies have investigated the economic impact of fieldwork education (Chung & Spelbring, 1983; Chung, Spelbring, & Boissonneau, 1980; Kautzmann, 1986; McGourty, 1986; Shalik, 1987; Shalik & Shalik, 1988). Leiken, Stern, and Baines (1983) found no negative impact of Level I fieldwork on productivity in an occupational therapy department.

A task group comprising clinical supervisors and faculty representatives from all six Wisconsin schools was established to develop this uniform Level I evaluation and to test its acceptance in Wisconsin. The process occurred in two stages. Stage 1 involved the development of a form to evaluate occupational therapy and occupational therapy assistant students at all Level I settings and a pilot test of this assessment. Stage 2 involved a revision of the form on the basis of the Stage 1 results.
A. **INTERPERSONAL INTERACTIONS**

Does the student demonstrate an ability to establish and maintain an effective relationship with client/patient/staff?

1. Student demonstrates a range of interpersonal interactions that meet the demands of the situation.

- Does not show a range of interpersonal interactions
- Attempts to vary approach and types of interactions

2. Professional behavior

- Professional behavior
- Data gathering and observational skills
- Program planning and implementation
- Verbal and written communication

**B. PROFESSIONAL BEHAVIOR**

Does the student demonstrate professional behaviors?

1. Examples of evaluation items. The descriptions correspond to scores of 1, 3, and 5. NA = not applicable.

- Student demonstrates an ability to communicate with others with appropriate others
- Periodically
- Frequently

- Student demonstrates an ability to establish and maintain an effective relationship with client/patient/staff?

- Student demonstrates an ability to collect useful or accurate data from observational and/or available written resources?

11. Student analyzes available information and recognizes implications information has for treatment.

- Student interprets useful information accurately
- Analyzes and applies information appropriately for treatment

**C. DATA GATHERING AND OBSERVATIONAL SKILLS**

Does the student demonstrate an ability to establish and maintain an effective relationship with client/patient/staff?

1. Examples of evaluation items. The descriptions correspond to scores of 1, 3, and 5. NA = not applicable.

- Student checks with supervisor when in doubt about proper procedure.
- Student doesn't check, and inappropriately seeks supervision.

2. Professional behavior

- Professional behavior
- Data gathering and observational skills
- Program planning and implementation
- Verbal and written communication

**D. PROGRAM PLANNING AND IMPLEMENTATION**

Does the student plan/organize and/or implement a program?

1. Examples of evaluation items. The descriptions correspond to scores of 1, 3, and 5. NA = not applicable.

- Student considers safety factors in implementing treatment.
- Student does not attend to safety, with minimal reminders.

**E. VERBAL AND WRITTEN COMMUNICATION**

Does the student demonstrate an ability to communicate effectively with verbal and written skills?

1. Examples of evaluation items. The descriptions correspond to scores of 1, 3, and 5. NA = not applicable.

- Student does not communicate with others, with appropriate others.
- Student periodically communicates with appropriate others.

In addition to a final score, a subscore can be derived for each category. The final score for the assessment can be determined by dividing the total number of points by the number of items utilized. This number will always be between 1 and 5 (see Figure 1).

For the pilot test, all faculty members, clinical supervisors, and students involved in Level I fieldwork were asked to use the form and evaluate its effectiveness for 1 year. The students were also required to perform a self-evaluation on the form.

During the pilot year, 224 occupational therapy students and 100 occupational therapy assistant students were assessed with the Level I evaluation form. The assessments of the Level I evaluation form were returned by 202 students, 51 fieldwork supervisors, and 6 faculty representatives.

