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Train-the-Trainer Course
APTA Credentialed Clinical Instructor Program
March 30 – April 1, 2017

Course Schedule

Thursday, March 30, 2017
8:00 - 8:30 AM  Continental Breakfast

8:30 - 8:45 AM  Welcome and Introductions
Orientation to the Train-the-Trainer Course
  • Role of faculty and participants
  • Purpose of the covenant
  • Purpose and objectives of the training
  • Roles and responsibilities of Credentialed Clinical Trainers
  • Profile of the group

8:45 - 9:00 AM  Opening activity

9:15 AM - 12:15 PM  Teaching Videotaped Segment #1
  • Participants teach assigned pages of content from Sections 1, 2, or 3 of the Trainer Manual to an audience of novice CIs; participants will be split in two classrooms
  • Feedback and verbal comment session - self, peer, and faculty assessments of instructional segment

12:30 - 1:15 PM  Lunch
  • Set personal goals for the 3-day program

1:15 - 2:15 PM  Review and discuss Sections 1, 2, and 3 of the Credentialed Clinical Instructor Program (CCIP) Manual highlighting critical points; clarify content presented during teaching segments

2:15 - 3:45 PM  Teaching Effectiveness - Designing an effective active training program - examining issues of structure, sequencing, pacing, timing, and creativity

3:45 - 4:00 PM  Break

4:00 - 5:30 PM  Credentialed Clinical Instructor Program Management and Administration
  Managing the Business of the CCIP
  • Eligibility for the Credentialed Clinical Instructor Program
  • Credentialing experienced CIs - use of outcome criteria for experienced clinical educator self-assessment
  • Discussion of sample schedules
  • Alternative configurations for providing the Program
  • Intent of the CI Credentialing Program financially
  • Logistical administration of the program on-site; cost saving measures

  APTA Program Administration
  • Review, utilization of, and deadlines for forms provided (eg, Participant Dossier, APTA Manual Order Form)
  • Review participant course evaluation process
  • Program fees (variable), group rate, and international partners
Train-the-Trainer Course
APTA Credentialed Clinical Instructor Program
March 30 – April 1, 2017

program

• Responsibilities of the Credentialed Trainer

5:30 PM Homework

• Review Sections 4, 5, and 6 of the CI Training Manual in preparation for teaching segment #2 and follow-up discussion
• Review Assessment Center response sheets in preparation for Day 3 “Mock Assessment Center” session
Train-the-Trainer Course
APTA Credentialed Clinical Instructor Program
March 30 – April 1, 2017

Course Schedule

**Friday, March 31, 2017**

8:00 - 8:30 AM  Continental Breakfast

8:30 - 8:45 AM  Questions and answers from day one of the training

9:00 AM - 12:00 PM  Teaching Videotaped Segment #2
  - Participants teach assigned pages of the content from Sections 4, 5, or 6 of the Trainer Manual to an audience of experienced CIs from physical therapy and other disciplines, transitioning from lecture to an activity; participants will be split in two classrooms
  - Feedback and verbal comment session - self, peer, and faculty assessments of instructional segment

12:15 - 1:00 PM  Lunch
Select and sign up partner(s) for team teaching segment #3

1:00 - 1:45 PM  Teaching Effectiveness - Designing opening and closing segments for engaging participants on-the-job applications

1:45 - 3:15 PM  Review and discuss Sections 4, 5, and 6 of the Clinical Instructor Education Manual and highlight critical points, clarify content presented during teaching segments

3:15 - 3:30 PM  Break

3:30 - 4:45 PM  Teaching Effectiveness - Alternative designs and methods for providing active teaching and experiential learning and assessment of participant learning based upon level and type of learners, group size, and resource availability.

4:45 - 5:15 PM  Concepts of Team Teaching
Multidisciplinary Professional Participants/Exercise

5:15 - 5:25 PM  Homework
  - Prepare with your partner(s) for teaching segment #3 using an experiential design for learners at all levels and from multiple disciplines
  - Revisit personal goals and revise as needed
  - Review Assessment Center response sheets in preparation for Day 3 “Mock Assessment Center” session
  - Review Trainer Manual in preparation for any final questions

5:25 PM  Team Teaching Preparation
  - Prepare for teaching segment #3 with a partner to learners representing both novice and experienced CIs from multiple disciplines using only an experiential design.
  - **Goal:** Identify content to be addressed in the active teaching design from the Trainer Manual and commit to your topic on the sign-up sheet
Train-the-Trainer Course  
APTA Credentialed Clinical Instructor Program  
March 30 – April 1, 2017

Saturday, April 1, 2017

7:15 - 8:00 AM  Continental Breakfast  
• Questions and answers, if needed

8:00 AM - 12:15 PM  Teaching Videotaped Segment #3  
• Participant teams teach a segment of the content as identified on day two to learners who are at varying levels of experience and representing different disciplines using an experiential design only (reflect on self, peer, and faculty evaluations and videotape)  
• Feedback and verbal comment session - self, peer, and faculty assessments of instructional segment

12:15 - 1:00 PM  Lunch

1:00 - 1:15 PM  Complete a “Mock” Assessment Center folder

1:15 - 2:00 PM  Group activity: Manage three typical scenarios that occur during the Assessment Center

2:00 - 2:45 PM  Final Comments, Questions, and Closing Remarks  
• Notification of Credentialed Clinical Trainer status  
• Credential portfolio renewals (three years)  
• Credentialed Clinical Trainer network opportunities (CSM, Hub communities)  
• Awarding CEUs and Certificates for the CCIP  
• Advanced Credentialed Trainer opportunity  
• Other questions/issues?

2:45 - 4:15 PM  And finally work while you snack…  
• Participant Debriefing Sessions and Evaluations with Faculty  
• Participants complete final self-assessment evaluation form relative to readiness to provide the Credentialed Clinical Instructor Program for others and submit to faculty during debriefing session  
• Complete Train-the-Trainer course evaluation  
• CEU Certificates  
• Something to pass the time…surprise!

5:00 PM  Adjourn after debriefing session completed and celebrate!
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Course Goals

The purpose of this 3-day instructional course is to:

1. Train a select group of experienced and competent clinical educators, using a standard valid and reliable curriculum, to provide high-quality, active learning clinical instructor education and a competency assessment program that results in the awarding of APTA Clinical Instructor Credentialing.

2. Train a select group of experienced and competent clinical educators in how to effectively manage, coordinate, and administer the Credentialed Clinical Instructor Program.

Course Objectives

At the completion of this course the participant will:

1. Review, understand, and apply all didactic content provided in the standard Credentialed Clinical Instructor Program.

2. Evaluate instructional strengths and limitations of self and other participants by teaching and assessing selected segments of the Credentialed CI Program.

3. Apply principles of instructional design, team teaching, and adult learning to formulate alternative approaches for designing and sequencing active learning experiences within the clinical instructor education curriculum for different levels of learners and varied health professions clinical educators.

4. Examine the “Assessment Center” as a teaching/learning tool to determine strengths and limitations in using this competence-based assessment method and demonstrate competence in handling 3 situations that may “typically” occur when providing the Assessment Center.

5. Demonstrate how to manage the logistics of the Credential CI Program including negotiating with a sponsor to provide the program, processing and ordering CCIP Participant Manuals, managing and coordinating the Assessment Center, completing the appropriate information at the completion of the program to obtain APTA CI Credentialing for participants and provide course summary evaluation information.

6. Complete a portfolio, in advance of the course, as a baseline for growth and future comparisons.
Academic Coordinator/Director of Clinical Education (ACCE/DCE) – Person employed by the academic institution responsible for maintaining the affiliation contract between the academic program and the clinical site. This individual reviews student performance evaluations from clinical instructors and assigns a grade for the course. Also acts as a resource for clinical instructors and sites for problem-solving with students and training clinical instructors. The ACCE/DCE may also teach in the educational program’s classroom setting. (ie, academic faculty, classroom instructor, academic program director, etc.) Note: In some models, faculty may also serve as clinical instructors (ie, nursing, dental, and medical models).

Center Coordinator of Clinical Education (CCCE) – Person employed by the clinical site responsible for scheduling student experiences, training clinical instructors, communicating with the educational program(s), monitoring contracts between the facility and the educational programs, and ensuring compliance with clinical experience standards. (ie, student coordinator, residency director, student program director, etc.)

Clinical Experience – Designated period of time scheduled at a clinical site for a student to practice skills under the supervision of a qualified instructor/preceptor. Written and verbal evaluation of the student’s performance is provided by the clinical instructor and contributes to the completion of an educational degree, postprofessional residency, fellowship, or certificate program. (ie, internship, preceptorship, residency, fellowship, etc.)

Clinical Instructor (CI) – Clinician employed by the clinical site who is responsible for teaching and supervising the student, approving the learning objectives for the clinical experience and evaluating the student’s performance at the clinical site. (ie, preceptor, field instructor, student supervisor, etc.)

Clinical Instructor Education Workgroup (CIEW) – Groups coordinated by APTA staff to facilitate the work of the Credentialed Clinical Instructor Program and Advanced Credentialed Clinical Instructor Program. Workgroups may be convened for the purpose of application review for the CCIP and ACCIP, portfolio renewal reviews, review of Train-the-Trainer participant performance, review/revision/update of CCIP and ACCIP curriculum, review of CCIP and ACCIP policies and procedures, etc.

Clinical Site – Location(s) where the clinical experience occurs; facility that agrees to supervise students under a contract/affiliation agreement with the student’s academic program. The clinical site is also a possible location/facility for a residency or fellowship program.

Credentialed Clinical Instructor – This PT or PTA has completed the Credentialed Clinical Instructor Program and successfully passed the Assessment Center for competency testing by achieving a score of 21 or better.
Credentialed Clinical Trainer – This PT or PTA has applied for and been invited to participate in the Train-the-Trainer course after having earned Credentialed Clinical Instructor status. Subsequently, this person has successfully met the criteria for completion of this course based on mastery of the standardized curriculum, demonstration of competence in teaching the standard content to 3 different audiences, and provision of peer and self-assessments throughout the course. The CIEW awards the Credentialed Clinical Trainer status. This person provides the Credentialed Clinical Instructor Program to clinical educators.

Credentialed Clinical Trainer Faculty – This individual must have earned Credentialed Clinical Instructor and Credentialed Clinical Trainer status to serve as a faculty member to provide instruction at the Train-the-Trainer course. This person serves as a role model, educator, evaluator, and mentor during this course for others and is recommended for this role by the CIEW.

Dossier - Document that is completed by the participant and immediate supervisor prior to attending the CCIP to ensure competence as a clinician.

Evaluation Tools – A form or instrument containing standards or criteria for assessing student’s clinical performance. A tool used to describe a specific incidence of performance. A tool used for the student to provide self-assessment. Examples: Clinical Performance Instrument (CPI), PTMACS, American Occupational Association Fieldwork Evaluation for the Occupational Therapist, Clinical Instructor Evaluation of Student Performance, Anecdotal Record, Weekly Planning Form, etc.

Portfolio – This is a compilation of the “work” of the Credentialed Clinical Trainer to be used by the CIEW to assess his or her ability to continue to offer either the CCIP or ACCIP for clinical educators. The “work” includes documentation of continued membership in APTA, current license/registration/certification, number of courses offered, summaries of participant evaluations from courses provided by the Credentialed Clinical Trainer, continuing professional development, willingness to continue as a Clinical Trainer, etc.

Student – Person enrolled in an educational program responsible for achieving a designated set of skills and performance behaviors at a clinical site. The student is also responsible for obtaining the necessary preparation for the clinical experience and providing feedback to the clinical instructor. (ie, intern, resident, trainee, etc.)
Materials in this Trainer’s Manual were originally developed based on a grant provided by the American Physical Therapy Association under the direction of principal investigator Michael Emery, PT, EdD and with co-investigators Nancy Peatman, PT, JD, MEd, and Lynn Foord, PT, PhD, MS, Med and with the support of the New England Consortium of Academic Coordinators of Clinical Education Inc. The Association is most appreciative of the exceptional effort and remarkable contributions of these individuals in developing the initial comprehensive Trainer’s Manual to be used by credentialed trainers to conduct the APTA Credentialed Clinical Instructor Program.
Introduction to the Credentialed Clinical Instructor Program: Program and Assessment Center

Overview

A blueprint for the Clinical Instructor Education and Credentialing Program (CIECP – initial name), developed with the support of a grant from the Department of Physical Therapy Education of the American Physical Therapy Association is contained, in its entirety, within this manual. The process is divided into 2 distinct parts: 1) clinical instructor education via a program format and 2) assessment of training outcomes through a 6-station assessment center. These 2 components are used together to first provide and then assess the knowledge and skill identified as essential for clinical instructors of physical therapist and physical therapist assistant students.

The Guidelines for Clinical Instructors, endorsed by the House of Delegates of the American Physical Therapy Association (APTA) in June 1993 and most recently revised and adopted in March 2004 by the APTA Board or Directors, provide the foundation of this Clinical Instructor Education and Credentialing Program. The content of the program was selected and developed to address, at a minimum, the knowledge and skills recommended in the Guidelines for Clinical Instructors as necessary for all clinical instructors.

Outcomes of the education program are measured through an Assessment Center format. The Assessment Center was created to measure the applicant’s ability to apply critical knowledge and skill in simulated situations. The Guidelines for Clinical Instructors were also used in the development of the Assessment Center Stations, so that as many Guidelines as possible are evaluated through this process. Several of the Guidelines, specifically those related to the applicant’s clinical competence, professional skills, ethical behavior and time management abilities were felt to be better assessed by the applicant’s direct supervisor. These have been included in a Participant Dossier that must accompany each applicant’s registration form.

Therefore, the Assessment Center Stations in conjunction with the Participant Dossier provide a comprehensive assessment of each applicant’s degree of adherence with the Guidelines for Clinical Instructors.

Organization of the Trainer’s Manual: Part I (tabs)

1. The first portion of this manual is devoted to the clinical instructor education program. The Trainer’s Manual contains all seven (7) sections of the participant CI Manual, in their entirety. The sections are as follows:

   Section I  The Clinician as Clinical Educator
   Section II  Readiness to Learn
   Section III  Facilitating Learning in the Clinical Environment
   Section IV  Performance Assessment - The Clinical Environment
   Section V  Legal, Regulatory, and ADA Issues in Clinical Education
   Section VI  Managing the Exceptional Student in Clinical Education
   Section VII  Answer Keys and Additional Recommended Resources

2. Suggestive narrative (in shaded areas) and possible responses to activities (shaded) are interspersed throughout.
3. Special sections entitled “Instructor’s note” are included where necessary, to clarify the intent or emphasis of a particular section.

4. A picture of each corresponding slide is included with the relevant content, so that the credentialed trainer will always have available a representation of what is on the screen. In many cases the content provided on the slide is not provided again following the slide to reduce redundancy. In those cases where there are citations, additional narrative, or Instructor’s note related to the slide content the same information is shown.

5. Directions at the right side of each page in bold font inform the Trainer to advance to the next slide and page, or the next page only. Trainers should follow these cues to ensure that they remain coordinated with the narrative that is being presented.

Organization of the Trainer’s Manual: Part II (tabs)

1. The second portion of this manual describes the organization and administration of the Assessment Center. A complete set of materials for each of the 6 stations is included as well as guidelines for scoring. Refer to the Introduction to the Assessment Center for a more detailed description.

2. A description of the 7 outcome criteria to be used by experienced physical therapy CIs to self-assess their readiness to complete the Assessment Center is included. These criteria serve as a mechanism to determine whether the experienced physical therapy CI is likely to be able to successfully complete the Assessment Center Stations without taking the Clinical Instructor Education Program component. In addition, requirements associated with this category of applicant are also provided. It is expected that the experienced Clinical Instructor will meet all of these criteria to pursue the completion of this program through an Assessment Center only format.

3. Related functions for the Assessment Center including:
   - Additional persons (Station Managers) needed to conduct an Assessment Center with recommended instructions
   - Instructions for copying and collating materials
   - Sample Program Announcement
   - Agreement of Participants taking the CCIP
   - Sample program schedules
   - Sample room designs
   - Recommendations for group size and space requirements to conduct a program

USB Drive

1. Included in your materials is a USB drive that includes the CCIP Power Point slides for Sections I-VI, Assessment Center Video, video on effective and ineffective feedback for Section III, and video of the Case of Fran in Section VI.
Organization of the Trainer’s Manual: Part III (tabs)

The third part of this manual describes administrative and business tasks and functions related to providing an APTA Credentialed Clinical Instructor Program, Roles and Responsibilities of Trainers, Disciplinary Procedures, and Appeals that are included in the Policy and Procedures for the CCIP.

1. Administrative functions are directed toward the responsibilities of the trainer and/or sponsoring organization that include:
   - Simple Administrative Steps to Organize and Coordinate the Program through APTA
   - Administrative Responsibilities of the Trainer
   - Portfolio Renewal Form
   - Documentation that must be completed by the applicant such as the Participant Dossier, Participant CCIP evaluation, etc.

2. Business functions are directed toward the management and coordination of the business related aspects of the CCIP that include:
   - Business Aspects of the CCIP
   - Trainer’s checklist
   - CI Manual Order Form to be completed by the Trainer and/or sponsoring organization to track applicants for payment of fees and completion of Participant Dossier
   - Group Rate Discount Fees
   - Policy and Procedure Notables
   - Cost analysis breakdown

3. Program description, Trainer benefits, roles and responsibilities of credentialed trainers, Credentialing Decisions of the CCIP Advisory Workgroup, Trainer renewal, Credentialing Decisions, Disciplinary Procedures, and Appeals are provided for your reference that are included in the CCIP Policy and Procedures.

MATERIALS TO BE PROVIDED ONSITE

1. Information and handouts related to the 3-day training on interactive training, helpful hints for teaching the 6 sections, managing the CCIP and Assessment Center, and the overall processes used to conduct any educational program will be provided onsite. In addition, a text on Active Training by Dr Mel Silberman will be provided onsite.
Considerations for Presentation of the Credentialed CI Program

1. To prepare participants for the Assessment Center, it is critical that the information contained within Part I of the Trainer's Manual be adequately covered each time the program is offered. Occasional opportunities for customizing the presentations have been included and are clearly identified in the Instructor's Note section or the shaded text areas.

