TAI Mentor Training Course

Realizing your ability to mentor

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Eugene, OR

Therapeutic Associates, Inc.
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Contents

COURSE DETAILS

Course Description

This one day course is aimed at identifying the mentor and mentor potential in all TAI clinical staff. The course uses lecture, discussion, lab, and pre- and post-course work to help participants awaken, inspire, and sharpen their own mentor abilities.

Audience: This course has been developed for all TAI clinical staff. It is required of all residency faculty and any therapist wanting to provide mentorship hours in TAI mentoring programs for clinical education credit. This particular course has been modified to accommodate the hospital-based mentor as well as the outpatient clinical mentor.

Contact Hours

4-6 contact hours

Instructors

William Temes, PT, MS, David Deppeler PT, DSc, Chris Hoekstra, PT, DPT

Description of Teaching Methods and Learning Experiences

Pre-course reading and pre-course survey
Lecture, discussion, lab, active participation
Post-course assignment – 2-3 hours mentorship observation with TAI Lead Mentor

*Post-course assignment is a component of the TAI Certified Mentor requirements
*Post-course assignment is not required for continuing education credit

Course Prerequisites

None

Course Requirements

Active participation in course lab, discussions, and pre- and post-assignments
Enthusiastic approach to learning

Course Goals

1. Create the potential to enhance engagement around career development
2. Empower all staff as mentors
3. Enhance the learning environment in all TAI services
4. Connect all staff and speed the distribution of knowledge and experience
5. Identify potential faculty and mentors for future mentor and residency programs

Course Learning Objectives

Participants will:

1. Understand the APTA Vision 2020 as it relates to mentoring
2. Self-identify the characteristics of an “Expert”
3. Understand the key elements of adult learning
4. Develop a mentoring intervention plan based on the Integrated Model of Clinician Development
5. Self-assess and evolve your mentoring abilities based on the 5 principles of mentoring
6. Demonstrate an ability to accurately complete a clinical reasoning form

THE VISION of MENTORING

APTA Vision Sentence for Physical Therapy 2020

By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

APTA Vision Statement for Physical Therapy 2020

Physical therapy, by 2020, will be provided by physical therapists who are doctors of physical therapy and who may be board-certified specialists. Consumers will have direct access to physical therapists in all environments for patient/client management, prevention, and wellness services. Physical therapists will be practitioners of choice in patients'/clients' health networks and will hold all privileges of autonomous practice. Physical therapists may be assisted by physical therapist assistants who are educated and licensed to provide physical therapist directed and supervised components of interventions.

Guided by integrity, life-long learning, and a commitment to comprehensive and accessible health programs for all people, physical therapists and physical therapist assistants will render evidence-based services throughout the continuum of care and improve quality of life for society. They will provide culturally sensitive care distinguished by trust, respect, and an appreciation for individual differences. While fully availing themselves of new technologies, as well as basic and clinical research, physical therapists will continue to provide direct patient/client care. They will maintain active responsibility for the growth of the physical therapy profession and the health of the people it serves.

TAI Vision

The TAI Mission is to be an integral part of the journey toward positive health and wellness. TAI is guided by the core values of:

Excellence
Integrity
Stewardship
Community

TAI has identified itself as a lifelong learning institution and a leader in progressive staff development through organized education programs and leadership training. We commit ourselves to the constant evolution that is part of being a learning organization.

TAI CERTIFIED MENTOR REQUIREMENTS

TAI Certified Mentors are TAI physical therapists who have been recognized as leaders in clinical practice and have demonstrated an ability to facilitate learning.

LEVEL 1 MENTOR

The following criteria must be met.

Required

a. APTA Clinical Instructors Course
b. TAI Mentor Training Course
c. Minimum of three years clinical experience
d. Have supervised at least one entry level student
e. 2-3 hours of mentor: mentor training
f. Submit appropriate paperwork to support the mentorship requirements
g. Acceptance by the TAI Mentoring Committee*
   *Current TAI Mentoring Committee: Temes, Deppeler, Hoekstra

The Level I Mentor is eligible to mentor entry level staff and others if designated by a residency or fellowship key mentor. There is no bonus pay associated with the status of a level 1 mentor.

LEVEL 2 MENTOR

The following criteria must be met.

Required

a. Level 1 Mentor Requirements
b. ABPTS certification (OCS, SCS, GCS, etc.)

Recommended

a. Completion of a Residency program

The Level 2 Mentor may mentor entry, or resident level staff. The mentor receives a bonus based on the following schedule for all correctly completed increments of time, generally performed outside of the mentor's home clinic.

¼ day - $40; ½ day - $80; ¾ day - $120; 1 day -$160

LEVEL 3 MENTOR

The following criteria must be met.

Required

a. Level 2 Mentor Requirements
b. COMT (recognized by NAIOMT, OGI, or other credentialed program)

Recommended

a. Completion of a Residency program

The Level 3 Mentor may mentor entry, or resident level staff. The mentor receives a bonus based on the following schedule for all correctly completed increments of time, generally performed outside of the mentor's home clinic.