**Final Score:**

```
<table>
<thead>
<tr>
<th>Category</th>
<th>No. of Items</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interpersonal Interactions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Professional Behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Data Gathering and Observational Skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Program Planning and Implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Verbal and Written Communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Points</td>
<td>=</td>
<td></td>
</tr>
</tbody>
</table>

Maximum points = 190; Maximum number of items = 38; Maximum score = 5
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Figure 1. Examples of evaluation items. The descriptions correspond to scores of 1, 3, and 5. NA = not applicable.

Figure 2. Process used to compute the final score of the assessment. NA = not applicable.

Stage 1: Development and Pilot Study of the Form

To develop an evaluation consistent with the fieldwork objectives described by Leonardelli and Caruso (1986), the task group identified five behavioral areas of student performance: (a) interpersonal interactions, (b) professional behavior, (c) data gathering and observational skills, (d) program planning and implementation, and (e) verbal and written communication. Forty-one items were developed to evaluate behaviors for all of the categories. Each item consisted of an observable, descriptive behavior, ranked ordinally on a Likert scale ranging from 1 (poor) to 5 (excellent). Behavioral descriptions were added to identify the points 1, 3, and 5 on the scale (see Figure 1). A student's performance was to be assessed relative to the behavioral descriptors listed. When an item was judged to be not applicable, the item was not scored.
Students' scores for grading. The students' scores on the assessment ranged from 2.25 to 5.00 (SD = .529). Figure 3 illustrates that the overall distribution of scores was skewed positively (M = 4.32). The occupational therapy students' scores (M = 4.44) were slightly higher than the occupational therapy assistant students' scores (M = 4.06). Only 12 students scored 3.00 or below.

Students' assessment of the form. The students rated the form as described earlier and also with an additional question about how worthwhile they found the self-evaluation process. Table 1 illustrates the results for the 202 completed assessments. The students rated the form as follows: 69.2% rated the form from good to excellent in its ability to evaluate both occupational therapy and occupational therapy assistant students; 70.2% rated the form from good to excellent in its ability to be used either in physical disability or psychosocial settings; and 59.7% rated the form from good to excellent in its ability to distinguish between poor and excellent performance. A majority (57.7%) rated the form from good to excellent for efficiency, and 67.7% rated the self-evaluation component from good to excellent.

Clinical supervisors' responses. The clinical supervisors rated the form as described earlier and also with an additional question about whether the form met their needs. Of the 51 clinical supervisors who responded, 89.2% rated the form from good to excellent in response to this question. The assessment's ability to be used in various settings was rated from good to excellent by 91.4% of the clinical supervisors. A majority (60.9%) rated the form from good to excellent in efficiency, and 60.9% rated the form from good to excellent for its applicability for both occupational therapy and occupational therapy assistant students.

Further investigation of these results showed some differences in responses between the larger fieldwork facilities offering clinical experiences to both occupational therapy and occupational therapy assistant students and the smaller centers offering experiences only at one of these levels. Supervisors from the larger, multilevel facilities seemed more favorable toward the form, with 45% rating it from very good to excellent regarding its ability to meet their needs, in contrast to 31.9% of the smaller, one-level facilities. The larger facilities were also more favorable toward the assessment in comparison with previous assessments, with 56% rating the current form very good to excellent, versus 38.9% of the smaller facilities rating the current form very good to excellent—a difference of 17.1%.

Faculty respondents. Only 6 of the 12 faculty members who had Level I components in their courses responded to the survey. Of the 6 respondents, 3 occupational therapy assistants and 1 occupational therapy faculty member gave the form positive evaluations overall, and 2 occupational therapy faculty

Table 1
Students' Ratings of the Form (n = 202)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Poor (1)</th>
<th>Fair (2)</th>
<th>Good (3)</th>
<th>Very Good (4)</th>
<th>Excellent (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to evaluate occupational therapy and</td>
<td>8.5</td>
<td>14.4</td>
<td>45.3</td>
<td>19.9</td>
<td>4.0</td>
</tr>
<tr>
<td>occupational therapy assistant students</td>
<td>(24)</td>
<td>(10.4)</td>
<td>(42.8)</td>
<td>(22.4)</td>
<td>(5.0)</td>
</tr>
<tr>
<td>Usefulness in a variety of settings</td>
<td>17.9</td>
<td>13.9</td>
<td>33.8</td>
<td>19.9</td>
<td>6.0</td>
</tr>
<tr>
<td>Ability to distinguish between poor and</td>
<td>20.9</td>
<td>18.4</td>
<td>37.3</td>
<td>14.4</td>
<td>6.0</td>
</tr>
<tr>
<td>excellent performances</td>
<td>(9.5)</td>
<td>(10.0)</td>
<td>(26.9)</td>
<td>(26.4)</td>
<td>(14.4)</td>
</tr>
<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Numbers in the table represent percentage of respondents. Some students did not respond to all questions; therefore, the percentages indicate the percentage of the 202 students who selected the rating.
members gave the form negative evaluations overall (see Table 2).

In summary, the results of the pilot study demonstrated that a majority of clinical supervisors and students believed the evaluation

- Is useful in the evaluation of occupational therapy and occupational therapy assistant students.
- Is useful in the evaluation of students in physical disability and psychiatric settings.
- Could meet their needs.
- Is efficient.