2. The following time frames have been demonstrated to be sufficient to complete the material in each Section and can be used to assist with scheduling.

<table>
<thead>
<tr>
<th>Section</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1.5 hours</td>
</tr>
<tr>
<td>II</td>
<td>2.5 hours</td>
</tr>
<tr>
<td>III</td>
<td>2 hours</td>
</tr>
<tr>
<td>IV</td>
<td>2 hours</td>
</tr>
<tr>
<td>V</td>
<td>2 hours</td>
</tr>
<tr>
<td>VI</td>
<td>2 hours</td>
</tr>
<tr>
<td>Assessment Center</td>
<td>3 hours (can occur at the end or interspersed throughout the program)</td>
</tr>
</tbody>
</table>

3. If possible, it is suggested that Day 1 of the CCIP (Sections 1, 2, and 3) include Assessment Center Stations 1 and 2. Both of these stations can be done in a large group and can be completed based on the information already presented. Scheduling in this manner helps to keep the participants actively engaged in the process and decreases the anxiety associated with completing the Assessment Center and the amount of writing required in Day 2. NOTE: Stations 1 and 2 must also be offered on Day 2 only if experienced CIs taking only the Assessment Center are scheduled.

An alternative to the proposed schedule would be to present Sections I-IV on Day I and Sections V-VI in the morning of Day 2. The Assessment Center would fill the afternoon of Day 2.

4. A sample schedule for Day 1 and Day 2 of the CI Education and Credentialing Program, which delineates a preferred schedule, is included below for reference (See Related Functions for the Assessment Center).

5. Group size is limited by the availability of space and personnel.

Day 1 requires: A large room, set classroom style (with tables) or crescent rounds with tables to accommodate the total number of participants. Additional seating should be added for members of the sponsoring group.

Day 2 requires: A large room as above for total number of participants 2 breakout rooms that will each accommodate 1/3 the total number of workshop participants. (NOTE: Program participants are divided into 3 evenly numbered groups to navigate the stations of the Assessment Center. Stations 3 and 4 of the Assessment Center benefit from a smaller group size).<br>  < room 1: set classroom style in front of a screen and LCD with computer<br>  < room 2: set classroom style but with chairs set
across the table from each other for dialogue in pairs

Debriefing room (for scoring and asking questions), which accommodate the total number of participants. (NOTE: Experienced Physical Therapy CIs will require additional space in the debriefing room).

< If a separate debriefing room is not available, it is possible to use the large lecture room for debriefing and scoring. This will limit the amount of conversation that may be allowed, since some participants may still be completing one or more Assessment Center Stations in that room.

6. **Participant CI Manuals**
Participant Credentialed CI Program Manuals are provided to each registered participant, including persons completing the program and Assessment Center as well as the experienced CI completing only the Assessment Center. The information contained within the CCIP Manual is identical to the Trainer’s Manual, minus the narrative, Instructor’s notes, videotape sessions, some of the activities, and the Assessment Center.
Credentialed Clinical Instructor Program
Master Schedule

Day 1
7:30 am Registration
7:45 am Welcome and Introductions
Section I
The Clinician as Clinical Educator
9:15 am Break
9:30 am Section II
Readiness to Learn
12:00 pm Lunch
1:00 pm Section III
Facilitating Learning in the Clinical Environment
3:00 pm Questions and Answers
Orientation to the Assessment Center
3:30 pm Assessment Center Station 1
4:00 pm Assessment Center Station 2
4:30 pm Scoring Assessment Center - Stations 1 & 2
5:00 pm Adjourn

Day 2
7:30 am Check-in for Day 2
7:45 am Section IV
Performance Assessment - The Clinical Environment
9:45 am Break
10:00 am Section V
Legal, Regulatory, and ADA Issues in Clinical Education
12:00 pm Lunch
1:00 pm Section VI
Managing the Exceptional Student in Clinical Education
3:00 pm Assessment Center Begins
Stations 3, 4, 5, and 6
5:00 pm Scoring Assessment Center - Stations 3, 4, 5, and 6
5:30 pm Adjourn
CREDENTIALED TRAINER MANUAL

Credentialed Clinical Instructor Program

American Physical Therapy Association
Department of Physical Therapy Education
1111 North Fairfax Street
Alexandria, VA 22314
Preface

Good morning and welcome to the Credentialed Clinical Instructor Program (CCIP).

All of you are here because of your interest in and commitment to clinical education, and we thank you for taking the time out of your busy schedules to participate in this program and learning experience. This program is recognized by the American Physical Therapy Association (APTA) as the Credentialed Clinical Instructor Program (CCIP).

The program was developed through a grant funded by APTA under the direction of principal investigator Michael J Emery, PT, EdD, with co-investigators Nancy Peatman, PT, JD, MEd, and Lynn Foord-May, PT, PhD, MS, MEd, and with materials used by the New England Consortium of Academic Coordinators of Clinical Education, Inc. The program was initiated in 1997 with the first group of Trainers completing the 3-day program in June 1997. Since then, more than 37,000 PTs and PTAs have successfully completed this program to be recognized as Credentialed CIs.

Program Outcomes Overview

The outcomes of this program are for the participant to be able to:

1. Describe the parallels between the characteristics of the practitioner and clinical educator.
2. Plan and prepare for students during their clinical education experiences.
3. Identify student learning needs and areas of competence.
Program Outcomes Overview (cont’d)

4. Design high-quality learning experiences for students at all levels of experience.
5. Implement clinical teaching methods and supervisory techniques that support ongoing adult learning.
6. Provide effective formative and summative evaluation.

7. Identify legal and supervisory implications for clinical educators, including issues presented by ADA legislation, Medicare regulations, and the Patient’s Bill of Rights.
8. Manage the student who is demonstrating problem or exceptional performance.
The Assessment Center component of this program provides physical therapists and physical therapist assistants with an opportunity to apply information from the education program in simulated situations. Successful completion of each station in the Assessment Center results in the awarding of APTA Clinical Instructor credentialing. The six stations of the Assessment Center have been integrated into the program schedule. **As a reminder, it is essential that all physical therapists and physical therapist assistants participating in this program attend all sessions of the Course and Assessment Center in its entirety to be eligible for credentialing.**

Lastly, this program and its contents are copyrighted and therefore, cannot be duplicated in the current format for any other expressed purpose without the written consent of APTA. There are several forms that may be copied, however, for use in the clinic when working with students. Forms that may be duplicated include:

- The Anecdotal Record
- Summary Weekly/Planning Form
- Learning Contract
- Student Program Planning Flowchart
- Memorandum of Agreement

next slide/page
Section I

Good morning and welcome to Section I of the clinical instructor education and credentialing program. Since the introduction, objectives, and assumptions are all in your book, we won’t be talking about them this morning except to highlight a few of the more important concepts. They do, however, give us a foundation on which to build this section, so I’ll give you a few minutes to read through them as we go through the slides.

Introduction

Section 1 describes the relationship between the academic program and the clinical site and those involved in the clinical education of students. It further describes the parallels in the roles of the clinician and the clinical instructor (CI). Characteristics of an effective physical therapist and CI are discussed, and the responsibilities of the CI are identified. Section I provides a framework on which subsequent sections will build.
Objectives

Following the completion of Section I, the participant will be able to:

1. Describe the partnership that exists between the academic program and the clinical site.
2. Identify the role and relationships of the ACCE/DCE, CCCE, CI, and student within physical therapy education.

Objectives (cont’d)

3. Explain the role of the clinical educator as defined by the assumptions about clinical education.
4. Identify at least 4 characteristics of an effective CI.
5. Recognize the similarities in the roles of the clinician and clinical educator.
Objectives (cont’d)

6. Incorporate core values in professionalism.
7. Incorporate the voluntary APTA Guidelines and Self-Assessments for clinical instructors.

Assumptions

1. The relationship between an academic program and the clinical site is a voluntary partnership.
2. Successful clinical experiences require that each “player” fulfills his or her role and responsibilities and follows established lines of communication in a timely manner.
Assumptions (cont’d)

3. The CI is the student’s role model throughout the course of his or her training.

4. Clinical education is an essential component of professional education that complements academic education.

5. Clinical education addresses all essential areas of physical therapist (PT) and physical therapist assistant (PTA) education:
   a. Professional behaviors and attitude
   b. Safety
   c. Interpersonal relationships and communication skills
   d. Problem-solving process
   e. Clinical performance skills
   f. Administration/management
Assumptions (cont’d)

6. A goal of clinical education is to provide an environment that fosters a student’s professionalism and encourages the development of an autonomous and competent clinician.

7. The clinical environment is designed to promote adult learning.

8. The role of the clinical educator parallels the role of the clinician.

Instructor’s note: It’s usually helpful before beginning the session to know who your audience is. It is suggested that you ask a few questions such as:

“How many of you have never had a student?” “Only one student?” “More than three students?” etc. “How many PTs in the audience?” “PTAs?” “Other health professionals?” “Are there any center coordinators of clinical education (CCCEs) in the audience?” A general comment about the demographics of the group can wrap up this piece.

The intent of the section is to establish the parallels between who the audience is already and the characteristics/traits that have been identified as
A. Clinical Education in Physical Therapy Education

Voluntary Partnership

Instructor's Note: It is important at this point to establish the relationship between the academic program and the clinical site. Your audience should understand that this is a collaborative relationship and that both parties should benefit from this partnership. It may be helpful to ask the audience how each “partner” benefits from this relationship and also what responsibilities each has to the other.

The voluntary partnership between an academic program and the clinical site is contractual and includes:

- CI development and training,
- consistent and effective communication,
- knowledge about clinical education objectives,
- strategies for alternative models for the delivery of clinical education, and
- assessment of congruence between clinical facilities and the curriculum.
B. “Players” in Clinical Education

Instructor’s Note: It is critical that participants understand each person involved in the clinical experience. It may be helpful for you to discuss the various roles and responsibilities of each person so that groundwork is laid for discussion as the course proceeds. **NOTE: the patient is at the center of clinical education.**

At this point, also, it is important to define the various levels of communication between members and the importance that this plays. Especially stress that the ACCE should be involved early in any situations of concern but that this person also can serve as a resource in CI development.
C. Roles and Responsibilities

Roles and Responsibilities

- Director of Clinical Education (DCE)/Academic Coordinator of Clinical Education (ACCE)
- Center Coordinator of Clinical Education (CCCE)
- Clinical Instructor (CI)
- Student

**Academic Coordinator/Director of Clinical Education (ACCE/DCE):** An individual who is responsible for managing and coordinating the clinical education program at the academic institution, including facilitating development of the clinical education site and clinical educators. This person is also responsible for coordinating student placements, communicating with clinical educators about the academic program and student performance, maintaining current information on clinical education sites, and assessing overall outcomes of the clinical education program.2,3 Unique faculty roles assumed by the ACCE/DCE beyond those of core faculty (teaching, service, and scholarship) include the development of student clinicians, development of clinical education faculty, development and assessment of the clinical education program, management and coordination, leadership and collaboration in building and strengthening partnerships between academic and clinical communities, advancing the vision of the profession, communication, and modeling professional behaviors.4 Development of student tools designed for those who interact with the ACCE/DCE to assess his or her performance are available for use.4,5

**Center Coordinator of Clinical Education (CCCE):** Individual(s) who administers, manages, and coordinates clinical instructor assignments and learning activities for students during their clinical education experiences. In addition, this person determines the readiness of persons to serve as clinical instructors for students, supervises experiences, communicates with the academic program regarding student performance, and provides essential information about the clinical education program to physical therapy programs. *This individual may or may not be a physical therapist.*2,3

**Clinical Instructor (CI):** An individual at the clinical education site, who directly instructs and supervises students during their clinical learning experiences. This individual is responsible for carrying out clinical learning experiences and assessing students’ performance in cognitive, psychomotor, and affective domains as related to entry-level clinical practice and academic and clinical performance expectations. (Synonyms: clinical teacher; clinical mentor; clinical tutor; clinical supervisor)2,3
Student: Student is a learning worker who participates in clinical education to practice what is learned in the classroom.  

D. Rights and Privileges of Partnership

Physical therapy programs offer CIs benefits or incentives for serving as CIs for their PT and PTA students. Benefits or incentives may include:

- Access to texts
- Opportunity to conduct clinical research
- Continuing education offerings and CEUs
- In-services provided by academic faculty
- Library access, where available
Rights and Privileges of Partnership*
(cont’d)

- Opportunity to serve on a Clinical Education Advisory Committee
- Opportunity to serve as a lab instructor or guest lecturer
- Reduced tuition for postprofessional degree program
- Recognition as an adjunct faculty appointment
- Access to website for clinical educators

*Benefits or incentives vary for each academic institution with whom you affiliate so check with the academic program to determine what may be offered to you as a CI.

We have now explored the voluntary partnership between the academic program and clinical site and the players involved in coordinating and managing the experience for the purpose of providing an effective learning experience for students. Now we need to ask the question, what makes an effective CI? Those of who have never had a student before may be asking yourselves or thinking...

- What am I supposed to look like?
- What am I supposed to do?
- What are my responsibilities and to whom?
- How am I supposed to behave or act?
- I took an education class in school, but don’t recall much of it or how it applied to the role of the CI.
- I am anxious because I am suddenly responsible for someone else’s education.

** Before you open your books, let’s just generate some ideas.

Think back to your clinical experiences. How many of you had great CIs? Why were they so good? What did your CI do or how did your CI act that made him/her such a powerful influence on you? What characteristics did they possess that would be labeled as positive attributes? (Large group task—verbal responses from audience).

Now take a look at page 5 of your CI Manual at the affective characteristics of physical therapists identified by Hess (Affective Characteristics of Physical Therapists). The similarities are clear.
E. Characteristics of Clinicians and CIs

1. Characteristics of Effective Physical Therapists

Affective Characteristics of Physical Therapists

- Enjoys work/positive attitude
- Flexible
- Open
- Caring
- Well-disciplined
- Confident
- Has a sense of humor
- Friendly
- Open to ideas
2. Clinical Instructor Behaviors

Clinical Instructor Behaviors (Emery)

- Communication
- Interpersonal
- Professional skills
- Teaching skills

You can clearly see the parallel relationship between those characteristics you identified as being critical in a clinical instructor and those traits that many of you already possess by virtue of being a clinician. Who you are as a physical therapist, physical therapist assistant, or other health professional orients you for your role as a CI.

- In 1984, Dr. Emery, also examined CI behaviors in more detail.
- He looked at behaviors in four categories:
  - Communication – included in this category were such things as ability to share information, provide feedback, listen actively, and encourage dialogue.
  - Interpersonal relations – establishes a comfortable environment, empathetic, supportive of student
  - Professional skills – practices competently, systematic in problem solving
  - And lastly, teaching skills – allows student progressive independence, provides constructive criticism
- Of those 4 categories, which do you think students rated as most important?
  - Right! Communication and interpersonal skills were rated the highest.
  - Professional skills and teaching skills are less important in the overall feeling of the experience.
Dr. Emery’s result point once again to the importance of communication and interpersonal skills, the “people skills” as opposed to the “technical skills” in the role of the CI.

- The assessment in full is included in your manual on pages 6 and 7.
- It is designed as a self-assessment but some clinics find it really useful to have students rate you at the completion of the experience.

What we know is …
- A good CI is the key to a successful experience.
- You can have a great CI in a less-than-desirable setting and it can be a great experience. You are a role model of the highest order and students will walk like you and talk like you.
- You can also have a less-invested CI in a very high tech, state-of-the-art setting, etc and it can be an awful experience.

We also know that...
- Some of us are natural teachers. Some people just innately know what’s needed to move a student from point A to Point B; they know exactly what’s needed to ensure that the student grasps the concept or skill.
- Others of us need to work (hard) at it and must, at least initially, consciously apply principles of teaching and learning until it becomes innate. CCCEs need to support these individuals to help them develop professionally.