¼ day - $60; ½ day - $120; ¾ day - $180; 1 day -$240

LEVEL 4 MENTOR

The following criteria must be met

Required

a. Level 3 Mentor Requirements
b. Completion of APTA approved Fellowship Program

The Level 4 Mentor may mentor entry, resident or fellow level staff. The mentor receives a bonus based on the following schedule for all correctly completed increments of time, generally performed outside of the mentor's home clinic.

¼ day - $80; ½ day - $160; ¾ day - $240; 1 day -$320

WHAT MAKES AN EXPERT

The Expert

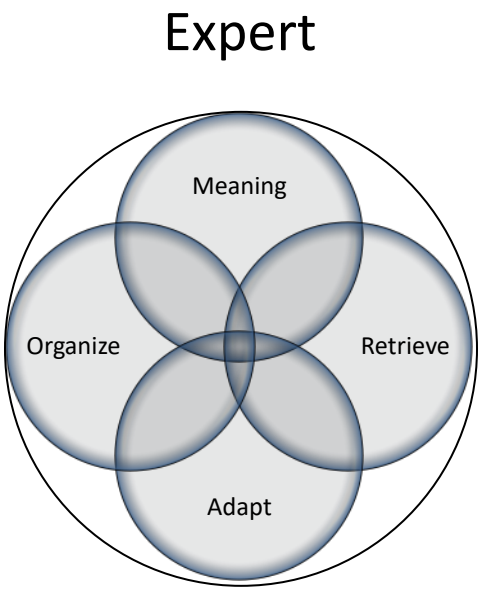
Expert clinicians are especially good at finding meaning, organizing information, retrieving information, and adapting knowledge. It's important to develop an awareness of these traits in yourself so that you can further develop them in yourself and the clinicians you mentor. Experts don't always know more, they just remember more.

Find meaning. This includes the ability to recognize patterns not recognized by the novice. When mentoring, it is valuable to link basic science concepts to specific clinical signs and symptoms of a patient.

Organize knowledge around core concepts and "big ideas," not as lists of facts or formulas. When mentoring, consider building conceptual understanding. Link new information to previous experience. Teach for depth, not breadth.

Retrieve knowledge through efforts to understand the problem rather than feeling a need to jump to a solution. Engage in problem solving. When mentoring, facilitate the process of fully understanding the problem or situation, not just the accuracy of a solution.

Adapt expertise through the metacognitive strategies of self-awareness. This refers to the ability to self-monitor one's own level of understanding. It is the ability to recognize what is known and the limits of knowledge. When mentoring, demonstrate the mental process of using known information to help identify what is not known. It is about teaching and assessing self-awareness to promote intellectual humility. An expert does not know everything; and is able to reveal this while pursuing the answer.



Professional Competence

(Epstein R, Hundert E)

Professional competence refers to the required skills of the mentor. It also points toward the skills that a mentor aims to facilitate and develop in a learner, or mentee.

Professional Competence Definition: Habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions values, and reflection in daily practice for the benefit of the individual and community being served.

Traditional View: Professional Competence requires three levels of knowledge

Cognitive: This refers to core knowledge, communication, information management, problem solving, and learning from experience

Technical: Examination skills, procedural skills, computer skills, systems

Integrative: Integrating scientific, clinical, and humanistic judgment

Human Science View: The "soft" side that renders delivery of the knowledge effective, or not

Context dependent: Working in different context of clinical delivery

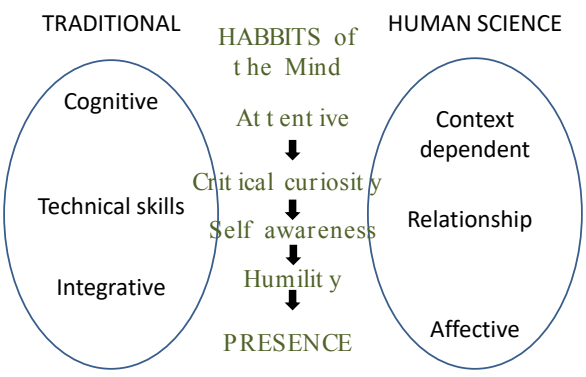
Relationship skills: Communication skills, handling conflict, teamwork, teaching

Affective/moral presence: Tolerance for ambiguity, emotional intelligence, respect, caring

Habits of the Mind: This is the practice that helps grow the other two (Traditional and Human Science). These are often referred to as metacognition skills, or the ability to think about thinking and truly reflect. This magnifies learning.

- **Humility:** Freedom from pride, arrogance, and vanity
- **Self-awareness:** Objective observers of self, self separate from thoughts
- **Critical curiosity:** Sincere interest in finding the relative truth
- **Attentive:** True and genuine listening and observing

Dimensions of Professional Competence



Habits of the Mind

Newberg A, Waldman R.