**Stage 2: Revision of the Form**

A Wiscouncil meeting was devoted to a review of the pilot study data on the clarity of items and descriptors and on the necessity for inclusion of each item on the form. On the basis of the review, redundant items were eliminated and descriptors were clarified, thereby reducing the total number of items from 41 to 38. Additionally, because of the concerns expressed about the length of the form, faculty, clinical supervisors, and students from the six schools studied the frequency and percentages of items scored. Some items on the short form were eliminated because the majority of students received a score of *excellent* on these items; therefore, these items were not helpful in discriminating performance. The items on which students received moderate to low scores were used to compile a short form of 23 items.

The students believed that the self-evaluation component was important and worthwhile, and the ratings of the students demonstrated that the assessment could discriminate between occupational therapy and occupational therapy assistant students' performances and among the performances of the students within each of these categories.

**Discussion**

Inferences that may be drawn from the data are limited for two reasons. First, only 6 faculty members responded to the questionnaires. At the Wiscouncil meeting, those faculty members who most vociferously objected to item inclusions or exclusions were those who were not directly involved in the project; therefore, their responses could not be represented in the data. Second, the questionnaires used for quantitative analysis were not subjected to rigorous statistical scrutiny because the data generated only allowed for a descriptive analysis. This situation is typical of exploratory investigations in which the investigators are unsure of the most relevant questions to ask.

The initial push for the development of a single Level I evaluation form came from the clinical supervisors of the larger centers, who took Level I students from more than one college and offered clinical experiences to occupational therapy and occupational therapy assistant students. Those supervisors from the smaller, one-level centers rated the forms less favorably overall, perhaps because of the lack of a perceived need for a uniform Level I evaluation tool or perhaps because these centers had fewer students upon whom to base a comparison.

The participants in the project identified several tentative explanations for some negativism, especially from faculty, toward the project. These included the following:

- Respondents' sensitivity to productivity issues that had begun to and continue to affect all clinical sites
- Actual loss of sites for Level I experiences with the fear that this trend will continue
- Respondents' protection of already established procedures and evaluation forms
- Respondents' perception that this standard evaluation tool invaded "academic turf"

The committee dealt with concerns about the halo effect by using clear criterion-based descriptors. These descriptors were developed on the basis of the comments of more than 70 fieldwork and academic educators, and they were reviewed over the 2-year period of development and pilot testing. The committee valued the descriptors as a means to provide each student with clear and specific feedback. The
process of student self-evaluation was incorporated as a means to initiate students into the process of assuming responsibility for their own behavior and learning—a highly valued professional behavior. Noting the cluster of students who performed in the 4.35 to 4.95 (of a possible 5.00) range, however, we believe this halo effect may need to be further assessed (see Figure 3).

Because the general objectives for Level I fieldwork were developed on the basis of entry level experiences that seemed common to both occupational therapy and occupational therapy assistant levels, the use of the form seems adaptable, particularly because supervisors can select the not applicable category for items they feel are inappropriate for the clinical setting, the course content associated with the Level I experience, the educational level of the student, or a combination of any of these factors.

Further testing of both the long and short forms is indicated. We think it is important that performance evaluations be reliable among and between raters as well as valid in the discriminative dimension. The possibility of the prediction of future performance levels is desirable. Tests of reliability as well as of past and future relationships are the obvious next steps in the development of these instruments.

Conclusion

Level I clinical experiences warrant the development of specific, well-defined objectives. These objectives provide the opportunity to clarify expectations for the students, faculty, and clinicians in providing this essential element of occupational therapy curricula.

With well-developed objectives, an effective evaluation tool for use in both the occupational therapy and occupational therapy assistant curricula can be agreed on and effectively implemented for all Level I experiences. The objectives provide a basis for the types of experiences offered and assist in making clinical experiences specific to the facility.

The criterion-referenced form provides clear expectations for each objective on the form. Such clear expectations allow clinicians, regardless of their experience or inexperience as student supervisors, greater familiarity with the competencies expected of students. The form also provides a format in which the students' strengths and weaknesses can be identified and discussed objectively. Additionally, the students can obtain a positive first self-evaluation experience with a competency-based evaluation format.

This study generated several questions:

1. What impact do Level I experiences have on success in Level II experiences?

2. Do Level I experiences provide valuable feedback before Level II?

3. Do the descriptors on the form make it a more valid and reliable evaluation tool?

4. Is there a geographical bias around the concerns and issues with the use of this form?

5. Are Level I experiences essential in occupational therapy curricula?

6. Are students more critical than their supervisors in the evaluation process?

In 1987, Wiscouncil recommended the adoption of the use of either the long or short form by all six schools in Wisconsin and appointed an ad-hoc committee to monitor the implementation of the form and its impact on Level I experiences in Wisconsin. We hope that this beginning will assist in the continued study of the purposes, cost-effectiveness, and standard evaluation methods for Level I experiences.

As of this writing, the Wiscouncil member schools continue to use this Level I evaluation, and several researchers have initiated plans for reliability and validity studies. Educational programs nationwide have indicated interest in using this tool.

Acknowledgments

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