We also know, from experience, that
- Not every good clinician is interested in being a good CI. CCCEs need to support these individuals also and try to instill in them a joy of teaching or consider not giving them primary responsibility for a student.
Activity 1
Clinical Instructor Behaviors Self-Assessment
### Activity 1
**Clinical Instructor Behaviors**

#### Self-Assessment

<table>
<thead>
<tr>
<th>Communication Behaviors</th>
<th>1=low</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Make himself/herself understood</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Provides useful feedback</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Is an active listener</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Provides positive feedback on performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Communicates in a non-threatening manner</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Openly and honestly reveals perceptions that the clinical instructor has of the student</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Provides timely feedback</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Is open in discussing issues with the student</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Teaches in an interactive way; encourages dialogue</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Provides feedback in private</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Interpersonal Relations Behaviors

| 1. Establishes an environment in which the student feels comfortable | 1 | 2 | 3 | 4 | 5 |
| 2. Provides appropriate support for student concerns, frustrations, anxieties | 1 | 2 | 3 | 4 | 5 |
| 3. Is empathetic | 1 | 2 | 3 | 4 | 5 |
| 4. Demonstrates a genuine concern for patients | 1 | 2 | 3 | 4 | 5 |
| 5. Presents student as a professional to others | 1 | 2 | 3 | 4 | 5 |
| 6. Demonstrates positive regard for student as a person | 1 | 2 | 3 | 4 | 5 |

#### Professional Skills Behaviors

| 1. Employs physical therapy practice with competence | 1 | 2 | 3 | 4 | 5 |
| 2. Demonstrates professional behavior as a member of the health care team | 1 | 2 | 3 | 4 | 5 |
| 3. Demonstrates a systematic approach to problem solving | 1 | 2 | 3 | 4 | 5 |
| 4. Explains the basis for interventions based on evidence | 1 | 2 | 3 | 4 | 5 |
| 5. Explains physiological basis of physical therapy examination | 1 | 2 | 3 | 4 | 5 |
| 6. Demonstrates appropriate role of physical therapy as part of health care | 1 | 2 | 3 | 4 | 5 |
| 7. Serves as an appropriate role model | 1 | 2 | 3 | 4 | 5 |
| 8. Manages own time well | 1 | 2 | 3 | 4 | 5 |
| 9. Demonstrates leadership among peers | 1 | 2 | 3 | 4 | 5 |

#### Teaching Behaviors

| 1. Provides the student with progressive learning opportunities and situations | 1 | 2 | 3 | 4 | 5 |
| 2. Is available to the student | 1 | 2 | 3 | 4 | 5 |
| 3. Makes the formal evaluation a constructive process | 1 | 2 | 3 | 4 | 5 |
| 4. Makes effective learning experiences out of situations as they arise (teachable moments) | 1 | 2 | 3 | 4 | 5 |
| 5. Plans effective learning experiences | 1 | 2 | 3 | 4 | 5 |
| 6. Provides a variety of patients | 1 | 2 | 3 | 4 | 5 |
| 7. Questions/coaches in a way to facilitate student learning | 1 | 2 | 3 | 4 | 5 |
| 8. Points out discrepancies in student’s performance | 1 | 2 | 3 | 4 | 5 |
| 9. Provides unique learning experiences | 1 | 2 | 3 | 4 | 5 |
| 10. Draws a relationship between academic knowledge and clinical practice | 1 | 2 | 3 | 4 | 5 |
Activity 1 (cont’d)
Clinical Instructor Behaviors
Self-Assessment

<table>
<thead>
<tr>
<th>Teaching Behaviors (continued)</th>
<th>1=low</th>
<th>3=moderate</th>
<th>5=high</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Is accurate and objective in documenting student performance evaluation</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Assists the student to define specific objectives for the clinical education experience</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Observes performance in a discrete manner</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Schedules regular meetings with the student</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Plans learning experiences before the student arrives</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Manages the student’s time constructively</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Is timely in documenting the student’s performance</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Is perceived as a consistent extension of the academic program</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Additional CI Characteristics Supportive to Student Learning

Additional CI Characteristics Supportive to Student Learning

a. Care
b. Respect
c. Empathy
d. Providing clear expectations
e. Being approachable
f. Allowing room for the student to make mistakes
Instructor’s note: The characteristics of effective CI’s (paralleled to the PT) have been established. But there are other factors that influence the outcome of a clinical experience. At this point, we begin to examine some of the other issues that affect whether a clinical experience is perceived as positive or negative: namely, how the student is treated, the mood of the department/facility, and involving students in political issues/personnel issues within the facility.

Recent literature regarding characteristics of CIs can be found, including several articles comparing credentialed and non-credentialed CIs. For more information refer to:


**SO WE KNOW THAT YOUR AFFECTIVE CHARACTERISTICS WILL SERVE YOU WELL AS A CI.**

- What other factors go into making a good clinical experience?
- Think back to your clinical experiences. Over and above what your CI contributed, what made them effective learning experiences?
- Take a few minutes and jot down a few ideas in the boxes for Activity 2A and 2B on pages 6 and 7.
Activity 2A
Examples of Learning Experiences

Briefly describe an example of an **ineffective** clinical learning experience.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

next page/next slide
Activity 2B
Examples of Learning Experiences

Briefly describe an example of an **effective** clinical learning experience.
Instructor’s note: Ask for ideas in each category. This activity is a setup for examining the “Absolutely Essential Factors” identified by Moore and Perry.

It’s useful to comment on “negatives” and try to give an example of how it could have been different. EX: “My CI always introduced me to other professionals by saying, ‘Oh, this is my student from PT University.’”

Something as simple as calling a student by his/her name can make such a difference in how that student feels about himself/herself; makes it clear that you see the student as an individual and not lumped into the generic “student” category.

**POTENTIAL POSITIVE RESPONSES MAY INCLUDE:**
- Welcoming environment
- Taking time for me as a student
- Letting me try my wings
- Positive feedback
- Feeling part of the department

**NEGATIVES MAY INCLUDE:**
- Political issues within the facility
- Grilling students with low-level questioning
- Feeling that students are in the way... a burden
- Introducing the student as “student” instead of by name
1. Absolutely Essential Factors

Listed below are a number of factors that were named as “absolutely essential” by at least 50% of the respondents to a survey conducted by Moore and Perry. The respondents included new graduates, CIs, CCCEs, and academic coordinators of clinical education (ACCEs).

*=factor that was essential for beginning students  
#= factor that was essential for advanced students

a. Opportunity for students to practice patient care *#

b. Atmosphere receptive to students *#

c. Staff interested in teaching students*#

d. Sufficient feedback on performance *#

e. Students with a purpose *#

f. Assignment sufficiently long to accomplish objectives *#

g. Students who are well prepared *#

Absolutely Essential Factors
(Moore & Perry)

Factors essentials for beginning students
• Opportunity for students to practice patient care
• Atmosphere receptive to students
• Staff interested in teaching students
• Sufficient feedback on performance
• Students with a purpose
• Sufficient time to accomplish objectives
• Well-prepared students
You can see by looking at this list that what the beginning student thinks is important is somewhat different from what the advanced student thinks is important. This has implications for the clinical experience, what you plan for them, and how you structure the experience.

**Beginning student**

- **Hands-on experience:** These early students want the opportunity to do goniometry on someone with real limitations; to use manual muscle testing on someone with a real weakness. They have mostly just practiced on their normal lab partners.

This may also be a cue to CIs and CCCEs to reserve those other opportunities/observations such as surgery, observation with occupational therapist, speech therapist, etc for more advanced students, or at the very least until you’re sure this student is on the right track.

- **Receptive atmosphere:** introduced by name, instead of “student”; staff who are glad the student is there; not feeling like a burden
- **Feedback:** Students need to know how they are doing; speaks to importance of building in time for commentary. With early clinical experiences, frequency is important. They can’t wait until the end of the week … too much is happening to them. They need the immediacy of feedback, at least early on. Students will often be more than willing to come in early or stay late to receive this information from you.
- **NOTE:** Students who are on their last clinical experience often need increased frequency of feedback early in the experience. Keep in mind that his might be their last clinical experience, but it may be the first time in this kind of setting.

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**Additional Essential Factors**

*(Moore & Perry)*

Factors essential for advanced students

- Patient variety
- Talented staff
- Variety of educational experiences
- Opportunity to explore own objectives
1. Absolutely Essential Factors\(^{10}\) (cont’d)

h. Patient variety #

i. Talented staff #

j. Variety of educational experiences #

k. Opportunity for students to explore own objectives #

**Advanced student**

- **More patient variety:** Sometimes learners need to be reminded of the variety that they are seeing. (“Lots of fractured hips.” Need to point out that in fact one patient is an older woman with a long standing cerebrovascular condition; another patient has diabetes and a heart condition. All are different in their own way.)

- **Alternative experiences:** This is where it is important to build in the other observations. Advanced students can appreciate it more; they have a solid grasp of the fundamentals.

- **Feedback:** More experienced students may be able to wait until the end of the week, but they definitely need to know that they will have the time with you. Even if they are students completing their final clinical experience, this may be the first time they are in a practice setting like yours, dealing with the specific patient population. In that respect, they may need just as much, and just as frequent, feedback as a beginning student.

- **Talented staff:** Typically, the more advanced student has a greater appreciation of highly experienced staff, master clinicians, or clinical specialists. This may be truer of second-career students, who may be much more focused in their interests.

**Instructor’s note:** Having identified what’s important for a good quality clinical experience, we can recap by posing some general questions CIs and CCCEs might ask themselves about what they can provide to and for students. This is a precursor to Section 3 which will address more specifically what CIs and CCCEs have to offer from the perspective of their facility as a whole and also from their departmental level.
As a new CI it is important to have some of these issues.

- What are your resources?
- What kinds of patient variety can this clinical site typically offer?
- What kinds of alternative learning experiences can we provide?
- What’s available to me in the facility as a whole?
- What’s available to me within my own department?
- Is the staff supportive of CIs who have students? Do they understand if you need to build in time to talk, and not pick up that extra patient?
- Is there other staff willing to share their expertise with “my” student?

We’ve talked about how your characteristics as a clinician are going to serve you well as a CI. But the parallels in the roles of clinician and CI actually go much farther.

Take a look at page 9 in your workbook where the parallels are outlined for you. Would you agree that the list on the left-hand side is a fair assessment of what you do as a clinician?

The steps on the right-hand side are very much the same. We’re actually not teaching you very much that is new...we’re just asking you to apply what you already know to a different population.

The hope is that after we’ve completed this section, you’ll recognize that the process of clinical education/clinical instruction is one that you use everyday with patients.

Let’s look briefly at these steps.
F. Parallels in the Roles

Developing skill as a CI includes being aware of the parallels that exist between your role as a clinician and your role as a clinical educator.

### Clinician vs Clinical Instructor

#### Parallels in the Roles

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Clinical Instructor</th>
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</thead>
<tbody>
<tr>
<td>Referral/history</td>
<td>Preplanning</td>
</tr>
<tr>
<td>Initial examination, evaluation, diagnosis, and problem identification</td>
<td>Student assessment/problem identification</td>
</tr>
<tr>
<td>Long-term goals</td>
<td>Overall objectives</td>
</tr>
<tr>
<td>Short-term goals</td>
<td>Behavioral objectives</td>
</tr>
<tr>
<td>Plan of care</td>
<td>Learning experiences</td>
</tr>
<tr>
<td>Reexamination/progression of care and interventions</td>
<td>Formative evaluation/modification of performance with feedback</td>
</tr>
<tr>
<td>Outcome assessment/discharge</td>
<td>Summative evaluation</td>
</tr>
</tbody>
</table>

Unconditional positive regard

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Instructor’s note: The preplanning section of the “parallels” is important in making participants realize that they really have considerable information to work with, and therefore to make some assumptions about, before the student arrives on day 1. The need to preplan should be stressed...effective learning is planned, and it’s always easier to modify an existing plan than to have to develop one on the spot. Begin by having participants generate a list of things they know before the student arrives and fill in as necessary.
Preplanning:

Do you have information about the student before he/she arrives? What kind of information?

- which academic institution and what are its expectations for student performance
- the evaluation tool/instrument being used
- academic preparation—level of student
- student self-assessment
- student's previous clinical experiences (type and location)
- student goals for the experience
- student biographical information
- student pre-test to assess knowledge required relative to your specific clinical setting

Do you have information about your resources?

What do you do with all this information?

- All of it helps you to make some basic assumptions about this student and the student's level...before he/she even arrives. You may have to alter your assumptions later, but you can still make some basic plans for this student's experience with you.
- If he/she is a first-level student, you know you should build in lots of time for discussion, especially early on. Experienced students can be a bit more flexible usually.
- You may know that school A is typically strong in musculoskeletal preparation--a check of these areas, and perhaps you can move on to higher-level skills earlier than expected.
- Perhaps students from school B are typically weaker than you would like in neurological examinations...so you know that you will need to front-load the experience with extra teaching time to get the student up to speed.

By the way: if you've not had a student before, your CCCE or another experienced CI is a great resource for you in helping to identify trends in student preparation, etc.

All of this information can be used to preplan the clinical experience. You will always need to make modifications somewhere along the line, but this gives you a very definite advantage.

CAVEAT: Keep in mind that while this may be the student's final clinical experience, it may be his/her first experience in your type of setting. We have to be willing to adjust our assumptions based on student's previous experience/exposure. The student may never have done a definitive Manual Muscle Test (MMT) (especially lately with the emphasis on function). Now the student's with you in a rehabilitation setting and definitive MMTs are important. The student will probably need help or assistance along the way. THIS SHOULD NOT BE PERCEIVED AS A WEAKNESS OR GRADED AS A DEFICIENCY.

Maybe the student has never been in an acute care setting and does not know an A line from a catheter. BUT the expectation is that his/her process skills will generalize. Content may take a while to catch up.
Overall Objectives:

Discuss goals for the clinical experience (overall goals):

In clinical education, this usually occurs before we've completed our student assessment.

Usually, one of the first things we do with students, after orienting them to the facility, is to sit down and talk about our goals for the clinical experience.

This should include a discussion of the student's goals for the experience.

- Are they realistic given our resources; our time frame
- Are they realistic for the student's level of knowledge and skill

Discussion should also include your goals.

- Where do you expect the typical student to be at the end of the clinical experience?
- What should the student be able to do?

Attention also needs to be paid to the academic institution's goals for a student at this level in your type of setting.

Together, you should arrive at a set of mutually acceptable goals for the experience. These goals are long-term goals or overall objectives for the experience, what the student should be able to perform, and what the student should know at the end of the clinical experience.

Having completed this, the next step is to determine where the student is now... from what baseline are you starting. Knowing both of these things will assist you in breaking the experience down into behavioral objectives or short-term goals.
Student Assessment/Problem Identification:

What do we do when the student arrives?
- Begin checking our assumptions; those that we established during the preplanning stage.
- Get to know the student.
- Ask the student questions...testing out his/her level of knowledge.
  Does the student's level of knowledge fit with our expectations?
- Have him/her shadow us, gradually having the student take over parts of treatment/interventions, examinations, etc.
- Observe the student performing a variety of skills/techniques.

During this time what are we really doing? We're gathering data.
- Can the student do what he/she says they can do? Is he/she as skilled as I expected?
- Was his/her self-assessment accurate?
- How are the student's hands? Is he/she clumsy and awkward?
- Does the student demonstrate an ability to plan ahead?
- Does the student think on his/her feet?
- If you ask a question and get a blank stare, it tells you one thing.
- If you can engage the student in discussion or if he/she initiates discussion it tells you something quite different.

Does he/she ask questions? What kind?
- Low-level questions such as "What do I do now?" or
- Higher-level questions that indicate that the student is processing some of the information and thinking for himself/herself such as "This is what I've been thinking about doing with Mr. Jones. What do you think?"

Is the student invested in the process of education...appear eager to learn?
Or do you have to encourage him/her to participate and get involved?

Observe the student doing things he/she says he/she has experience in. Is his/her self-assessment accurate?

THIS STEP OF ASSESSMENT ALLOWS YOU TO DO A PRELIMINARY IDENTIFICATION OF PROBLEM AREAS AS WELL AS IDENTIFY AREAS OF STRENGTH.

NOTE: We tend to do well identifying areas that need remediation. But we must not forget to continually challenge those who excel or exceed minimal competency. This can be equally difficult to address.
Behavioral Objectives:

So we know where we want to be, what we want the student to be able to do at the end of the clinical experience (overall goals).

And now we have a better understanding of where the student is beginning...what his/her present level is as a result of the assessment process.

How are we going to go from where we are now...to where we want to be? Think back to how you plan a program for a patient? How do you take a patient from initial examination to discharge? You establish short-term goals, correct? Well, we’re going to do the same thing with students.

We’re going to establish a road map of sorts, and I recommend that you do this weekly, just like the short-term goals that you write for patients. We call these behavioral objectives.

Behavioral objectives provide a stepwise progression, a logical sequencing of how to achieve our overall goals. Establish short-term goals and review and modify as necessary on a weekly basis during your meeting with the student.

We’re going to come back to behavioral objectives and talk about them in some detail later. But let's first finish talking about the parallels.

Planning Learning Experiences:
This is analogous to planning a treatment/intervention program.

Ask yourself:
- What knowledge do they need to achieve this objective?
- Do they have this knowledge or do I need to plan an activity to help them get it?
- What skills do they need? Can they do it now...or do I have to teach them?
- What is a logical way to present this information?
- What is my role going to be vis-à-vis supervision, feedback, manager of instruction, etc?

ALL OF THESE THINGS WILL BE DISCUSSED IN MORE DEPTH LATER.
Unconditional Positive Regard

- Respect
- Objectivity
- Separate values from performance
- Communication

Instructor's note: The section on unconditional positive regard is included to emphasize the expectation that regardless of personal feelings toward a student, the CI will remain committed to being objective and to doing the best job that he/she knows how to do for that student. It's interesting, but frequently no one has ever told the CI that it's OK not to like the student.

Unconditional Positive Regard:
Do you like all of your patients? Not likely that you will. What if you don't? Do you do less than your best for that patient? Do you run to your supervisor and demand that this patient be transferred to another therapist? No, because you have a professional commitment to provide the best physical therapy service that you can for your patients, regardless of race, creed, color, gender, age, national or ethnic origin, sexual orientation, or disability or health status.

Guess what? You're not likely to like all of your students either. Your student may not be someone that you would ever choose as a friend. Maybe the student's value system is completely different from yours. Maybe his/her style is the complete antithesis of yours. But, by agreeing to supervise a student, you have made a professional commitment, just like you do with your patients, to provide the best clinical experience you can for that student.

Unconditional Positive Regard:
This is the expectation that you will not let your personal feelings about the student cloud your objectivity when assessing him/her. It is a matter of respecting people for who they are, whether or not you agree or even like them personally.

Ask yourself, is the way the student did something really an issue or is it just another way of performing the same thing. It is of critical importance to be able to separate differences in values from the ability or inability to perform clinically.
Instructor’s note: With respect to Professionalism, APTA has defined a set of 7 core values that comprehensively describe what is meant by professionalism. Professionalism has often been used synonymously with professional behaviors and the Code of Ethics; however it has come to mean something far more broad and comprehensive to include not only professional behaviors but ethical decision making, self-image and identity, professional esteem, etc. Below are the core values with their definitions and indicators that would be seen if the individual demonstrated these core values in clinical practice. You may want to have a brief discussion regarding these core values and how they may relate to clinical education, clinical teaching, and modeling by the clinical instructor.

**Professionalism in Physical Therapy: PT Core Values**

1. Accountability
2. Altruism
3. Compassion/Caring
4. Excellence
5. Integrity
6. Professional Duty
7. Social Responsibility
G. Role Modeling and Mentoring Professionalism in Physical Therapy

1. Core Values for the Physical Therapist

For each core value listed, a definition is provided with sample indicators (not exhaustive) that describe what one would see if the physical therapist were demonstrating that core value in his/her daily practice.