Single photon emission computerized tomography (SPECT).

Newberg and Waldman present information that suggests meditation and prayer have positive effects on brain function and can even cause permanent beneficial brain changes.

They point out the effects of prayer and meditation on the balanced activity between **frontal cortex** (new brain) and the **limbic system** (old brain). This signifies the balance between logical thought and emotions. The **anterior cingulate** cortex is identified as the mediator between thoughts and feelings. Meditating on any form of love seems to strengthen the function of the anterior cingulate cortex and the same neurological circuits that allow us to feel compassion toward others.

Parietal activity is associated with a connection to the concepts of space and time. Decreases in parietal activity are noted with meditation. A decrease in parietal activity is identified as an ability to observe life outside the realm of time and space.

Mindful Practice Epstein, R

Mindful practitioners attend in a nonjudgmental way to their own physical and mental processes during ordinary, everyday tasks. This critical self-reflection enables physicians to listen attentively to patients' distress, recognize their own errors, refine their technical skills, make evidence-based decisions, and clarify their values so that they can act with compassion, technical competence, presence, and insight.

Explicit knowledge is readily taught, accessible to awareness, quantifiable and easily translated into evidence-based guidelines.

Tacit knowledge is usually learned during observation and practice, includes prior experiences, theories-in-action, and deeply held values, and is usually applied more inductively.

Mindful practitioners use a variety of means to enhance their ability to engage in moment-to-moment self-monitoring. They bring to consciousness their tacit personal knowledge and deeply held values. They use peripheral vision and subsidiary awareness to become aware of new information and perspectives. They are curiosity about both ordinary and novel situations.

In contrast, mindlessness may account for some deviations from professionalism and errors in judgment and technique. Although mindfulness cannot be taught explicitly, it can be modeled by mentors and cultivated in learners. As a link between relationship-centered care and evidence-based medicine, mindfulness should be considered a characteristic of good clinical practice.

HOW PEOPLE LEARN

The Adult Learner

It is helpful to spend a little time on the topic of adult learning, as most of the clinicians we work with can also be considered adults (as are out patients). Malcolm Knowles, the American father of Adult Learning strategy defines an adult as someone who acts as an adult and considers him/herself an adult. The value of considering strategies around "adult learning" is obvious in professional clinical mentoring environments. Knowles defined the following characteristics.

1. **Autonomous**. Adults are *autonomous* and *self-directed*. It is important to actively involve participants in the learning process. Adults need to be responsible for their decisions on education; involvement in the planning and evaluation of their instruction. There is generally a greater sense of leadership, so it is fair to assume the value of presentations and small group projects.

   Action:

   a. *Let the learner choose a project on a relevant topic and present the information to a small group*
   b.
   c.

2. **Life Experiences**. Adults have *life experience* and *knowledge* that includes a broad breadth of venues: work-related activities, family responsibilities, and previous education. Effective teaching links new information with these aspects of life and must demonstrate value. Experience (including error) provides the basis for learning.

   Action:

   a. *Explain cervical stabilization (new concept) relative to the known lumbar stabilization model of involving the local, regional, and global system.*
   b.
   c.

3. **Goals.** Adults are goal-oriented. Adult learning is problem-centered rather than content-oriented.

   Action:

   a. *When teaching a posterior glide shoulder joint mobilization, relate it to the patient's difficulty in tucking in a shirt.*
   b.
   c.

4. **Relevancy**. Adults are relevancy-oriented. Adults are most interested in learning subjects having immediate relevance to their work and/or personal lives.

   Action:

   a. *Prioritize topics of mentoring on the most frequent conditions seen by that clinic.*

b.
c.

5. **Need to know**. Adults are practical and need to know the reason for learning something.

   Action:

   a. *Explain the reason for learning the process around using a functional outcomes measure. It allows us to identify educational needs and also allows us to provide valuable tracking information to payers, which in turn helps us negotiate higher reimbursement, which in turn allows us to pay the salaries that we do.*
   b.
   c.

6. **Internal motivation**. Adults respond better to internal versus external motivators. Respect is a key issue.

   Action:

   a. *Understand that creating a work environment that allows a therapist to feel like a valued part of the clinic or rehab team may do more to increase productivity than simply giving a bonus.*
   b.
   c.

MENTORING STRATEGIES

Student to Fellow Expected Performance

Clinical mentoring opportunities exist at a variety of levels. This course is biased toward the post-graduate level of mentoring, but many of the mentoring skill sets transcend the various levels. Still, it is helpful to orient ourselves toward the different levels of expected skills to help develop appropriate expectations and assessments. The student starts as a *novice* and may progresses to an *expert, or master* post fellowship.