<table>
<thead>
<tr>
<th>Core Values</th>
<th>Definition</th>
<th>Sample Indicators</th>
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</table>
| Accountability| Accountability is active acceptance of the responsibility for the diverse roles, obligations, and actions of the physical therapist including self-regulation and other behaviors that positively influence patient/client outcomes, the profession and the health needs of society. | 1. Responding to patient's/client's goals and needs.  
2. Seeking and responding to feedback from multiple sources.  
3. Acknowledging and accepting consequences of his/her actions.  
4. Assuming responsibility for learning and change.  
5. Adhering to code of ethics, standards of practice, and policies/procedures that govern the conduct of professional activities.  
6. Communicating accurately to others (payers, patients/clients, other health care providers) about professional actions.  
7. Participating in the achievement of health goals of patients/clients and society.  
8. Seeking continuous improvement in quality of care.  
9. Maintaining membership in APTA and other organizations.  
10. Educating students in a manner that facilitates the pursuit of learning. |
| Altruism      | Altruism is the primary regard for or devotion to the interest of patients/clients, thus assuming the fiduciary responsibility of placing the needs of the patient/client ahead of the physical therapist's self interest. | 1. Placing patient's/client's needs above the physical therapists.  
2. Providing pro-bono services.  
3. Providing physical therapy services to underserved and underrepresented populations.  
4. Providing patient/client services that go beyond expected standards of practice.  
5. Completing patient/client care and professional responsibility prior to personal needs. |
| Compassion/Caring | Compassion is the desire to identify with or sense something of another’s experience; a precursor of caring.  
Caring is the concern, empathy, and consideration for the needs and values of others.                                                                 | 1. Understanding the socio-cultural, psychological and economic influences on the individual's life in their environment.  
2. Understanding an individual’s perspective.  
3. Being an advocate for patient’s/client’s needs.  
4. Communicating effectively, both verbally and non-verbally, with others taking into consideration individual differences in learning styles, language, and cognitive abilities, etc  
5. Designing patient/client programs/interventions that are congruent with patient/client needs.  
6. Empowering patients/clients to achieve the highest level of function possible and to exercise self-determination in their care.  
7. Focusing on achieving the greatest well-being and the |
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<tr>
<th>Core Values</th>
<th>Definition</th>
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<td>highest potential for a patient/client.</td>
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<td>8. Recognizing and refraining from acting on one’s social, cultural, gender, and sexual biases.</td>
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<td>10. Attending to the patient’s/client’s personal needs and comforts.</td>
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<td>11. Demonstrating respect for others and considers others as unique and of value.</td>
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<td>Excellence</td>
<td>Excellence is physical therapy practice that consistently uses current knowledge and theory while understanding personal limits, integrates judgment and the patient/client perspective, embraces advancement, challenges mediocrity, and works toward development of new knowledge.</td>
<td>1. Demonstrating investment in the profession of physical therapy.</td>
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<td>2. Internalizing the importance of using multiple sources of evidence to support professional practice and decisions.</td>
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<td>3. Participating in integrative and collaborative practice to promote high quality health and educational outcomes.</td>
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<td>4. Conveying intellectual humility in professional and interpersonal situations.</td>
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<td>5. Demonstrating high levels of knowledge and skill in all aspects of the profession.</td>
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<td>6. Using evidence consistently to support professional decisions.</td>
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<td>7. Demonstrating a tolerance for ambiguity.</td>
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<td>8. Pursuing new evidence to expand knowledge.</td>
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<td>9. Engaging in acquisition of new knowledge throughout one’s professional career.</td>
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<td>10. Sharing one’s knowledge with others.</td>
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<td>11. Contributing to the development and shaping of excellence in all professional roles.</td>
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<tr>
<td>Integrity</td>
<td>Steadfast adherence to high ethical principles or professional standards; truthfulness, fairness, doing what you say you will do, and “speaking forth” about why you do what you do.</td>
<td>1. Abiding by the rules, regulations, and laws applicable to the profession.</td>
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<td>2. Adhering to the highest standards of the profession (practice, ethics, reimbursement, Institutional Review Board [IRB], honor code, etc).</td>
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<td>3. Articulating and internalizing stated ideals and professional values.</td>
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<td>4. Using power (including avoidance of use of unearned privilege) judiciously.</td>
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<td>5. Resolving dilemmas with respect to a consistent set of core values.</td>
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<td>7. Taking responsibility to be an integral part in the continuing management of patients/clients.</td>
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<td>8. Knowing one’s limitations and acting accordingly.</td>
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<td>9. Confronting harassment and bias among ourselves and others.</td>
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<td>10. Recognizing the limits of one’s expertise and making referrals appropriately.</td>
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<td>11. Choosing employment situations that are congruent with practice values and professional ethical standards.</td>
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<td>12. Acting on the basis of professional values even when the results of the behavior may place oneself at risk.</td>
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<tr>
<td>Core Values</td>
<td>Definition</td>
<td>Sample Indicators</td>
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</tbody>
</table>
| Professional Duty   | Professional duty is the commitment to meeting one’s obligations to provide effective physical therapy services to individual patients/clients, to serve the profession, and to positively influence the health of society. | 1. Demonstrating beneficence by providing “optimal care”.  
2. Facilitating each individual’s achievement of goals for function, health, and wellness.  
3. Preserving the safety, security and confidentiality of individuals in all professional contexts.  
4. Involved in professional activities beyond the practice setting.  
5. Promoting the profession of physical therapy.  
6. Mentoring others to realize their potential.  
7. Taking pride in one’s profession. |
| Social Responsibility| Social responsibility is the promotion of a mutual trust between the profession and the larger public that necessitates responding to societal needs for health and wellness. | 1. Advocating for the health and wellness needs of society including access to health care and physical therapy services.  
2. Promoting cultural competence within the profession and the larger public.  
3. Promoting social policy that effect function, health, and wellness needs of patients/clients.  
4. Ensuring that existing social policy is in the best interest of the patient/client.  
5. Advocating for changes in laws, regulations, standards, and guidelines that affect physical therapist service provision.  
6. Promoting community volunteerism.  
7. Participating in political activism.  
8. Participating in achievement of societal health goals.  
9. Understanding of current community wide, nationwide and worldwide issues and how they impact society’s health and well-being and the delivery of physical therapy.  
10. Providing leadership in the community.  
11. Participating in collaborative relationships with other health practitioners and the public at large.  
12. Ensuring the blending of social justice and economic efficiency of services. |

2. Value-based Behaviors for the Physical Therapist Assistant
For each values-based behavior listed, a definition is provided with sample indicators (not exhaustive) that describe what one would see if the physical therapist assistant were demonstrating that values-based behavior in his or her daily work.  
([http://www.apta.org/uploadedFiles/APTAorg/PTAs/Careers/Values/ValuesBasedBehaviorsforPTA.pdf](http://www.apta.org/uploadedFiles/APTAorg/PTAs/Careers/Values/ValuesBasedBehaviorsforPTA.pdf))

<table>
<thead>
<tr>
<th>Values-Based Behavior With Definition</th>
<th>Sample Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Altruism</strong></td>
<td></td>
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</tbody>
</table>
| Altruism is the primary regard for or devotion to the interests of the patient/client, assuming responsibility of placing the needs of the patient/client ahead of the PTA’s self interest. | 1. Providing patient/client-centered interventions.  
2. Readily offering to assist the physical therapist in providing patient/client interventions.  
3. Generously providing the necessary time and effort to meet patient/client needs.  
4. Placing the patient/client’s needs ahead of one’s own, as evidenced by willingness to alter one’s schedule, delay other projects or tasks, etc.  
5. Contributing, as able, to the provision of physical therapy services to underserved and underrepresented populations. |
| **Caring and Compassion**             |                   |
| Compassion is the desire to identify with or sense something of another’s experience; a precursor of caring. Caring is the concern, empathy, and consideration for the needs and values of others. | 1. Actively listening to the patient/client and considering the patient/client’s needs and preferences.  
2. Exhibiting compassion, caring, and empathy in providing services to patients/clients.  
3. Demonstrating respect for others and considering others as unique and of value.  
4. Considering social, emotional, cultural, psychological, environmental, and economic influences on the patient/client (eg, learning styles, language abilities, cognitive abilities) and adapting approach accordingly.  
5. Recognizing and refraining from acting on one’s social, cultural, gender, and sexual biases; ie, demonstrates a nonjudgmental attitude. |
| **Continuing Competence**             |                   |
| Continuing competence is the lifelong process of maintaining and documenting competence through ongoing self-assessment, development, and implementation of a personal learning plan, and subsequent reassessment. | 1. Identifying strengths and limitations in knowledge, skills, and behaviors through self-assessment and feedback from physical therapists and others, and developing and implementing strategies to address the limitations.  
2. Maintaining continuing competence using a variety of lifelong learning strategies (eg, continuing education, reflective journals, journal clubs, working with a mentor).  
3. Seeking further education in the use and delivery of interventions based on new evidence as it becomes available.  
4. Developing and implementing a career advancement plan based on interests, opportunities, and career aspirations. |
**Duty**

Duty is the commitment to meeting one’s obligations to provide effective physical therapy services to individual patients/clients, to serve the profession, and to positively influence the health of society.

1. Demonstrating behaviors, conduct, actions, attitudes, and values consistent with the roles, responsibilities, and tasks of the PTA.
2. Facilitating each patient/client’s achievement of goals for function, health, and wellness, as directed in the plan of care.
3. Preserving the safety, security, and confidentiality of individuals in all patient/client contexts.
4. Participating in quality assurance/quality improvement activities in physical therapy care.
5. Promoting the profession of physical therapy.
6. Providing student instruction and mentoring other PTAs.

**Integrity**

Integrity is the steadfast adherence to high ethical principles or standards; truthfulness, fairness, doing what you say you will do, and “speaking forth” about why you do what you do.

1. Adhering to applicable laws regarding scope of work, payment policies and guidelines, institutional policies and procedures, and APTA policies, positions, and guidelines to ensure optimal patient/client care and fiscal management.
2. Adhering to the highest standards of the profession for the PTA, including the Standards of Ethical Conduct for the Physical Therapist Assistant, Guide for Conduct of the Physical Therapist Assistant, state practice acts, and payment requirements.
3. Demonstrating the ideals of the values-based behaviors of the PTA.
4. Demonstrating honesty and trustworthiness in all interactions and relationships.
5. Choosing employment situations that are congruent with ethical principles and work standards.
6. Identifying ethical and legal concerns and initiating actions to address the concern, when appropriate.

**PT/PTA Collaboration**

The PT/PTA team works together, within each partner’s respective role, to achieve optimal patient/client care and to enhance the overall delivery of physical therapy services.

1. Educating the PT as needed about the roles, responsibilities, and appropriate utilization of the PTA in the PT/PTA team using available resources (e.g., state licensure/practice rules and regulations, PTA clinical problem-solving algorithm, PTA direction and supervision algorithms, Minimum Required Skills of Physical Therapist Assistant Graduates at Entry-Level).
2. Promoting a positive working relationship within the PT/PTA team.
3. Demonstrating respect for the roles and contributions of both the PT and PTA in achieving optimal patient/client care, including the PT’s responsibility for the PTA’s performance in patient/client interventions.
4. Seeking out opportunities to collaborate with the PT to improve outcomes in patient/client care.
5. Working with the PT in educating consumers and other health care providers about physical therapy.
### Responsibility

Responsibility is the active acceptance of the roles, obligations, and actions of the PTA, including behaviors that positively influence patient/client outcomes, the profession, and the health needs of society.

1. Identifying strengths and limitations in knowledge and skill, and working within limitations of personal ability.
2. Completing patient/client care and other tasks in a timely and efficient manner.
3. Identifying, acknowledging, and accepting responsibility for actions and, when errors occur, following error reporting processes.
4. Communicating in a timely manner with others (eg, PTs, patients/clients, and others).

### Social Responsibility

Social responsibility is the promotion of a mutual trust between the PTA, as a member of the profession, and the larger public that necessitates responding to societal needs for health and wellness.

1. Advocating for patient/client needs in the clinical setting.
2. Demonstrating behaviors that positively represent the profession to the public.
3. Promoting a healthy lifestyle, wellness, and injury prevention strategies in the community.
4. Serving the profession and the community, including activities occurring in conjunction with work or outside of work (eg, community health fairs, National Physical Therapy Month events, APTA service).
5. Advocating for changes in laws, regulations, standards, and guidelines that positively affect physical therapy and patient/client services.
3. **APTA position on Mentoring of Professionalism in Academic and Clinical Education (HOD 06-03-29-27)**

**Mentoring of Professionalism In Academic and Clinical Education (HOD 06-03-29-27)**

“It is the position of the APTA that:

It is the responsibility of all academic and clinical faculty, CIs, and professional mentors to actively promote to PT students the importance of professionalism as a critical component of a doctoring profession. Professionalism requires ongoing membership and active participation in the APTA and support of its policies, positions, guidelines, standards, and Code of Ethics. Academic and clinical faculty, CIs, and mentors of PTA students shall promote behaviors that are consistent with APTA’s policies, positions, guidelines, standards, and the Standards of Ethical Conduct for the PTA, and that support the importance of ongoing membership and active participation in the APTA.”

**Background**

The Student Assembly brought a motion of particular importance to academic programs and clinical educators, Mentoring of Professionalism in Academic and Clinical Education (RC 32-03), to the 2003 House of Delegates. RC32-03 was the handiwork of enthusiastic and passionate student leaders who felt a need to address the issue of professionalism. The motion was conceptualized and actively discussed by students participating at the October 2002 National Student Conclave. Subsequently, students discussed this issue with classmates at their respective academic programs, component leaders and members, and practitioners to assess whether their perspective had merit sufficient to raise this issue in the House. Members of the Student Assembly are passionate about professionalism based on their observations and interactions that primarily occur during their clinical education and academic experiences.

The intent of this position is to focus on the pivotal role of academic faculty and clinical educators and other professional mentors who, in helping students prepare for a career as a physical therapist (PT) or physical therapist assistant (PTA), routinely embody behaviors and values indicative of professionalism. Although the motion identifies active membership in the APTA as one of the indicators of professionalism, it is not the sole indicator. Upholding the ethical values, positions, policies, guidelines, and standards of the Association are also considered essential along with consistently demonstrating APTA’s core values. Following a supportive discussion by delegates, the motion passed by a clear majority and states the following on the next page.
NOTE: The intent of sharing this information with participants is to highlight the importance of the clinical educator as a role model of professional behavior in all professions. For participants who are not physical therapists or physical therapist assistants, you can emphasize the importance of all aspects of being a member of a profession: belonging to the professional association, knowing and following the professions’ Code of Ethics, and modeling and encouraging students to uphold the professions’ core values. This might be an opportunity to share these elements of professions in the course with participants who represent different professions.

MENTORING OF PROFESSIONALISM IN ACADEMIC AND CLINICAL EDUCATION (HOD 06-03-29-27)

“It is the position of the American Physical Therapy Association that:

It is the responsibility of all academic and clinical faculty, clinical instructors, and professional mentors to actively promote to physical therapist students the importance of professionalism as a critical component of a doctoring profession. Professionalism requires ongoing membership and active participation in the American Physical Therapy Association (APTA) and support of its policies, positions, guidelines, standards, and Code of Ethics. Academic and clinical faculty, clinical instructors, and mentors of physical therapist assistant students shall promote behaviors that are consistent with APTA’s policies, positions, guidelines, standards, and the Standards of Ethical Conduct for the Physical Therapist Assistant, and that support the importance of ongoing membership and active participation in the APTA.”

1. **Code of Ethics for the Physical Therapist** (HOD S06-09-07-12)
   Full text at: http://www.apta.org/Ethics/Core

2. **Ethics and Judicial Committee. APTA Guide for Professional Conduct**
   Full text at: http://www.apta.org/Ethics/Core

3. Ethics and Judicial Committee. APTA Guide for Conduct of the Physical Therapist Assistant
   Full text at: http://www.apta.org/Ethics/Core

   Full text at: http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/BOD/Practice/PrinciplesofProfessionalism.pdf
Instructor’s Note: Included in this manual are the detailed voluntary APTA Guidelines and Self-Assessments for Clinical Instructors only. The full version of this document, APTA Guidelines and Self-Assessments for Clinical Education, contains the specific guidelines and self-assessments for clinical education sites, clinical instructors, and center coordinators of clinical education. This document is available to members for free on-line at http://www.apta.org/Educators/Clinical/SiteDevelopment/ and for nonmembers a bound copy can be purchased through APTA’s Member Services (800)999-2782, ext 3395, Order Number E-48 for $7.00.

You may want to discuss Educator Resources also available through APTA. If you have internet access, you can show participants where to find on APTA website.

The Guidelines for Clinical Instructors are presented below in detail so the participant will have the documents as a key reference and as a working tool. Guidelines are divided into six key areas: (1) clinical competence and ethical and legal behavior, (2) communication skills, (3) interpersonal relationships, (4) instructional skills, (5) supervisory skills, and (6) performance evaluation skills. These 6 guidelines were used as a basis for the development of the original Clinical Instructor Education and Credentialing Program (1997).

F. APTA Guidelines for Clinical Instructors


1. Voluntary APTA Guidelines for Clinical Instructors

APTA Voluntary Guidelines For Clinical Instructors

a. The CI demonstrates clinical competence, and legal and ethical behavior that meets or exceeds the expectations of members of the profession of physical therapy.

b. The CI demonstrates effective communication skills.

c. The CI demonstrates effective behavior, conduct, and skill in interpersonal relationships.
d. The CI demonstrates effective instructional skills.

e. The CI demonstrates effective supervisory skills.

f. The CI demonstrates performance evaluation skills.
2. **APTA Self-Assessments for Clinical Instructors**

   a. The self-assessment tool, based on the Clinical Instructor Guidelines, allow the participant to self-assess his or her readiness and ongoing performance as a clinical instructor and mentor across the 6 areas.

   **Guidelines for Clinical Instructors (APTA)**

   2. Self-Assessment for Clinical Instructors

      a. Tool that provides the CI with a mechanism to assess his or her readiness and ongoing performance as a CI and mentor across the 6 competencies.

3. **Glossary of Terms**

   a. The glossary of terms is provided to ensure that participants are using language that is consistent throughout the profession.