	Expected Performance	Teaching
Student	Rules driven	Help organize knowledge
*(novice)	Analytic	Point out connections: history & evaluation
	Uses cause and effect	Help to eliminate irrelevant information
	Challenged by synthesis	Identify discriminating data/features
	Difficult to see broad view	
Entry Staff	Sorts through rules and info to decide what is relevant based on past exp.	Exposure to cases to continue to build illness scripts
*(adv. begin)	Uses analytic reasoning and pattern recognition	Work from common to uncommon cases
		Verbalize hypothesis setting
		Coaching to recognize meaningful data
Resident	Emotional connection	Balance supervision with autonomy
*(competent)	Confident with increased responsib.	Hold accountable for decisions
	Sees basic level of "big picture"	Help see breadth and depth of cases
	Uses analytic reasoning for complex	
*(proficient)	Experience in pattern recognition	work along side and "be" mentored
	Increasing intuitive approach	Important to engage in critical self-reflection
	Uses analytic for tough cases	Help slow down and find evidence
	Comfort with uncertainty allows cases to unfold	Help trust intuition and realize limitations
		Mentor as facilitator
Fellow	Open to notice unexpected	Keep challenged
*(expert)	Integration of thought, feeling, action	Apprentice with a master to model skills
	Perceptive in discrimination features that do not fit usual case	Mentor as colleague
*(master)	Exercise practical wisdom	Model self motivated life-long leaning and practice improvement
	Consistently sees big picture of culture and context to every case	Habitually engage plan-study-act-reflect
	Deep level of commitment to work and life-long learning	
	Reflects in, on, and for action	

A Few Words about Mentoring Strategies

The following are two of many mentoring strategies that further clarify and inspire your teaching approach. The first 5 points are very applicable to the PT setting and have been included in the APTA Residency and Fellowship Mentor training (2010). The second 5 points are offered in much more general terms, and are not specifically found in the APTA course. The two share many common features. We think both are valuable. You are encouraged to study both as you develop an appreciation for your style. Consistent with the general message of this course, self-awareness is where the power to mentor effectively originates.

Micro Skills for Clinical Teaching

(Neher, Gordon, Meyer, et al. 1992)

1. **Get a commitment**

   Ask the learner, "What do you think about the data/information?" This will help you diagnose their learning needs. It also builds a collaborative role in the resolution of the problem.

   Examples: What are three things that could be causing this problem? What do you think is causing the problem? What would you like to accomplish with this visit? Why do you think the patient is not compliant? What do we know, and what don't we know that we'd like to know?

2. **Probe for supporting evidence**

   Before offering your opinion, ask for evidence to support their opinion. Ask mentees to reveal their thought process to help you find out what they know and where there are gaps. This will help you avoid targeting your instructions inefficiently.

   Examples: What findings brought you to your conclusion? Were there other areas of consideration? What questions are arising in your mind? What are the key features of this case?

3. **Teach general rules**

   Provide general rules that will impact other patient care. Instruction is more transferable if offered as a general rule. Avoid using idiosyncratic preferences whenever possible.

   Examples: If the patient has these key features, these are key tests, or key interventions for patients with this type of presentation…

4. **Tell them what they did right**

   Tell the learner the specific good points of their performance and the effect it had. Unless skills are reinforced, competencies may not become well established.

   Examples:
   You were open-minded in developing your hypothesis… this will really help with…..
   Your sensitivity to … will likely improve compliance in…
   Did you see how much easier the rest of the interview flowed once you decreased the jargon? That was great.

5. **Correct mistakes**

   Discuss what went wrong and how to avoid the error in the future. Create a teachable moment. Learners are eager for tips to avoid uncomfortable situations. Avoid judgmental comments like, "you did what?" Remember that many of these discussions are best without the patient present. It is important to balance timing close to the incident with the availability of emotional energy of the learner.

   Examples:
   Next time you might try…
   Detail the negative effects of the error and define corrective action. There is no value in simply pointing out an error without offering a solution.

Guiding Lights, How to Mentor and Find Life's Purpose

(Liu 2004)

1. **Receive before you transmit**

   The most powerful teachers are those who listen with full-body intensity, and customize feedback individually. As a listener, no feedback is provided until the unique and ever-fluctuating frequency of the learner has been detected. Detect the learner's particular mix of temperament, skills, intelligence, and motivation. It requires us as teachers to put aside our own egos and preconceptions about what makes this particular lesson so important, or our way as the absolute best way.

   "The inner preparation, the awareness of oneself and one's student and of the traps and opportunities that lie within each, is where the critical work truly resides" Eric Liu

2. **Unblock, Unlock**

   Insecurity is the key element in prohibiting learning. It is the fear of failure and humiliation that slows progress. In the first step of "receive before you transmit" the mentor learns to get out of the way. In this step, the mentor helps learners get out of their own way. The most effective mentors teach learners to take inventory of their fears (undernourished egos) and delusions (over nourished egos) as a way to demystify them. This step is often subtle and without a tangible and identifiable process. Common threads of all ways to achieve this step are nonjudgmental awareness and the offering of support. When done well, it creates a learning environment of ease.