APTA has valuable information to assist PTs and PTAs in their roles as clinical educators. These tools are to help you assess your readiness and skills as a clinical instructor or a center coordinator of clinical education and are provided to APTA members at no cost and to nonmembers for a cost. Please visit www.apta.org to access the Guidelines and Self-Assessments for Clinical Education and the Center Coordinators of Clinical Education Reference Manual.

*Reference Manual for Center Coordinators of Clinical Education*

Available to members: www.apta.org/Educators/ClinicalEducatorDevelopment/
Available to nonmembers: (E-61) from the APTA Bookstore: www.apta.org/store/

*Guidelines and Self-Assessments for Clinical Education*

Available to members: www.apta.org/Educators/Clinical/SiteDevelopment/
Available to nonmembers (E-48) from the APTA Bookstore: www.apta.org/store/
GUIDELINES AND SELF-ASSESSMENTS
for
CLINICAL EDUCATION

2004 Revision

Endorsed by APTA’s House of Delegates, June 13, 1993

Adopted by APTA’s Board of Directors, 1992, 1999, 2004
DIRECTIONS FOR USE

This resource document should be used to guide the development and enhancement of clinical education sites and to clarify the roles, responsibilities, and expectations of CIs and CCCEs. There are 17 guidelines for clinical education sites and 6 guidelines for CIs and for CCCEs. Below each guideline are statements that clarify the intent, scope, and meaning of the guideline. These guidelines should be used by practice facilities to help determine their readiness to become a clinical education site, and by clinicians to help determine their readiness to become a CI or CCCE.

Following each set of guidelines is a companion self-assessment tool. Response options on the self-assessment forms include yes, no, or developing boxes. The user should check only one box for each item. A yes response indicates that the assessor demonstrates the item, a no response indicates that the assessor has not demonstrated the item, and a developing response indicates that this is an item that is in progress and that the assessor is working toward a yes response. When either a no or developing box is checked, the Comments/Plan section should be completed by briefly describing the actions to be taken to demonstrate the item(s). It is plausible that in some situations a no response could be checked because a particular item may not be relevant for the specific practice setting. Self-assessments for clinical education sites, CCCEs, and CIs may be separated and used in conjunction with their respective set of guidelines. They are most effective, however, when used as a comprehensive document for evaluating the effectiveness of the clinical education site’s program and its clinical teachers.

To provide clarity, the terms academic program, clinical education site, and provider of physical therapy are used consistently throughout the documents. Academic program is used to describe that part of the curriculum that occurs at the academic institution of higher education. Clinical education site indicates the entire clinical facility. Provider of physical therapy indicates that part of the clinical education experience that is managed and delivered exclusively under the direction and supervision of the physical therapist with the ability to direct and supervise the physical therapist assistant in providing physical therapy interventions. An asterisk indicates that the word can be found in the glossary. Users of this document are strongly encouraged to refer to the glossary because some commonly used terms may now have different meanings or intent. In addition, the plural form of “students” is used throughout the document to encourage clinical education sites to provide clinical learning experiences to more than one student simultaneously, using alternative collaborative and cooperative approaches to student supervision where feasible.

Opportunities should be provided for CIs and CCCEs to discuss the guidelines and self-assessments to determine how they should be applied to their specific clinical setting and how they may be used to determine an individual’s readiness to become a CI or CCCE. In addition, academic programs should consider using information from the clinical educators’ completed self-assessments to help in the development of the clinical site and the clinical educators. Based on this information, academic programs can ensure high-quality clinical learning experiences for their students by providing in-service and continuing education programs that will enhance the overall clinical education site* and will help CIs and CCCEs keep up-to-date on current practice.
GUIDELINES FOR CLINICAL INSTRUCTORS

1.0 THE CLINICAL INSTRUCTOR (CI) DEMONSTRATES CLINICAL COMPETENCE, AND LEGAL AND ETHICAL BEHAVIOR THAT MEETS OR EXCEEDS THE EXPECTATIONS OF MEMBERS OF THE PROFESSION OF PHYSICAL THERAPY.

1.1 One year of clinical experience is preferred as minimal criteria for serving as the CI. Individuals should also be evaluated on their abilities to perform CI responsibilities.

   1.1.1 The CI demonstrates a desire to work with students by pursuing learning experiences to develop knowledge and skills in clinical teaching.

1.2 The CI is a competent physical therapist or physical therapist assistant.

   1.2.1 The CI demonstrates a systematic approach to patient/client care using the patient/client management model described in the Guide to Physical Therapist Practice.

   1.2.2 The CI uses critical thinking in the delivery of health services.

   1.2.3 Rationale and evidence is provided by:

      1.2.3.1 The physical therapist for examination, evaluation, diagnosis, prognosis, interventions, outcomes, and reexaminations.

      1.2.3.2 The physical therapist assistant for directed interventions, data collection associated with directed interventions, and outcomes.

   1.2.4 The CI demonstrates effective time-management skills.

   1.2.5 The CI demonstrates the core values (accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility) associated with professionalism in physical therapy.

1.3 The CI adheres to legal practice standards.

   1.3.1 The CI holds a valid license, registration, or certification as required by the state in which the individual provides physical therapy services.

   1.3.2 The CI provides physical therapy services that are consistent with the respective state/jurisdictional practice act and interpretive rules and regulations.

   1.3.3 The CI provides physical therapy services that are consistent with state and federal legislation, including, but not limited to, equal opportunity and affirmative action policies, HIPAA, Medicare regulations regarding reimbursement for patient/client care where students are involved, and the ADA.
1.3.3.1 The physical therapist is solely responsible for ensuring the patient/client is aware of the student status of any student involved in providing physical therapy services.

1.4 The CI demonstrates ethical behavior.

1.4.1 The CI provides physical therapy services ethically as outlined by the clinical education site policy and the APTA Code of Ethics, Standards of Ethical Conduct for the Physical Therapist Assistant, Guide for Professional Conduct, Guide for Conduct of the Affiliate Member, and Guide to Physical Therapist Practice.

2.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE COMMUNICATION SKILLS.

2.1 The CI uses verbal, nonverbal, and written communication skills and information technology to clearly express himself or herself to students and others.

2.1.1 The CI defines performance expectations for students.

2.1.2 The CI and student(s) collaborate to develop mutually agreed-on goals and objectives for the clinical education experience.

2.1.3 The CI provides feedback to students.

2.1.4 The CI demonstrates skill in active listening.

2.1.5 The CI provides clear and concise communication.

2.2 The CI is responsible for facilitating communication.

2.2.1 The CI encourages dialogue with students.

2.2.2 The CI provides time and a place for ongoing dialogue to occur.

2.2.3 The CI initiates communication that may be difficult or confrontational.

2.2.4 The CI is open to and encourages feedback from students, clinical educators, and other colleagues.

3.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE BEHAVIOR, CONDUCT, AND SKILL IN INTERPERSONAL RELATIONSHIPS.

3.1 The CI forms a collegial relationship with students.

3.1.1 The CI models behaviors and conduct, and instructional and supervisory skills that are expected of the physical therapist/physical therapist assistant and demonstrates an awareness of the impact of this role modeling on students.
3.1.2 The CI promotes the student as a colleague to others.

3.1.3 The CI demonstrates cultural competence with respect for and sensitivity to individual and cultural differences.

3.1.4 The CI is willing to share his or her strengths and weaknesses with students.

3.2 The CI is approachable by students.

3.2.1 The CI assesses and responds to student concerns with empathy, support, or interpretation, as appropriate.

3.3 The CI interacts with patients/clients, colleagues, and other health care providers to achieve identified goals.

3.4 The CI represents the physical therapy profession positively by assuming responsibility for career and self-development and demonstrates this responsibility to the students.

3.4.1 Activities for development may include, but are not limited to, continuing education courses, journal clubs, case conferences, case studies, literature review, facility sponsored courses, post-professional/entry-level education, area consortia programs, and active involvement in professional associations, including APTA.

4.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE INSTRUCTIONAL SKILLS.

4.1 The CI collaborates with students to plan learning experiences.

4.1.1 Based on a plan, the CI implements, facilitates, and evaluates learning experiences with students.

4.1.2 Learning experiences should include both patient/client interventions and patient/client practice management activities.

4.2 The CI demonstrates knowledge of the student's academic curriculum, level of didactic preparation, current level of performance, and the goals of the clinical education experience.

4.3 The CI recognizes and uses the entire clinical environment for potential learning experiences, both planned and unplanned.

4.4 The CI integrates knowledge of various learning styles to implement strategies that accommodate students’ needs.

4.5 The CI sequences learning experiences to promote progression of the students’ personal and educational goals.
4.5.1 The CI monitors and modifies learning experiences in a timely manner based on the quality of the student’s performance.

5.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE SUPERVISORY SKILLS.

5.1 The CI supervises the student in the clinical environment by clarifying goals, objectives, and expectations.

5.1.1 The CI presents clear performance expectations to students at the beginning and throughout the learning experience.

5.1.2 Goals and objectives are mutually agreed on by the CI and student(s).

5.2 Feedback is provided both formally and informally.

5.2.1 To provide student feedback, the CI collects information through direct observation and discussion with students, review of the students’ patient/client documentation, available observations made by others, and students’ self-assessments.

5.2.2 The CI provides frequent, positive, constructive, and timely feedback.

5.2.3 The CI and students review and analyze feedback regularly and adjust the learning experiences accordingly.

5.3 The CI performs constructive and cumulative evaluations of the students’ performance.

5.3.1 The CI and students both participate in ongoing formative evaluation.

5.3.2 Cumulative evaluations are provided at least at midterm and at the completion of the clinical education experience and include student self-assessments.

6.0 THE CLINICAL INSTRUCTOR DEMONSTRATES PERFORMANCE EVALUATION SKILLS.

6.1 The CI articulates observations of students’ knowledge, skills, and behavior as related to specific student performance criteria.

6.1.1 The CI familiarizes herself or himself with the student’s evaluation instrument prior to the clinical education experience.

6.1.2 The CI recognizes and documents students’ progress, identifies areas of entry-level competence, areas of distinction, and specific areas of performance that are unsafe, ineffective, or deficient in quality.
6.1.3 Based on areas of distinction, the CI plans, in collaboration with the CCCE and the ACCE/DCE when applicable, activities that continue to challenge students’ performance.

6.1.4 Based on the areas identified as inadequate, the CI plans, in collaboration with the CCCE and ACCE/DCE when applicable, remedial activities to address specific deficits in student performance.

6.2 The CI demonstrates awareness of the relationship between the academic program and clinical education site concerning student performance evaluations, grading, remedial activities, and due process in the case of student failure.

6.3 The CI demonstrates a constructive approach to student performance evaluation that is educational, objective, and reflective and engages students in self-assessment (eg, problem identification, processing, and solving) as part of the performance evaluation process.

6.4 The CI fosters student evaluations of the clinical education experience, including learning opportunities, CI and CCCE performance, and the evaluation process.

The foundation for this document is:


Revisions of this document are based on:


SELF-ASSESSMENTS FOR CLINICAL INSTRUCTORS

1.0 THE CLINICAL INSTRUCTOR (CI) DEMONSTRATES CLINICAL COMPETENCE AND LEGAL AND ETHICAL BEHAVIOR THAT MEETS OR EXCEEDS THE EXPECTATIONS OF MEMBERS OF THE PROFESSION OF PHYSICAL THERAPY.

1. Do you, as the clinical instructor (CI), have at least 1 year of clinical experience?  
   #Yes  #No  #Developing

2. Do you demonstrate a desire to work with students by pursuing learning experiences to develop knowledge and skills in clinical teaching?  
   #Yes  #No  #Developing

3. Do you, as the CI, demonstrate competence as a physical therapist or a physical therapist assistant by:
   
   a) Utilizing the patient/client management model in the Guide to Physical Therapist Practice to demonstrate a systematic approach to patient care?  
      #Yes  #No  #Developing

   b) Using clinical reasoning and evidence-based practice in the delivery of health services?  
      #Yes  #No  #Developing

   c) Providing rationale for the patient/client?
      
      ▪ Examination, evaluation, diagnosis, prognosis, interventions, outcomes, and reexaminations (PT)  
      #Yes  #No  #Developing

      ▪ Interventions (including data collection and outcomes associated with those interventions) as directed and supervised by the PT and within the plan of care (PTA)  
      #Yes  #No  #Developing

   d) Demonstrating effective time-management skills?  
      #Yes  #No  #Developing

4. Do you, as the CI, adhere to legal practice standards?

   a) By holding a current license/registration/certification as required by the physical therapy practice act in the state in which you practice?  
      #Yes  #No  #Developing

   b) By providing physical therapy services that are consistent with your state practice act
and interpretive rules and regulations? #Yes  \(\Gamma\) No #Developing

c) By providing physical therapy services that are consistent with state and federal legislation, including, but not limited to:

- Equal opportunity and affirmative action policies #Yes  #No #Developing
- Americans With Disabilities Act (ADA) #Yes  #No #Developing

d) By ensuring that the patients/clients have been informed of and consent to have a student involved in providing physical therapy services? #Yes  #No #Developing

5. Do you, as the CI, demonstrate ethical behavior, as outlined by the clinical education site policy and the APTA Code of Ethics and Guide for Professional Conduct? #Yes  #No #Developing

6. Do you, as the CI, consistently demonstrate the APTA Core Values (http://www.apta.org/documents/public/education/professionalism.pdf) of accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility? #Yes  #No #Developing

COMMENTS/PLAN:

2.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE
COMMUNICATION SKILLS.

1. Do you, as the CI, use verbal, nonverbal, and written communication skills and information technology to clearly express yourself to students to:

   a) Define performance expectations for students?  #Yes  #No  #Developing
   b) Collaborate to develop mutually agreed-on goals and objectives for the clinical education experience?  #Yes  #No  #Developing
   c) Provide feedback?  #Yes  #No  #Developing
   d) Demonstrate skill in active listening?  #Yes  #No  #Developing

2. Do you, as the CI, facilitate communication by:

   a) Encouraging dialogue with students?  #Yes  #No  #Developing
   b) Providing time and a place for ongoing dialogue to occur?  #Yes  #No  #Developing
   c) Initiating communication that may be difficult or confrontational around an issue of concern?  #Yes  #No  #Developing
   d) Remaining open to and encouraging feedback from students, clinical educators, and other colleagues?  #Yes  #No  #Developing

COMMENTS/PLAN:

3.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE BEHAVIOR,
### Conduct, and Skill in Interpersonal Relationships

1. Do you, as the CI, form a collegial relationship with students?
   - Yes
   - No
   - Developing

2. Do you model behaviors and conduct and instructional and supervisory skills that are expected of the PT or PTA?
   - Yes
   - No
   - Developing

3. Do you demonstrate an understanding of the impact of your behavior and conduct as a role model for students?
   - Yes
   - No
   - Developing

4. Do you promote the student as a colleague to others?
   - Yes
   - No
   - Developing

5. Do you demonstrate respect for and sensitivity to individual differences?
   - Yes
   - No
   - Developing

6. Are you willing to share your strengths and weaknesses with students?
   - Yes
   - No
   - Developing

7. Do you, as the CI, remain approachable by assessing and responding to student concerns with empathy, support, or interpretation, as appropriate?
   - Yes
   - No
   - Developing

8. Do you, as the CI, interact appropriately with patients, colleagues, and other health professionals to achieve identified goals?
   - Yes
   - No
   - Developing

9. Do you represent the physical therapy profession positively by assuming responsibility for career and self-development and demonstrate this responsibility to the student by participation in activities, such as:
   
   a) Continuing education courses?
   - Yes
   - No
   - Developing

   b) Journal club?
   - Yes
   - No
   - Developing

   c) Case conferences?
   - Yes
   - No
   - Developing

   d) Case studies?
   - Yes
   - No
   - Developing

   e) Literature review?
   - Yes
   - No
   - Developing

   f) Facility sponsored courses?
   - Yes
   - No
   - Developing

   g) Post-entry-level education?
   - Yes
   - No
   - Developing
h) Area consortia programs? #Yes #No #Developing
i) Membership and active involvement in the profession (eg, America Physical Therapy Association) #Yes #No #Developing

**COMMENTS/PLAN:**

**4.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE INSTRUCTIONAL SKILLS.**

1. Do you, as the CI, implement, facilitate, and evaluate learning experiences for students based on a plan created in collaboration with students? #Yes #No #Developing

2. Do you, as the CI, review the student’s academic curriculum, level of didactic preparation, current level of performance, and the goals of the clinical education experience? #Yes #No #Developing

3. Do you include learning experiences in the patient/client management model (eg, examination, evaluation, diagnosis, prognosis, plan of care, intervention, and outcomes for the PT student; directed interventions with the plan of care for the PTA student) and practice management activities (eg, billing, staff meetings, marketing)? #Yes #No #Developing

4. Do you, as the CI, maximize learning opportunities by using planned and unplanned experiences within the entire clinical environment? #Yes #No #Developing

5. Do you, as the CI, integrate knowledge of various #Yes #No #Developing
learning styles to implement strategies that accommodate students’ needs?

6. Do you, as the CI, sequence learning experiences to allow progression towards the student’s personal and educational goals?  
   #Yes  #No  #Developing

7. Do you, as the CI, monitor and modify learning experiences in a timely manner, based on the quality of the student’s performance?  
   #Yes  #No  #Developing

COMMENTS/PLAN:

5.0 THE CLINICAL INSTRUCTOR DEMONSTRATES EFFECTIVE
SUPERVISORY SKILLS.

1. Do you, as the CI, present clear performance expectations to students at the beginning of and throughout the learning experience?

   #Yes  #No  #Developing

2. Are goals and objectives mutually agreed on by you and students?

   #Yes  #No  #Developing

3. Do you, as the CI, provide both formal and informal feedback?

   #Yes  #No  #Developing

4. To provide student feedback, do you collect information through:
   a) Direct observation and discussions with students?

   #Yes  #No  #Developing

   b) Review of the students’ patient/client documentation?

   #Yes  #No  #Developing

   c) Available observations made by others?

   #Yes  #No  #Developing

   d) Students’ self-assessments?

   #Yes  #No  #Developing

5. Do you, as the CI, provide feedback to students that is:
   a) Frequent?

   #Yes  #No  #Developing

   b) Positive?