   "Powerful teachers have a decongestant effect, clearing clogged heads of mental blocks and maladaptive self-images." Eric Liu

3. **Zoom In, Zoom Out**

   "All thinking is analogy-making. All learning is analogy-finding. All teaching is analogy-showing." Eric Liu

   The hidden architecture of the subject is broken down to its core elements (zoom in). Those elements are then combined and recombined and shown how they connect to themselves and to elements of other structures (zoom out). It is the process that allows us to accurately answer the questions, "how does this relate to something we already know" and "how will this new representation help me know what to do with this current situation."
   Engaging this process is the process of teaching a learner how to think. It keeps the experience from being idiosyncratic.

4. **Invisible hands**

   "Whenever we enter a bustling marketplace we like to think that invisible hands naturally align all individual agendas. But markets are not natural. Chaos is natural. Markets work only because of the man-made grid of rules and norms we put in place to steer and to save people from their own worst instincts." Eric Liu

   Wise teachers understand the same about learning spaces. Careful design of the environment and strategic selection of materials create and reinforce the culture. What matters most is that we develop the culture and then develop the trust to let the culture do much of the teaching. This takes the burden off individuals while diluting the limitations that each individual mentor brings forward. A well designed system allows the best of many mentors to contribute. It provides stability and security.

5. Switch shoes

We intuitively understand the concept of stepping into our student's shoes with "receive before transmitting." This step is as much about letting the learner step into our shoes. The most transformative learning occurs when we allow the learner to teach. This might include asking the learner to teach a concept just addressed or it might be allowing learner teaching to an area of strength. This helps to blur the lines between "learner" and "mentor." These labels, if left unchecked, have potential to create a false identity that slows learning.

***"Those who look like great teachers are usually just great students**, working overtime to learn." Eric Liu*

CLINICAL REASONING, tools to direct content

Just to Review **Core Concepts of Mentoring**

Clinical mentoring aims to help the clinician experience:

- Professional competence
- Professional involvement
- Clinical judgment
- Metacognitive skills
- Moral agency
- Clinical reasoning

Teaching strategies that develop critical thinking, reasoning and general "presence"

Clinical Reasoning

The purpose of any clinical reasoning tool is to help the clinician get to the answer without the help of the mentor. The process helps the clinician think more broadly and include contextual issues that are more than the simple presenting pathology.

Clinical Reasoning mentoring, done well, incorporates all 5 points from both sources.

Use the Evidence Wisely

Mentoring the Clinical Reasoning Process Key Points (Based on 5 TAI Skills for Clinical Teaching)

- You must look past your preferences and meet the Mentee where they are **(Get a commitment)**
- You are worried about the process not the actual final answer **(Probe for supporting evidence)**
- You may have to correct the mentee if the process is wrong (even if the final answer is correct) **(Teach General rules by connecting information / Correct Mistakes)**
- You must foster a relationship where risk taking is encouraged **(Reinforce behaviors)**
- The main goal is to help the mentee eventually act as their own mentor **(Teach General rules by connecting information)**

Reference

1. Doody C, McAteer M. Clinical reasoning of expert and novice physiotherapists in an outpatient orthopaedic setting. Physiotherapy. 2002;88(5):258–268.

2. Resnik L, Jensen GM. Using clinical outcomes to explore the theory of expert practice in physical therapy. Physical Therapy. 2003;83(12):1090.

3. Jensen GM, Gwyer J, Shepard KF, Hack LM. Expert practice in physical therapy. Physical Therapy. 2000;80 (1):28.

TAI Clinical Reasoning Form Orientation

The proposed clinical reasoning forms are generally used to help the learner prepare for a mentored experience. The clinician fills out the form before the mentored experience. The process guides the clinician in the assimilation of the broad-based information set into specific working hypothesis and plans. It also helps the mentor get a quick overview of the patient without the clinician having to take specific time out of the process to inform the mentor. This form is a required part of the mentoring process if you are pursing continuing education credits. It is recommended that the mentor retain a copy of the form, but it is the ultimate responsibility of the mentored clinician to keep the record.

The concepts of the ICF have been incorporated in the development of these forms. We have currently developed an Ortho, Neuro, and Acute form. These are included in the appendix sections.