   #Yes  #No  #Developing

   c) Constructive?

   #Yes  #No  #Developing

   d) Timely?

   #Yes  #No  #Developing

6. Do you, as the CI, review and analyze feedback regularly and adjust learning experiences accordingly?

   #Yes  #No  #Developing

7. Do you, as the CI, perform constructive (interim) and cumulative (final) evaluations of the students’ performance by:
   a) Participating with the student in ongoing constructive evaluations?

   #Yes  #No  #Developing

   b) Providing cumulative evaluations at least at midterm and at the completion of the clinical education experience?

   #Yes  #No  #Developing

   c) Including student self-assessments?

   #Yes  #No  #Developing
**COMMENTS/PLAN:**

**6.0 THE CLINICAL INSTRUCTOR DEMONSTRATES PERFORMANCE EVALUATION SKILLS.**

1. Do you, as the CI, familiarize yourself with the students’ evaluation instrument(s) prior to the clinical education experience?  
   - Yes  
   - No  
   - Developing

2. Do you, as the CI, use and articulate available information and observations when evaluating students’ knowledge, skills, and behavior as related to specific performance criteria?  
   - Yes  
   - No  
   - Developing

3. Do you, as the CI, recognize and document students’ progress by identifying areas of:
   - a) Entry-level competence?  
     - Yes  
     - No  
     - Developing
   - b) Exceptional performance?  
     - Yes  
     - No  
     - Developing
   - c) Unsafe or ineffective performance?  
     - Yes  
     - No  
     - Developing
   - d) Appropriate progression?  
     - Yes  
     - No  
     - Developing

4. In collaboration with the CCCE and ACCE/DCE, do you plan activities that continue to challenge student performance based on areas of:
   - a) Exceptional performance?  
     - Yes  
     - No  
     - Developing
   - b) Appropriate progression?  
     - Yes  
     - No  
     - Developing
c) Specific deficits? #Yes  #No  #Developing

5. Do you, as the CI, demonstrate awareness of the relationship between the academic program and clinical education site as it relates to:
   a) Student performance evaluations? #Yes  #No  #Developing
   b) Grading? #Yes  #No  #Developing
   c) Remedial activities? #Yes  #No  #Developing
   d) Due process in the case of student failure? #Yes  #No  #Developing

6. Do you, as the CI, demonstrate a constructive approach to student performance evaluation that is:
   a) Educational? #Yes  #No  #Developing
   b) Objective? #Yes  #No  #Developing
   c) Reflective? #Yes  #No  #Developing
   d) Directed at engaging students in self-assessment? #Yes  #No  #Developing

7. Do you foster student evaluation of the clinical education experience, including:
   a) Learning opportunities? #Yes  #No  #Developing
   b) CI performance? #Yes  #No  #Developing
   c) CCCE performance? #Yes  #No  #Developing
   d) The evaluation process? #Yes  #No  #Developing

COMMENTS/PLAN:
GLOSSARY

Academic Coordinator/Director of Clinical Education (ACCE/DCE): An individual who is responsible for managing and coordinating the clinical education program at the academic institution, including facilitating development of the clinical education site and clinical educators. This person is also responsible for coordinating student placements, communicating with clinical educators about the academic program and student performance, and maintaining current information on clinical education sites.

Academic program: That aspect of the curriculum where students’ learning occurs directly as a function of being immersed in the academic institution of higher education; the didactic component of the curriculum that is managed and controlled by the physical therapy educational program.

Accountability: Active acceptance of responsibility for the diverse roles, obligations, and actions of the physical therapist including self-regulation and other behaviors that positively influence patient/client outcomes, the profession, and the health needs of society. (Professionalism in Physical Therapy: Core Values; August 2003.)

ADA (Americans with Disabilities Act): The 1990 federal statute that prohibits discrimination against individuals in employment, public accommodations, etc.

Administration: The skilled process of planning, directing, organizing, and managing human, technical, environmental, and financial resources effectively and efficiently. A physical therapist or physical therapist assistant can perform administrative activities, based on recognition of additional formal and informal training, certification, or education.

Affective: Relating to the expression of emotion (eg, affective behavior).

Altruism: The primary regard for or devotion to the interest of patients/clients, thus assuming the fiduciary responsibility of placing the needs of the patient/client ahead of the physical therapist’s self interest. (Professionalism in Physical Therapy: Core Values; August 2003.)

Caring: The concern, empathy, and consideration for the needs and values of others. (Professionalism in Physical Therapy: Core Values, August 2003.)

Center Coordinator of Clinical Education (CCCE): Individual(s) who administer, manage, and coordinate clinical instructor assignments and learning activities for students during their clinical education experiences. In addition, this person determines the readiness of persons to serve as clinical instructors for students, supervises clinical instructors in the delivery of clinical education experiences, communicates with the academic program regarding student performance, and provides essential information about the clinical education program to physical therapy programs.

Clients: Individuals who are not necessarily sick or injured but can benefit from a physical therapist’s consultation, professional advice, or services. Clients are also businesses, school systems, families, caregivers, and others who benefit from physical therapy services.
Clinical education agreement: A legal contract that is negotiated between academic institutions and clinical education sites that specifies each party’s roles, responsibilities, and liabilities relating to student clinical education. (Synonyms: letter of agreement, affiliation contract)

Clinical education consortia: The formation of regional groups that may include physical therapy programs or clinical educators for the express purpose of sharing resources, ideas, and efforts.

Clinical education experience: That aspect of the curriculum where students’ learning occurs directly as a function of being immersed within physical therapy practice. These dynamic and progressive experiences comprise all of the direct and indirect formal and practical “real life” learning experiences provided for students to apply classroom knowledge, skills, and behaviors in the clinical environment. These experiences can be of short or long duration (e.g., part-time and full-time experiences, internships that are most often full-time postgraduation experiences for a period of 1 year) and can vary by the manner in which the learning experiences are provided (e.g., rotations on different units that vary within the same setting, rotations between different practice settings within the same health care system). These experiences include comprehensive care of patients across the life span and related activities. (Synonym: Clinical learning experiences)

Clinical education program: That portion of a physical therapy program that is conducted in the health care environment rather than the academic environment; the sum of all clinical education experiences provided.

Clinical education site: The physical therapy practice environment where clinical education occurs; that aspect of the clinical education experience that is managed and delivered exclusively within the physical therapy practice environment and encompasses the entire clinical facility.

Clinical instructor (CI): An individual at the clinical education site, who directly instructs and supervises students during their clinical learning experiences. These individuals are responsible for carrying out clinical learning experiences and assessing students’ performance in cognitive,* psychomotor,* and affective domains as related to entry-level clinical practice and academic and clinical performance expectations. (Synonyms: clinical teacher; clinical tutor; clinical supervisor)

Clinical Performance Instrument (CPI): American Physical Therapy Association developed student evaluation instruments that are used to assess the clinical education performance of physical therapist and physical therapist assistant students. The Physical Therapist CPI consists of 24 performance criteria and the Physical Therapist Assistant CPI consists of 20 performance criteria.

Cognitive: Characterized by knowledge, awareness, reasoning, and judgment.

Communication: A verbal or nonverbal exchange between two or more individuals or groups that is: open and honest; accurate and complete; timely and ongoing; and occurs between physical therapists and physical therapist assistants, as well as between patients, family or caregivers, health care providers, and the health care delivery system.

Compassion: The desire to identify with or sense something of another’s experience; a
precursor of caring. (*Professionalism in Physical Therapy: Core Values*; August 2003.)

**Competent:** Demonstrates skill and proficiency in a fluid and coordinated manner in rendering physical therapy care (physical therapist), or those aspects of physical therapy care (eg, interventions) as directed and supervised by the physical therapist (physical therapist assistant).

**Competencies:** A set of standard criteria, determined by practice setting and scope, by which one is objectively evaluated.

**Cultural competence:** Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Working definition adapted from *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda*, Office of Minority Health, Public Health Service, U S Department of Health and Human Services; 1999.)

**Cultural and individual differences:** The recognition and respect for and response to, age, gender, race, creed, national and ethnic origin, sexual orientation, marital status, health status, disability or limitations, socioeconomic status, and language.

**Data collection:** For the physical therapist assistant, this term is used in the context of providing interventions that are directed by the physical therapist and within the plan of care and consist of processes or procedures used to collect information relative to the intervention, which may include observation, measurement, and subjective, objective, and functional findings.

**Diagnosis:** Diagnosis is both a process and a label. The diagnostic process performed by the physical therapist includes integrating and evaluating data that are obtained during the examination to describe the patient/client condition in terms that will guide the prognosis, the plan of care, and intervention strategies. Physical therapists use diagnostic labels that identify the impact of a condition on function at the level of the system (especially the movement system) and at the level of the whole person. (*Guide to Physical Therapist Practice*. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

**Ethical and legal behaviors:** Those behaviors that result from a deliberate decision-making process that adheres to an established set of standards for conduct that are derived from values that have been mutually agreed on and adopted for that group.

**Excellence:** Excellence is physical therapy practice that consistently uses current knowledge and theory while understanding personal limits, integrates judgment and the patient/client perspective, embraces advancement, challenges mediocrity, and works toward development of new knowledge. (*Professionalism in Physical Therapy: Core Values*; August 2003.)

**Evaluation:** A dynamic process in which the physical therapist makes clinical judgments based on data gathered during the examination. No defined number or range of number of visits is established for this type of episode. (*Guide to Physical Therapist Practice*. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)
Examination: A comprehensive and specific testing process performed by a physical therapist that leads to diagnostic classification or, as appropriate, to a referral to another practitioner. The examination has three components: the patient/client history, the systems reviews, and tests and measures. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Integrity: Steadfast adherence to high ethical principles or professional standards; truthfulness, fairness, doing what you say you will do, and “speaking forth” about why you do what you do. (Professionalism in Physical Therapy: Core Values; August 2003.)

Intervention: The purposeful and skilled interaction of the physical therapist with the patient/client and, when appropriate, with other individuals involved in care (ie, physical therapist assistant), using various methods and techniques to produce changes in the condition. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Outcomes (assessment of the individual): Performed by the physical therapist and is a measure (or measures) of the intended results of patient/client management, including changes in impairments, functional limitations, and disabilities and the changes in health, wellness, and fitness needs that are expected as the results of implementing the plan of care. The expected outcomes in the plan should be measurable and time limited.

Patients: Individuals who are the recipients of physical therapy direct intervention.


Philosophy: Broad context and theoretical framework provided for program purpose, organization, structure, goals, and objectives; a statement of philosophy under some conditions may be synonymous with a mission statement.

Physical therapist: A person who is a graduate of an accredited physical therapist education program and is licensed to practice physical therapy.

Physical therapist assistant: A person who is a graduate of an accredited physical therapist assistant program and who assists the physical therapist in the provision of physical therapy. The physical therapist assistant may perform physical therapy procedures and related tasks that have been selected and delegated by the supervising physical therapist.

Physical therapist professional education: First level of education that prepares student to enter the practice of physical therapy.

Physical therapy: Use of this term encompasses both physical therapists and physical therapist assistants.
Physical therapy personnel: This includes all persons who are associated with the provision of physical therapy services, including physical therapists, physical therapist assistants who work under the direction and supervision of a physical therapist, and other support personnel. (Synonym: physical therapy staff)

Plan of care: Statements that specify the anticipated goals and the expected outcomes, predicted level of optimal improvement, specific interventions to be used, and proposed duration and frequency of the interventions that are required to reach the goals and outcomes. The plan of care includes the anticipated discharge plans. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Professional: A person who is educated to the level of possessing a unique body of knowledge, adheres to ethical conduct, requires licensure to practice, participates in the monitoring of one’s peers, and is accepted and recognized by the public as being a professional. (See Physical Therapist.)

Professional duty: Professional duty is the commitment to meeting one’s obligations to provide effective physical therapy services to individual patients/clients, to serve the profession, and to positively influence the health of society. (Professionalism in Physical Therapy: Core Values; August 2003.)

Prognosis: The determination by the physical therapist of the predicted optimal level of improvement in function and the amount of time needed to reach that level. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Provider of physical therapy: This indicates the part of the clinical education experience that is managed and delivered exclusively under the direction and supervision of the physical therapist including within the plan of care physical therapy interventions provided by the physical therapist assistant.

Psychomotor: Refers to motor activity that is preceded by or related to mental activity.

Reexamination: The process of performing selected tests and measures after the initial examination to evaluate progress and to modify or redirect interventions. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Screening: Determining the need for further examination or consultation by a physical therapist or for referral to another health professional. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.) (See also: Cognitive.)

Social responsibility: The promotion of a mutual trust between the physical therapist as a part of the profession and the larger public that necessitates responding to societal needs for health and wellness. (Professionalism in Physical Therapy: Core Values, August 2003.)

Student placement forms: A questionnaire distributed by physical therapy education programs to clinical education sites requesting the number and type of available placements for students to complete clinical education experiences.
Supervision: A process where two or more people actively participate in a joint effort to establish, maintain, and elevate a level of performance; it is structured according to the supervisee’s qualifications, position, level of preparation, depth of experience, and the environment in which the supervisee functions.

Treatment: The sum of all interventions provided by the physical therapist to a patient/client during an episode of care. (Guide to Physical Therapist Practice. Rev 2nd ed. Alexandria, Va: American Physical Therapy Association; 2003.)

Validity: The degree to which accumulated evidence and theory support specific interpretation of test scores entailed by proposed use of a test. The degree to which a test measures what it is intended to measure; a test is valid for a particular purpose for a particular group.

Variety of clinical education experiences: Considers multiple variables when providing students with clinical learning experiences relative to patient care including, but not limited to, patient acuity, continuum of care, use of a PT/PTA care-delivery team, complexity of patient diagnoses and environment, and health care delivery system.
Instructor’s Note: For other disciplines participating in the program, obtain the profession’s guidelines for clinical instructors from the professional organization (ie, ASHA for speech-language pathology and Audiology [www.asha.org], AOTA for occupational therapists and occupational therapy assistants [www.aota.org]).
Activity 3
Self-Assessment

- Take 10 minutes to perform a quick self-assessment of your current skill development as a clinical instructor. This will form the baseline for your current perceived performance and skill.

- Review your self-assessment prior to the beginning of your next student’s clinical education experience. This will serve as a reminder of the types of activities and behaviors that you want to perform as a CI for the student.

- After the completion of the student’s clinical experience, reflect on your performance as a CI based on the clinical instructor guidelines. Consider some of the following questions:

  What did I do effectively in working with this student?
  
  How do I know I was effective?
  
  What could I have changed that would have enabled the student to have progressed differently?
  
  What feedback did the student provide during the learning experience that was implemented?
  
  What feedback did the student provide during the learning experience that was not implemented? Why?

- Through the process of self-reflection, identify 1 or 2 skills that you would like to improve in mentoring and instructing your next student.

- As you continue this process, you will be able to see your growth and development in your performance and role as a clinical instructor and mentor.

End Section I
References


Additional Recommended Readings


Section II

Readiness to Learn

Readiness To Learn

Section II
Introduction

Section II addresses the student's readiness to learn. Consideration is given to the principles of adult learning, stages of learning, domains of learning, proper construction of behavioral objectives, and influence of learning style on the teaching/learning experience. Opportunities are provided for participants to develop beginning skill in writing and analyzing behavioral objectives.

The corollary to the student's readiness to learn is the clinical instructor's readiness to teach. Section III focuses on the instructor's readiness to teach. As you go through this section, begin to consider how you might think about teaching students to learn.

Whose readiness to learn? It is the student who is learning. This section will focus on understanding the student's preparation to learn, and how to accommodate the learning experience to individual student's readiness.

Section I of this training workshop focused on the clinician as a CI, including the skills necessary to be successful clinical educator. Section II will focus on the student.
Objectives

Following the completion of this section, the participant will be able to:

1. Describe how stages of learning influence the student’s readiness to learn.
2. Write a behavioral objective.
3. Analyze the components and domain(s) of a behavioral objective.
4. Identify characteristics of the adult learner.
5. Describe how clinical instruction can be designed to support the development of an adult learner.

What do we know about learning?

- **different levels of learning**: learning can be simple to complex, as illustrated by the levels of learning in each of the domains previously discussed.

- **different stages of learning**: learning builds from an exposure to something new, to practice, and finally to mastery.

- **learning builds upon previous learning**: previous experience, or a less complex application of the same information or skill.

Instructor’s note: However, it is important to note that differences in interpreting student’s performance in communications, evaluation and treatment performance, and affective issues (eg, motivation, self-initiative) may be rooted in different learning styles between the student and the CI.
Objectives (cont’d)

6. Relate differences in learning style to individual strengths in problem solving.
7. Incorporate the role of learning style in the teaching/learning experience.
8. Discuss the benefits of developing a flexible learning style.
9. Identify characteristics of the adult learner.

6. Discuss the benefits of developing a flexible learning style.

Our individual learning style(s) is a preferential approach to learning. It varies with each individual. It becomes a lens through which we acquire new knowledge, skills, and attitudes. Individual learning style(s) need to be understood to best facilitate learning. However, a single learning style is neither encouraged nor desired. As CIs we seek to understand our student’s approach to learning through his/her learning preferences, and at the same time challenge the student to become the most flexible and adaptable learner possible, using different learning styles in different situations. This section will help us explore the role that learning styles can play in student performance evaluation and planning learning experiences.
Assumptions

The assumptions associated with readiness to learn are listed below.

1. Students are able to assume responsibility for their own learning.
2. Individual learning style preferences are a factor in effective learning.
3. Clinical instructors and students should work together to develop flexible teaching and learning styles.
4. Learning is a lifelong process.

Instructor’s note: Give participants a chance to review the assumptions. It is not necessary to address each individually, unless questions arise. However, it should be noted that this is the baseline from which the remainder of Section II will develop.
Activity 1
Find Someone Who... ¹

Activity 1 on the next page should be copied onto a sheet of paper and handed out. To save paper you can duplicate the activity above in 2 sections of the paper.