Highlights

Out-Patient Orthopaedic Clinical Reasoning Form

Signs and symptoms you have been following through your visits

a. We recommend keeping the subjective issues tied to specific functional activities
b. With respect to the irritability of the condition, you will want to
    i. List how long the patient can perform the activity prior to symptoms
    ii. List how long patient can continue once the symptoms occur/increase
    iii. List how long the symptoms remain after the activity is ceased

For the 3 specific possible sources of pain

a. Be as specific as possible
b. This is your basis for differential diagnosis
c. Do not be afraid to be wrong (you need options to differentiate)

Completion of the six scales **(Great place to probe for supporting evidence)**

a. Do not allow yourself to mark in the center of the line
b. Pick a side based on your findings
c. This will serve as a learning tool, so do not be afraid to be wrong

Under the severity scale

a. List activities that are limited that urged you to select a specific level of severity
b. Think about the level of importance of each activity for the patient

Pain classification scale

a. Adaptive pain serves a useful purpose to protect an irritated body structure and helps prevent further or future injury
b. Maladaptive pain does not serve a useful protective function

i. Often this pain is mediated by the central nervous system, not peripheral nociceptors

c. The magnitude of pain often does not match the vigor of the inciting activity
d. There often is a component of catastrophization about the condition that facilitates the pain process
e. Patients typically are not at either edge of the spectrum but somewhere in the middle

Under the pain classification scale

a. List how the current pain processing state may affect patient's motivation to perform activities

Environmental and Personal Factors

a. Think about what barriers to success the patient may encounter
    i. Personal traits (Age, sex, work duties, past history, motivation level, etc)
    ii. Home and community factors (home support system, ability to perform home exercises based on living situation, need for specific skills to perform ADLs and work)

Prognosis

a. This is one of the hardest tasks for a newer (or even veteran) PT
b. Encourage a specific answer (who cares if you are wrong)

How can this mentorship experience help you?

a. Here is the best place to get a commitment
b. Ensure you focus where they need help (not where you want to focus)
    a. You may need to help them see where they need help but work to have them come to this conclusion vs. offering your own opinion
c. Many Mentees are vague in this question
    a. Force them to give you specific information that gets to the heart of their need
        i. vs. superficial answers (i.e. Help with manual techniques)

Neurological Clinical Reasoning Form

Impairments section

a. For each area think about what you would expect to find given the patient's medical condition
b. This will help you develop a clinical picture prior to your examination
c. Do not be afraid of being wrong

Contributing factors

a. Think about other potential barriers to recovery
    i. Other physical ailments
    ii. Other disease processes
    iii. Acuity of the condition

Home/Environmental factors

a. What home and environmental issues must you consider that may hinder recovery
b. Consider physical and social/personal barriers

Any impairments do not match the medical diagnosis

a. Clinical patterns must be flexible (not rigid as in textbook descriptions)
b. Use this area to help expand your understanding of the variety of presentations for a common diagnosis
c. Are the differences based on a faulty initial diagnosis or maybe an incomplete understanding of the potential presentation of the condition

THE TAI WAY

Basic building blocks to setting up a great experience

Prep:

- ☐ Establish time with the learner and include director (4 hour blocks are best)
- ☐ **Request short form completion on all follow up appointments**
- ☐ Discuss your hourly (bonus) rate for this experience. Consider using this as a time to help motivate the mentee take responsibility for the learning experience
- ☐ Review previous Mentor Reports
- ☐ **Request (45 min) discussion time**
    - Beginning session if new experience
    - Middle and end if experienced
    - None if well known – and with the intention to follow up after experience

Day of:

- ☐ Arrive 20-30 min early to review clinical reasoning forms and previous notes, any other logistics
- ☐ **Identify how you'd like to be introduced (get patient okay each time)**
- ☐ Request copy of schedule (front desk)
- ☐ **Complete Case Journal section with each patient, being aware of the perception and timing of writing things down in front of the learner and patient**
- ☐ **Watch time and help the learner stay on schedule**
- ☐ Its okay to allow some documentation time – see how they budget time.
- ☐ Provide review of Case Journals or schedule time to discuss in the next 48 hours

Follow up:

- ☐ Invite case follow-up from the learner on any patients
- ☐ Send Mentor Report to mentee and director within 24 hours
- ☐ Assignment follow up if appropriate

Some other important details:

1. **Self reflection**: Review this list and the Mentor Recipe Card
2. Mentor may leave the room. There may be times that you do not to stay in the room (observing an ultrasound, etc). Explain to the mentee ahead of time that there may be times that you choose to leave the room and it should not be interpreted as a negative commentary. There will be times that it may be appropriate to step if you feel that your presence is compromising the quality of the interaction between the therapist and the patient.
3. TAI Culture – the bare necessities
    a. Proficient using VHI (See TAI Guidelines for Home Programs)
    b. TAI List Serve
    c.. Personal Education Plan – contact David/Bill if personal education plan isn't done

TAI Forms and how they work - review

1. Clinical Reasoning/Case Journal Forms
2. Director Mentor Reports
3. TAI Mentor Evaluation
4. TAI Mentor Self-Assessment

Clinical Reasoning/Case Journal

TherapeuticAssociates **Daily Clinical Reasoning and Mentor Case Report**

Clinician's name: _____ Patient Initials _____ Patient age/sex _____
Date: _____ Medical Diagnosis _____ Visits _____ ☐ Follow up ☐ Assessment