The purpose of this activity is to provide participants with an opportunity to preview information that follows in Section II. The goal is for them to talk to others in the group and to find a different person who can respond to one of the eight items listed. If the individual agrees with the statement, he/she signs his/her initials on the line provided. The goal is to be the first one to get all eight lines initialed by a different participant.

Variations on this theme can be to allow this activity to continue for a defined amount of time (to limit how much time is required for this activity) and the person who has the most initials wins. You can also let the activity go until everyone has different initials for each item, however this will take more time for an already lengthy section.

You may have time to poll the group with regard to their responses to find out more about the members of the group with respect to their adult learning qualities (Items #1, #5, #8), stages of learning (#2), and learning styles (#3, #4, #6, #7). Let them know that the information that follows will provide them with greater depth of information on these topics. Try to integrate these responses throughout Section II and refer back to this activity.
### Activity 1

**FIND SOMEONE WHO**¹...

1. Has a degree in something other than physical therapy.
2. Is proficient at an activity that you are just beginning to learn or know little about (eg, sports, cooking, playing a musical instrument, etc).
3. Prefers to “listen and watch” when approaching a new learning situation.
4. Uses a systematic or analytical approach to problem solving.
5. Shares an interest in your same practice area.
6. Uses a “trial and error” problem solving approach.
7. Likes to “touch and feel” while learning.
8. Has sought out a new approach to manage a problem situation.

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next slide/page
Basic Principles of Learning\(^2\)\(^{\text{(Knowles)}}\)

1. There are different levels of learning.
2. There is a basic hierarchical order to learning.
3. Learning at any level builds upon and grows out of learning at different levels.
4. Learning generally occurs from simple to complex.
5. Students move through stages of learning at different rates (depending on skill).
6. Students move through stages at different rates from each other.

What is an example of a skill which is learned in the clinic, but which must be "built" over time?

Possible answers include:
- examination (PT)
- evaluation (PT)
- diagnosis (PT)
- patient education (PT, PTA)
- interventions (PT, PTA)
- data collection within interventions (PTA)

Given these examples:

- How do students learn these skills?
- How does each skill change with practice and with experience? (NOT with "time"!!)
- What influences the level at which a student is learning?
- What influences the student's progress to a higher level of learning?

These principles acknowledge a continuum of learning. Learning does not happen in a vacuum or in an isolated fashion. Rather, it builds from past learning to new learning. These principles encourage us to consider what the learner already knows and how we can attach new learning to something already known by the learner.

In assessing where the learner is on this continuum, we are establishing a **Learning Diagnosis**. That is to say, we are identifying a starting point, a degree of readiness. It is essential to know that starting point so that the next steps in the learning experience can be determined. It is also essential to understand the starting point if progress is to be evaluated over time.
Instructor’s note: Use examples of students who have had different exposures to learning objective (e.g., wound debridement). How would their differences in readiness be defined? How would you measure progress from a different starting point in each case?

What is a learning style anyway? What do we know about learning styles? Several authors have explored and labeled learning styles, leading to several configurations of different styles. Although we will not explore them individually here, we will summarize what is known about learning styles and consider how they apply to the clinical education setting.

B. Stages of Learning

Stages of Learning

1. Three stages (Beck et al)
   a. Exposure
   b. Acquisition (practice)
   c. Integration (mastery)
Rarely are we masters of something that we have done only once. In any skill, we develop mastery through initial exposure and observation, followed by the opportunity to practice, (eg, learning to ski, becoming proficient at writing progress notes).

Students progress through each of these three stages with each thing they learn, although they may move more rapidly or slowly depending upon a variety of factors such as previous skill development, the student’s confidence and maturation, and coaching on the part of the instructor.

Each of these three stages overlaps, as illustrated in the diagram in your manual. Therefore, we may exhibit both stages at one time (eg, demonstrating mastery of a skill but seeking more opportunities to practice to reinforce our confidence).

Depending upon the skill, a student may achieve mastery in the course of a single clinical experience (eg, sterile dressing technique), or may develop the skill more gradually over several clinical experiences, even the first year of practice (eg, representing physical therapy in team meetings).

Instructor’s note: Use an example, such as those noted above, or a story of a personal learning experience to illustrate in practical terms the stages of learning.

Progress in the learning experience, then, can be measured as each student moves through these stages of learning. Measurement of this progress can occur as we consider the student’s performance in relationship to these three stages (ie, Does the student demonstrate behaviors consistent with exposure, acquisition, or integration?).
2. **Parameters**

   **Stages of Learning (cont’d)**

   2. Parameters
      a. Novice to mature
      b. Dependent to independent

   3. Student needs and abilities vary by stage

   a. Novice to mature (*professional development and socialization; skill in learning*)

   b. Dependent to independent (*clinical instruction with respect to clinical judgment; ie, willingness to take risks*)

3. **Student needs/abilities vary by stage**

   Several parameters influence this progress. These include how experienced or inexperienced the CI is, how independent the learner is, and the complexity of the task to be learned.

   It is important to keep in mind that progress will vary with each student AND among the different skills learned by any one student. That is why it is best to evaluate progress (that is, the RATE of improvement) within a student, rather than across students. Ultimately, all students must demonstrate mastery, but how they get to that point will vary widely among students, and should be expected.

   The **Learning Vector Model on page 37** of your workbook provides a pictorial representation of what we have just been discussing.

   **Instructor’s note:** Describe examples of the continuum of learning from didactic foundations in school, through early clinical education and final clinical education, to ongoing professional development after entering practice.

   **next slide/page for Learning Vector Model**
The Learning Vector Model

Exposure
Acquisition
Integration

Novice
Professional Development
Mature

Instructor’s Note: You may use this model to begin to integrate the learning principles illustrated in the Clinical Performance Instrument (CPI). The horizontal axis somewhat parallels the anchors on the CPI’s visual analog scale (VAS): novice clinical performance to entry-level performance. The five (5) performance dimensions of the CPI performance criteria help inform the determination of dependent vs. independent levels of performance. There is an expectation for growth and change over time.
C. Clinical Education and Stages of Learning


Clinical Education and Stages of Learning

1. CPI Performance Instrument: 5 Performance Dimensions
   a. Supervision/guidance
   b. Quality
   c. Complexity
   d. Consistency
   e. Efficiency

   a. “Supervision/guidance refers to the level and extent of assistance required by the student to achieve entry-level performance. The degree of supervision and guidance may vary with the complexity of the patient or environment.”

   b. “Quality refers to the degree of skill or competence demonstrated, the relative effectiveness of the performance, and the extent to which outcomes meet the desired goals. A continuum of quality might range from demonstration of limited skill to a highly skilled performance.”

   c. “Complexity refers to the multiple requirements of the patient or environment. The complexity of the environment can be altered by controlling the number and types of elements to be considered in the performance, including patients, equipment, issues, etc. As a student progresses through clinical education experiences, the complexity of tasks/environment should increase, with fewer elements being controlled by the CI.”

   d. “Consistency refers to the frequency of occurrences of desired behaviors related to the performance criterion. As a student progresses through clinical education experiences, consistency of quality performance is expected to progress from infrequently to routinely.”

   e. “Efficiency refers to the ability to perform in a cost-effective and timely manner. As the student progresses through clinical education experiences, efficiency should progress from a high expenditure of time and effort to economical and timely.”
2. Exposure: Student is a novice; dependent on Cl.\textsuperscript{5}

Clinical Education and Stages of Learning (cont’d)

2. Exposure: Student is a \textit{novice}; \textit{dependent} on the Cl.\textsuperscript{(Stritter)}

a. CI must:
   i. set expectations for student.
   ii. plan learning activities.
   iii. perform demonstrations.
   iv. elicit student feedback through questioning.
   v. give feedback about the ability to answer questions.

b. Student must:
   i. answer questions.
3. **Acquisition:** Student can participate in planning and evaluating his/her learning experience.

Clinical Education and Stages of Learning (cont’d)

3. **Acquisition:** Student can participate in planning and evaluating his/her learning experience.

   a. CI must:
      i. give student options.
      ii. guide student through the activity.
      iii. give feedback on work.
      iv. give feedback on the ability to self-assess.

   b. Student must:
      i. perform skill.
4. Integration: Student takes responsibility for planning, implementing, and evaluating a learning experience. CI and student work together.

Clinical Education and Stages of Learning (cont’d)

4. Integration: Student takes responsibility for planning, implementing, and evaluating the learning experience. CI and student work together.

a. CI must:
   i. act as consultant.
   ii. provide feedback on skill and ability to self-assess.
   iii. give feedback on student’s ability to integrate feedback from other sources.

b. Student must:
   i. perform skill independently.
   ii. evaluate own work.
   iii. seek feedback from all appropriate sources.

Having considered these stages, can you think of other examples of skills which must be taught and learned in stages?

What did the CI do that helped the student to move through the stages?

Notice, as you move with your student through the three stages, that learning is initially more dependent on the CI and then gradually shifts to becoming more dependent on the student. Initially, the CI is the active participant in the learning activity, but takes a more secondary role to the student as the student moves toward mastery.

Be prepared to change YOUR instructor ROLE as the student’s abilities change. As CIs we have a tendency to become comfortable with our role at one stage and become reluctant to change our role. This can be a serious impediment to the student.

What did the student do to promote his/her progress through the stages?

As students move toward mastery, they also acquire more control for themselves and for their patients. As the CI, you must not only feel comfortable with this, but also encourage this increased independence. You are ALWAYS and ultimately responsible.

Make your expectations for the next stage of learning clear to the student. This allows the student to understand not only what must occur, but also how to progress and how his/her progress is going to be measured. Also, be prepared to move forward and backward within the stages of learning as the student’s needs dictate.
D. Definition of Domains

These domains describe three types of observable behavior and are therefore used to categorize behavioral objectives. The purpose of dividing learning into “domains” is to make it easier to identify the different aspects of the learning process. When planning learning experiences, it is important for the CI to consider how the processes described in each domain will be incorporated into the learning process for that experience.

1. Domains of Learning

Definition of Domains

Domains of Learning (Shea, Boyum, Spanke)

- Describes 3 types of observable behavior (cognitive/affective/psychomotor) used to categorize behavioral objectives.
Learning occurs in 3 primary domains: cognitive, psychomotor and affective.

**Cognitive Domain**

The *intent* is knowledge and understanding of subject matter.

*Example*

After the lecture, the student will correctly list 3 precautions for patients who have had coronary artery bypass graft (CABG) surgery.

- If the *intent* of the objective is knowledge or understanding of subject matter, it falls in the **cognitive** domain.

  **EXAMPLE:** After the lecture, the student will correctly list three precautions for patients who have had Coronary Artery Bypass Graft surgery (CABG) (cognitive)


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This goal is designed to assess the learner's knowledge of precautions for a patient following coronary artery bypass graft (CABG) surgery.
Psychomotor Domain

The *intent* is physical action or motor skills.

**Example**
Following a demonstration, the student will safely perform a sliding board transfer for a patient with left hemiparesis.

- If the *intent* of the object is physical action or motor skills, it is in the **psychomotor** domain.

**EXAMPLE:** Following a demonstration, the student will safely perform a sliding board transfer for a patient with left hemiparesis. (psychomotor)

This goal is written to assess whether the student can physically position the slide board, wheelchair and patient, then assist the patient during the transfer, so it can be considered psychomotor in nature.

However, to accomplish this goal, the student must have **knowledge** of the appropriate way to do each component, so some might consider it a mixed goal.

It is not unusual to have goals that span more than one domain, but it is useful to think of which domain is most critical at the time.
Affective Domain

The intent is feelings, attitudes, or values.

Example
During weekly clinical Instructor/student meetings, the student will accept formative feedback without defensive behavior.

- If the intent of the objective deals with feelings, attitudes, or values, it falls in the affective domain.

EXAMPLE: During weekly Clinical Instructor/Student meetings, the student will accept formative feedback without defensive behavior. (affective)

The intent of this objective is to assess whether the student receives and values formative feedback.

Look at the previous example for the cognitive domain--

“After the lecture, the student will correctly list 3 precautions for patients who have had coronary artery bypass graft (CABG) surgery.” I change the verb to “write” so that it reads “After the lecture, the student will “write” 3 precautions for patients who have had coronary artery bypass graft (CABG) surgery.”

I have just made this a psychomotor objective, RIGHT? NO...the intent is still knowledge based. I'm not really interested in the student's ability to “write.”

I use the word “intent” in the definition because often just looking at the verb in the objective is not going to be sufficient to tell you in what domain the objective really falls.

So, in summary, domains describe 3 types of observable behavior and are used to categorize behavioral objectives. The purpose of dividing learning into domains is to make it easier to identify the different aspects of the learning process.
Before we move on to looking at one last important characteristic of domains, let’s take a moment and categorize a few objectives into their primary domains. This is Activity 2 in your workbook and can be found on page 40.
Activity 2

Additional Practice in Identifying Domains

Label each of the following objectives:
“C” = Cognitive  “P-M” = Psychomotor  “A” = Affective

1. The student responds to constructive criticism in a manner that reflects an understanding of the feedback.
   - affective; condition is implied

2. The student uses correct spelling and grammar in all written work.
   - cognitive; condition is implied

3. Following an examination the student explains the nature of the physical therapy problem to the CI.
   - cognitive. Degree is not stated in this objective, but can be implied to be “correctly” explains.

4. The student effectively applies physical agents appropriate to the patient’s needs.
   - psychomotor; condition is implied

5. During interactions with patients, the student tactfully redirects conversations.
   - affective; condition is implied; cognitive knowledge needed regarding communication

6. The student develops realistic and timely short-term goals.
   - cognitive

   see answer key Section VII

So we know that learning occurs in one of 3 domains. You may be wondering at this point just how that knowledge can be useful to you when dealing with a student.

Let’s add one more piece to our examination of domains, a piece that will help to define the usefulness of domains in clinical education.

next slide/page
2. **Taxonomies of Domains**\(^{6,7}\)

Domains of Learning

**Taxonomies of Domains** (Shea, Boyum, Spanke; Anderson, Krathwohl, Airasian)

- Each domain is divided hierarchically into a series of progressive stages.
- Each stage is defined by useful verbs describing what a student should be able to do to have mastered that stage.

- Each domain is divided hierarchically into a series of progressive stages. This hierarchical system is often referred to as taxonomy.

Each stage builds upon the previous stage. In theory, one must achieve one level of the hierarchy before being able to progress to the next. This is sort of the “you must walk before you can run concept.”

- Each stage is further defined by a list of verbs describing what a student should be able to do in order to have mastered that stage.

We couldn’t get the whole taxonomy on a slide and still have it large enough to read. So you’ll need to refer to the last three pages in your workbook at the end of Section II for examples.

When a CI is establishing objectives for a student’s learning experience, these verbs are useful in identifying the particular area and skills that need to be completed for the student’s learning process to follow an orderly, stepwise progression.
Referring to the taxonomies of domains is very useful/helpful in planning learning experiences; in identifying where the student’s problems are (why he/she is having difficulty achieving a certain level of performance); or in identifying how to keep the student challenged by raising the expectations to a higher level; and making the activity more difficult.

It is useful to look at taxonomies with a student who is having difficulty with evaluation, for example.

- Maybe the student has good knowledge and comprehension, but has difficulty applying what he/she knows.
- If the student can’t apply what he/she knows, he/she is going to have difficulty with “evaluation”...much too high to the taxonomy.
- So, we may need to rewrite the objectives at a lower level.

It can also go the other way...and examine taxonomies to make the objective more challenging for the student.

Instructor's note: In a large group, the audience should take this opportunity to use the cognitive and psychomotor taxonomies to make an objective more challenging for a student. Give the participant a chance to examine the taxonomy and offer suggestions for increasing the difficulty. Any response that is higher on the taxonomy than “knowledge” (for the cognitive domain) and receiving (for the affective domain) is appropriate. This activity is a precursor to Activity 6.
Cognitive Domain

During the lab, the student will instruct the lab partner in supine to sit bed mobility while observing the precautions for cardiac arterial bypass graft (CABG) surgery.

*How could we make this objective more challenging?*

Refer back to my original example of the cognitive domain:

EX: After the lecture, the student will correctly list three precautions for patients who have had coronary artery bypass graft (CABG) surgery.

Where does this objective fall on the taxonomy?
Answer: knowledge level.

How could we make this more difficult, in order to challenge the student more?
- Ask the student to "explain" the purpose of these precautions.
- Ask the student to "incorporate" the precautions while transferring a patient.
- Have the student “design” alternative transfer strategies to help mobilize patients post surgery.

Refer to this example for the affective domain:

EX: During the patient interaction, the student will recognize the impact of his or her nonverbal communication.

Where does this objective fall on the taxonomy?
Answer: receiving level

How could we make this more difficult, in order to increasingly challenge the student?
- Ask the student to “modify” his or her communication to meet the message.

How might we know that this student is “valuing” the importance of congruent nonverbal communication?
- The student may be observed “pursuing” opportunities to learn appropriate nonverbal communication from other clinicians (i.e. through discussion, observations, etc.)

Now that you have a feel for how to use these taxonomies, let’s apply this knowledge in an activity that more closely approximates what you may need to do with your student.

Take a moment to read through Activity 3A, on page 41 and answer the questions that are posed. When you’re done, we’ll come back and discuss your responses.
**Activity 3A**

**Using Domains to Focus Objectives**

**Scenario 1—Lucy**

Lucy has wonderful examination and evaluation skills. Her examinations are complete, thorough, appropriate, effective, and efficient. However, at midterm, Lucy is still having difficulty planning effective treatment programs. She wants to manage all patients with low back pain the same, all patients with adhesive capsulitis the same, etc. Each time you provide her with a suggestion, she readily incorporates it into her “standard” treatment for that particular diagnosis.

1. Is Lucy having difficulty with a skill, her attitude, or knowledge?
   - skill-no
   - attitude-no
   - knowledge-yes

2. What is her problem?
   - She's unable to select the interventions that are most appropriate to the patient.

3. Where on the taxonomy does what you want Lucy to be able to do occur?
   - At the minimum level of evaluation or higher to include analysis or synthesis.