Signs and symptoms you have been following through your visits
Subjective:

Significant objective findings on exam that will require re-exam
Physical:

Functional limitations:

List 3 specific possible sources of the patient's symptoms (number most to least likely):

- MCID: Function: ☐ Projected # visits: ☐ Expected change ☐ Change/Visit: ☐
-
-

Based on your findings:
Does this condition sound primarily ☐ Mechanical ☐ Inflammatory ☐ Neurogenic ☐ Other _____

Describe the **SINSS** of this disorder

Severity: Mild |----------|----------|High
Irritability: Mild |----------|----------|High

PT Diagnosis (Be Specific) _____

Stage: Acute |----------|----------|Chronic
Stability Stable |----------|----------|Unstable

Pain Classification - Adaptive|----------|----------|Maladaptive

Treatment progressions thus far (Focus on body structure, activity changes, and participation factors)

Has any information changed your assessment of the nature of the condition?

What contributing factors or other anatomical areas did you consider at your evaluation but have not yet addressed in treatment?

List environmental and personal factors that may limit potential outcome

Prognosis: Does the current prognosis match your initial prognosis (explain)?

How can this mentorship experience help you?

(To be completed by mentor)
Assessment performance
Notes:

Intervention performance
Notes:

Mentor recommendations/comments: _____

_____

Level of Performance *(circle): Novice, Adv. Beginner, Competent, Proficient, Expert, Master*
Hours of 1:1 mentoring _____
Mentor signature: _____ Date: _____

Therapeutic Associates April 14

Clinical Reasoning/Case Journal Instruction

→ **TherapeuticAssociates** → **Daily Clinical Reasoning and Mentor Case Report** → → ¶

¶

Clinician's name: _____ Patient Initials _____ Patient age/sex _____ ¶

Date: _____ Medical Diagnosis _____ Visits _____ ☐ Follow-up ☐ Assessment ¶

¶

Signs and symptoms you have been following through your visits ¶

Subjective: → → → → → → → **Physical:** ¶

Provide information about patients described problem — be specific when possible → Provide significant objective findings on exam that will ¶

Example; limited ambulation — 2 blocks due to pain (6/10) → → → require re-examination ¶

¶

→ **Functional Limitations:** ¶

specific activity limitations ¶

¶

¶

List 3 specific possible sources of the patient's symptoms: (number most to least likely): ie (R) L4-5 disc pathology; hypomobile (L) talocrural joint, ¶

→ . → → → → → → MCID: Funtion: → Projected # visits: → Expected change → Change/Visit: ¶

→ .¶

→ .¶

Based on your findings: ¶

Does this condition sound primarily: (select only one) ☐ Mechanical ☐ Inflammatory ☐ Neurogenic ☐ Other _____ ¶

Describe the SINSS of this disorder ¶

Severity: → Mild | ---------- | ---------- | High ¶

(how it affects their function ie unable to work, unable to do usual work-out) ¶

Irritability: → Mild | ---------- | ---------- | High ¶

(how sensitive limiting and how long to recover ie, unable to stand >10', takes 20' to recover ¶

(pain intensity in contest of both how easily the level of pain is elevated and the duration required for pain to subside. ¶

PT Diagnosis (Be Specific) _____ ¶

(What you determine the physical therapy diagnosis to be ie anterior instability L4-5) ¶

Stage: → → Acute | ---------- | ---------- | Chronic ¶

(Stage of healing or mechanical instability) ¶

Stability → → Stable | ---------- | ---------- | Unstable ¶

(relative to consistency of findings) ¶

Pain Classification → → Adaptive | ---------- | ---------- | Maladaptive ¶

Adaptive — pt's behavior facilitates recovery ····· **Maladaptive** — pt's behavior interferes with recovery ¶

¶

Treatment progressions thus far (Focus on body structure, activity changes, and participation factors) ¶

¶

Has any information changed your assessment of the nature of the condition? ¶

¶

What contributing factors or other anatomical areas did you consider at your evaluation but have not yet addressed in treatment? → ¶

¶

List environmental and personal factors that may limit potential outcome ¶

¶

Prognosis: Does the current prognosis match your initial prognosis (explain)? ¶

¶

How can this mentorship experience help you? ¶

¶

¶

(To be completed by mentor) ¶

Assessment performance → → → → ¶

Notes: → → → → → → ¶

→ → → → → → ¶

¶

¶

¶

¶

Intervention performance → → → → ¶

→ **TherapeuticAssociates** → **Daily Clinical Reasoning and Mentor Case Report** → →

Notes: → → → → → →

Mentor recommendations/comments: _____

_____

Level of Performance *(circle): Novice, Adv. Beginner, Competent, Proficient, Expert, Master*

Hours of 1:1 mentoring: _____

Mentor signature: _____ Date: _____

Mentor Reports

CLINICALEDUCATION
TherapeuticAssociates
Mentor Report to Clinic Director

Dear (Clinic Director),

The following residency mentorship experience was completed with (mentored therapist) on (date) for (#) hours of mentoring. Cases included (list cases)

Personal Education Plan: (comment if addressed or reviewed)

Reviewed: (list any specific treatments, tests, philosophies)

Over-all level of performance (circle one): *Novice, Adv. Beginner, Competent, Proficient, Expert, Master*

Strengths
May use characteristics listed in the "expected level of clinical performance to help create this list. You may add other comments as well.
Sorts through rules and information to decide what is relevant based on learned information and past experience
Uses analytic reasoning and beginning level pattern recognition
Interest in continued professional development
Direct eye contact with patients during history taking (incorporated into all sessions), and minimizes distractions with computer and other information sources
History questions are sequenced well
Proficient use of VHI

Next Step in development
May also use characteristics listed in the "expected level of clinical performance to help create. For example.
Refine communication and emotional connection to patient through more strategic conversations and delivery. This will also help with time management.
Continue to develop an understanding of the big picture through the clinical reasoning process
Integrate strategic (individualized) scapular pattern training with neck, thoracic and UE conditions

Suggested teaching
May use teaching suggestion from the "expected level of clinical performance" form to help create. For example:
Encourage verbalization of hypothesis testing
Coaching to recognize meaningful data
Include a wide breadth and depth of cases
Engage critical self-reflection, especially as it relates to communication and clinical reasoning

Assignments: Tthis is optional, and for example:

1. Shirley Sahrmann's shoulder chapter
2. Increase awareness of tone, content and communication style with patients. Report findings.
    a. Self-monitor
    b. Record two interactions

I'm happy to discuss this case more if you have further questions or concerns. Thank you for participating in this program.

Sincerely
(Your name)

Mentor Evaluation

TherapeuticAssociates

TAI Mentor Evaluation

Initial mentor evaluation
TAI Residency mentor evaluation (every 2 years)
Remediation mentor evaluation

Mentor: _____ Current Mentor Level _____
Evaluated by: _____ Date: _____

Demonstrates appropriate behaviors consistent with the 5 TAI Principles of Mentoring

Objectively asks about data: Yes / No / Not observed

Example:

Appropriately helps identify process, conclusions, assumptions: Yes / No / Not observed

Example:

Helps connect information (1 & 2): Yes / No / Not observed

Example:

Appropriately reinforces behaviors and corrects mistakes: Yes / No / Not observed

Example:

Uses the structure of this process to facilitate the experience: Yes / No / Not observed

Example:

Develops appropriate expectations of clinical performance (pg 2): Yes / No / Not observed

Comments:

Is able to teach to the appropriate level of clinical performance (pg. 2): Yes / No / Not observed

Comments:

Recommendations:

Level 1 mentor

Level 2 mentor

Level 3 mentor

Level 4 mentor

Continued development:

Please fax or send completed form to Dorothy Klemetson (206) 241-0028 dorothyk@taiweb.com

Mentor Self-Assessment

TherapeuticAssociates

TAI Mentor Self-Assessment

Mentor in Training: _____ Location: _____
Mentor Trainer: _____ Date: _____

Demonstrates appropriate behaviors consistent with the identified Debriefing Strategies

Get a Commitment

Intro questions: Yes / No / Not observed

Basic Data questions: Yes / No / Not observed

Probe for Supporting Evidence

Conclusion and Assumption questions: Yes / No / Not observed

Teach General Rules Yes / No / Not observed

Example:

Reinforce Behaviors: Yes / No / Not observed

Example:

Correct Mistakes: Yes / No / Not observed

Example:

Develops appropriate expectations of clinical performance (pg 2): Yes / No / Not observed

Comments:

Is able to teach to the appropriate level of clinical performance (pg. 2): Yes / No / Not observed

Comments:

Integrates information from the Skill-Set (Residents) (pg. 3): Yes / No / Not observed

Comments:

Requested level of mentor certification:

☐ Level 1 mentor

☐ Level 2 mentor

☐ Level 3 mentor

☐ Level 4 mentor

Continued development:

APPENDIX

STATE EDUCATION REQUIREMENTS

For state education requirements, refer to these webpages:

Washington

http://apps.leg.wa.gov/WAC/default.aspx?cite=246-915-085

Oregon

http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_848/848_035.html

Idaho

http://ibol.idaho.gov/IBOL/BoardAdditional.aspx?Bureau=PHT&BureauLinkID=130

California

http://www.ptbc.ca.gov/licensees/cont_comp.shtml

TAKE AWAY

Create a supportive learning environment knowing that judgment impede the learning process

Don’t underestimate the power of self-awareness. Pursue practices for yourself.

Unveil the learner’s clinical reasoning process more than your own

Facilitating critical thinking is more powerful than dispensing knowledge

Link or connect information whenever possible

Use the forms and documents to help create structure that ups the chance for a successful experience

_____

_____

_____

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