4. Where might you start in trying to determine where the learning process has fallen apart for Lucy?
   - Lucy seems to have “knowledge” that the interventions she is choosing are appropriate. Has she considered all of the alternatives?
Let's take some time to practice yet another situation in Activity 3B, on page 42, and answer the questions that are posed. When you're done, we'll come back and discuss your responses.

Activity 3B
Using Domains to Focus Objectives

Scenario 2—Curt
Activity 3B

Using Domains to Focus Objectives

Scenario 2:
Curt is a PT student on his final clinical experience in an inpatient pediatric rehabilitation unit. He is meeting your expectations within the patient/client management model in the areas of examination, evaluation, and interventions. He is very eager to expand his knowledge base and frequently collaborates with other PT staff members for ideas. Your concern at this point is his limited participation in team meetings. He frequently interrupts other team members and does not seem to listen to their opinions. On occasion, he has also missed meetings entirely. When asked “why”, he responds by saying that he needed time to plan for a patient and could “catch up” with other team members at any time during the day if he wanted their input.

1. Is Curt having difficulty with a skill, his attitude, or knowledge?
   • Attitude

2. What is the problem?
   • Curt does not value the opinions of others and the team process as it relates to the care and management of his patients.

3. Where on the taxonomy does what you want Curt to be able to do occur?
   • “Receiving”

4. Where might you start in trying to determine where the learning process has fallen apart for Curt?
   • Seek to determine whether Curt recognizes the impact of his communication skills on other team members and the team process.
   • Have Curt develop an outline of team members and the value that each team member plays in a patient’s recovery.

If you’re not sure where in the process a student seems to be getting stuck, familiarity with the taxonomies can help you generate a few questions or tasks at various levels, which will help you to focus where to devote your attention. In Lucy’s case, one very basic question would establish whether or not she had “knowledge,” eg, “Name a variety of interventions that would be appropriate for...”
There is a nice description of the value of objectives by Moore and Perry in your book on page 43. But briefly, objectives are used in many ways.

- The entire program has objectives utilized in designing and developing the clinical education program.
- Individual learning experiences have objectives that help determine which teaching methods are going to be used and to assess learning itself through student’s achievement of the objective.

E. Writing Behavioral Objectives

1. An Overview

“The most basic step in the development of any aspect of clinical education is the determination of objectives. The literature is virtually unanimous in its emphasis on the importance of developing objectives as a basis for planning.”

“Many authors favor the use of objectives written in behavioral terms. These should describe the learner’s behavior at the end of the learning. (What the learner is capable of or can do), the conditions under which the learner must function, and the evaluation method that will be used to assess the learning.”

“In that format, the exact meaning of an objective can be clear and thus more helpful to an instructor in planning and evaluating a program and to a student in knowing where he/she is, and what to expect in the experience...”
“...Objectives for clinical education (desired outcomes) have several purposes. First, they can be utilized in designing and developing the clinical education program. Only after the desired outcomes are known can a program be designed to produce those outcomes. Second, developing objectives can help determine the teaching methods to be used. Only by knowing the objectives of the experience can the CI determine whether the student should observe, practice, discuss, or write something. Third, developing objectives can assess both the learning experience itself and the student's achievement of the objective. A fringe benefit to the development of objectives is the upgrading of the abilities of the developers. The increase in capability and commitment of persons who have been involved in the development of programs, including the development of objectives, have been documented by several sources and are certainly a phenomenon educators should be aware of.”

“The entire program has objectives and so does a specific learning experience. Objectives of a learning experience may be derived from several sources. All of them result from some type of evaluative process, asking questions about what is needed, what is available, what are the voids in knowledge. These questions can and should be asked by a variety of people. Through this process, several sets of objectives can be developed. The educational institution determines objectives that the student must achieve (requirements) and that the student may choose to achieve (electives). Clinical centers determine what experiences they have to offer and the objectives for those experiences. The clinical center may also develop objectives and experiences at the request of the academic institution or the students.”

“Both students and academic faculty may have unmet needs that they ask the clinical center to meet. The clinical center then assesses its ability to meet such objectives. Student objectives may be determined by a special area of interest, knowledge of the setting in which he or she will be working, or self-assessment of personal strengths and weaknesses. All sources can provide important meaningful objectives for learning experiences.”

“The clinical center’s function is to make each student clinical experience a coherent experience, and the ACCE’s function is to ensure that all clinical experiences come together to accomplish those overall objectives deemed appropriate by the academic institution.”
“...The **three major factors** that determine the objectives in physical therapy programs are the **health needs of society**, the **nature of the subject matter**, and the **characteristics of the learners**. A **fourth** factor, added by some authors, is **the profession**. The health needs of society are obviously crucial to the development of learning objectives in physical therapy. Health care is changing, both in where it is given, and what is given. The objectives of physical therapy education should reflect that change. The nature of the subject matter is also changing, expanding in both breadth and depth, and the objectives of the curriculum must reflect this. In a field that is changing rapidly, principles or processes rather than specific factual material should be stressed, thus equipping the graduate with tools to cope with new settings and knowledge. The characteristics of the learner are also an obvious consideration in the determination of objectives. Are they graduate students or undergraduates? Are they highly capable and motivated, or taking work because they must?”

---


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If well written and clear, behavioral objectives describe precisely what the student is expected to be able to do and how well he/she must do it before the objective is considered met. There are no questions from either side relative to expectations.

**Turn to page 44 in your book.**

---

First, there are 4 components to well-written objectives. Occasionally, these components are not specifically stated, but are implied. For our purposes however, and for anyone who is inexperienced in writing behavioral objectives, it is best to include all four. Components can easily be remembered by the “**A, B, C, D rule**.” This means:

- **Audience**
- **Behavior**
- **Condition**
- **Degree**

Another useful way to remember all components is to remember that behavioral objectives must contain “**who, what, when, and how well**.”
2. Components of Behavioral Objectives\textsuperscript{6,9}

\begin{center}
\textbf{Writing Behavioral Objectives (cont’d)}
\end{center}

Components of Behavioral Objectives\textsuperscript{2}(Kettenbach; Shea et al)

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. <strong>Audience</strong> (the “Who”)</td>
<td>always the learner or patient; never the instructor</td>
</tr>
<tr>
<td>Example</td>
<td>The physical therapy student will...</td>
</tr>
<tr>
<td>b. <strong>Behavior</strong> (the “What”)</td>
<td>what the learner must do, demonstrate, or perform</td>
</tr>
<tr>
<td>Example</td>
<td>DESCRIBE the physics of an ultrasound machine LOCATE the ischial tuberosity</td>
</tr>
<tr>
<td>c. <strong>Condition</strong> (the “When”)</td>
<td>the circumstances under which the objective will be achieved and/or the tools and equipment necessary</td>
</tr>
<tr>
<td>Example</td>
<td>Following a lecture,...  Given a skeleton,...</td>
</tr>
</tbody>
</table>

\textbf{hard, action verbs are best}
d. **Degree** (the “how well”)
def: the level of acceptable performance; how well the learner must perform

may also see this described as “**criterion**”

ex: accurately within one minute

---

**Writing Behavioral Objectives (cont’d)**

**Example of a Behavioral Objective**
Following a lecture, the student will describe the physics of an ultrasound machine accurately.

\[
\text{<condition>  <audience>  <behavior>}
\]

Following a lecture/ the student/ will describe the physics of the ultrasound machine/accurately.

\[
\text{<degree>}
\]

next slide/page
Just to complicate matters a bit more, there are 6 requirements that must be considered when writing a behavioral objective. In addition to containing all 4 components of well-written objectives, there must also be the following:

---

Writing Behavioral Objectives (cont’d)

Requirements of Well-Written Behavioral Objectives

– Student-centered
– Outcome-oriented vs process-oriented
– Outcome-oriented vs just stating material to be covered
– Describe 1 outcome only
– Specific vs general
– Observable and measurable

---

Let’s look at each of these requirements and some examples for clarification. You can find these in your workbooks on page 44.
3. Requirements of Well-Written Behavioral Objectives

Requirements of Well-Written Behavioral Objectives

Student Centered Objective

Incorrect
– The student will be shown how to perform a sliding board transfer.

Correct
– Following a demonstration, the student will safely perform a sliding board transfer for a patient with left hemiparesis. (psychomotor)

Requirements of Well-Written Behavioral Objectives (cont’d)

Outcome-Oriented vs Process-Oriented

Incorrect
– Within 3 days, the student will research iontophoresis.

Correct
– Within 3 days, the student will collect 5 articles on iontophoresis.
Requirements of Well-Written Behavioral Objectives (cont’d)

Outcome-Oriented vs Stating Materials to be Covered

Incorrect
– Biomechanical shoulder problems.

Correct
– Within 3 days, the student will collect 5 articles on iontophoresis.

Requirements of Well-Written Behavioral Objectives (cont’d)

Describe One Outcome Only

Incorrect
– The student will actively seek feedback and remain non-defensive to constructive remarks.

Correct
– The student will actively seek feedback on his performance.

The danger with more than one outcome included in an objective is that the student may meet (achieve) only one portion of the objective and not the other.
Requirements of Well-Written Behavioral Objectives (cont’d)

Specific vs General

Incorrect
– The student will demonstrate initiative.

Correct
– The student will actively seek out opportunities to observe other physical therapists or physical therapist assistants providing patient interventions.

Requirements of Well-Written Behavioral Objectives (cont’d)

Observable and Measurable (cont’d)

Incorrect
– The student will know the principles of motor learning.

Correct
– Prior to this week’s in-service, the student will explain the principles of motor learning.
It's important to use hard action verbs when writing objectives. You should avoid verbs that describe internal states such as "know," "understand," etc.

Try to remember that if you can "see" something, you can measure it.

You cannot “see” if someone “knows” something or if he/she “understands” something. To prove that someone “knows,” or “understands,” you would have to ask him/her to do something else, like “describe,” or “list,” or “explain,” etc. Easier to use these words initially.

Let's practice assessing some behavioral objectives to see if they're well written or not. Turn to page 45 in your workbook for Activity 4.

Take a few minutes and look at these objectives, in light of what we've just talked about.

Activity 4

Assessing Behavioral Objectives
Activity 4

Assessing Behavioral Objectives

1. Are there any components (audience, behavior, condition, degree) missing from the following objectives? If yes, which one(s)?
2. Does each statement satisfy all of the necessary requirements of a well-written objective? If not, why?
3. Rewrite each objective so that it is correct.

Participant see answer key Section VII

next slide for correction

a.1. Behavioral Objectives

a.1. Following a lecture, know the steps in applying a below-knee prosthesis.

No audience, no degree. Verb “know” describes an internal state and therefore cannot be measured except by using another verb.
a. corrected

a.2. Behavioral Objectives

a.2. Following a lecture, the student will correctly list the steps in applying a below-knee prosthesis.

b.1. Behavioral Objectives

b.1. Following a discussion with the CI, the student will study the preferred format for documenting initial examinations.

Components are all there (preferred format = degree), but verb "study" indicates a process rather than outcome.
b. corrected

b.2. Behavioral Objectives

b.2. Following a discussion with the CI, the student will document an initial examination, using the preferred format.

Section II, Slide 74

next slide

CREDENTIALED CLINICAL INSTRUCTOR PROGRAM

Section II, Slide 75

c.1. Behavioral Objectives

c.1. Given all the necessary supplies, the student will correctly demonstrate and explain the proper taping technique for a “goalkeeper’s thumb” injury.

Components are all there (proper = degree), but there are two verbs indicated. It is possible that the student might be able to explain the proper taping but is unable to demonstrate it. In such a circumstance, has the student met the objective or not? The simple correction here would be to write two goals, identical except for the verb.

next slide for correction/page
c.  corrected

c.2. Behavioral Objectives

c.2. Given all the necessary supplies, the student will correctly demonstrate the proper taping technique for a “goalkeeper’s thumb” injury.

d.1. Behavioral Objectives

d.1. The student will be shown how to take blood pressure.

There is no degree included in this objective, and it is instructor centered rather than being student centered.
d. corrected

**d.2. Behavioral Objectives**

By the end of the week, the student will be able to take an accurate resting blood pressure on all patients.

---

Now we will return to the previous Activity 3A and 3B to write objectives based on Scenario 1 for Lucy and Scenario 2 for Curt on pages 41-42.

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**Previous Activity 3A and 3B**

Using Domains to Focus Objectives
Previous Activity 3A

Using Domains to Focus Objectives (from page 41)

Scenario 1:
Lucy has wonderful examination and evaluation skills. Her examinations are complete, thorough, appropriate, effective, and efficient. However, at midterm, Lucy is still having difficulty planning effective treatment programs. She wants to manage all patients with low back pain the same, all patients with adhesive capsulitis the same, etc. Each time you provide her with a suggestion, she readily incorporates it into her “standard” treatment for that particular diagnosis.

1. List 3 short-term behavioral objectives that Lucy may have to work on to eventually achieve the long-term objective.
   1. Lucy will correctly list all the specific interventions appropriate for...
   2. Lucy will explain the rationale for all interventions she has identified.
   3. Lucy will compare and contrast identified interventions vis-à-vis outcomes, cost effectiveness, and resources.

Previous Activity 3B

Using Domains to Focus Objectives (from page 42)

Scenario 2:
Curt is a PT student on his final clinical experience in an inpatient pediatric rehabilitation unit. He is meeting your expectations within the patient/client management model in the areas of examination, evaluation, and interventions. He is very eager to expand his knowledge base and frequently collaborates with other PT staff members for ideas. Your concern at this point is his limited participation in team meetings. He frequently interrupts other team members and does not seem to listen to their opinions. On occasion, he has also missed meetings entirely. When asked “why”, he responds by saying that he needed time to plan for a patient and could “catch up” with other team members at any time during the day if wanted their input.

1. List 3 short-term behavioral objectives that Curt may have to work on to eventually achieve the long-term objective.
   1. Following a team meeting, Curt will recognize the impact of his communication skills on other team members.
   2. Curt will demonstrate value for team meetings by attending ALL meetings as scheduled.
   3. Following each team meeting, Curt will list one example or valuable insight he gained from another team member regarding one of his patients.
F. Characteristics of the Adult Learner

Characteristics of the Adult Learner (Knowles)

1. Is self-directed
2. Brings experience to learning
3. Is problem-centered
4. Demonstrates readiness to learn
5. Seeks relevant concepts
6. Recognizes there is more than one answer


Read the case of Fran, found in Section II, page 48, and jot down your responses to the questions at the bottom of the case.

Activity 5
The Case of Fran
(A former philosophy major)
On her final clinical education experience
### Activity 5

**The Case of Fran**  
*(Former Philosophy Major)*  
**On Her Final Clinical Experience**

Fran mailed her goals for the clinical experience to her center coordinator of clinical education (CCCE) before her clinical experience at an acute care hospital began. On her first day, she told her CI that she was interested in improving her examination skills and gaining the ability to manage her time in an acute care setting.

Her CI has been impressed by Fran’s ability to fit in with the staff and the patients. She attributes her interpersonal skills to her experience as a teacher in a day care center. Fran has asked to be able to select the patients that she manages from each day’s referrals. She maintains a realistic schedule with a caseload of patients with musculoskeletal diagnoses. On several occasions, Fran’s CI has suggested that she manage one of the patients with chronic obstructive pulmonary disease (COPD). Fran said that she is not interested in managing any patients with pulmonary problems because she plans to specialize in pediatrics as soon as she graduates.

1. Which of the characteristics of adult learners do you recognize in this case?
   
   | self-directed learner; problem-centered learner |

2. Is this a problematic situation? If so, why?
   
   Yes. Fran has not sought relevant concepts and is not ready to learn in this area. Fran does not appreciate the implications of respiratory function in a broad array of patient problems.

3. How would you reconcile Fran’s interests and the needs of an entry-level clinician?

   Review with Fran the relationships between pediatric diagnoses and pulmonary physical therapy (eg, cystic fibrosis, asthma, pediatric burns). Discuss pulmonary physical therapy as an entry-level competency.

*see answer key Section VII*

next slide/page for discussion of Fran
The Case of Fran

1. Which of the characteristics of adult learners do you recognize?
2. Is this a problematic situation?
3. How would you reconcile Fran’s interests and the needs of any entry-level clinician?

Instructor’s note: Allow 5-7 minutes for participants to complete this activity.

Ask participants for their answers to questions 1-3.

Note that Fran has demonstrated self-directed and problem-centered learning, both adult learning characteristics.

Fran’s response is a problem, however, as she has missed relevant concepts and does not appear to be ready to learn in this area of chest physical therapy...also adult learning characteristics.

Important points to make with Fran in reconciling this situation would be the relationship between pediatrics and respiratory care. (Kids have lungs, too!! Consider the diagnosis of cystic fibrosis, asthma, or pediatric patients with respiratory complications secondary to burns.)

Furthermore, although pulmonary care may not be a primary interest of Fran’s, it is an entry-level competency expected of all graduates.
Complete Activity 6 in Section II, pages 49-50. This is a compilation of a variety of learning style inventories and will help to provide insight into your learning style. If you find it difficult to choose a single right answer, this may be the result of having several predominant learning styles, or a balanced learning style repertoire. You also might consider using a tool such as this to explore learning styles with students.
### Activity 6

#### Learning Styles<sup>6, 10</sup>

Complete this checklist about how you learn best.

1. When you study new or complex material, (eg, the muscle spindle), do you prefer:
   - _____ a quiet place, such as a library
   - _____ a comfortable living room, with music playing

2. The best time for you to learn new material is:
   - _____ in the morning
   - _____ in the afternoon
   - _____ late in the evening

3. You have enrolled in a “Spanish for Health Professionals” class that meets weekly. Which method do you prefer to review the material?
   - _____ studying with a small group of your classmates
   - _____ studying independently

4. Your department recognizes your knowledge of neurophysiology and has asked you to present an in-service about the muscle spindle. Your supervisor has allowed you to spend 4 hours of your workday preparing your talk. How would you schedule that time?
   - _____ allow 4 free hours either before or after treating patients
   - _____ schedule alternate hours of patient treatments and in-service preparation

5. Which method would you choose to teach the structure of the muscle spindle?
   - _____ lecture about the spindle
   - _____ ask the audience to build a model of the spindle while you describe the basic structure

6. Which are you most likely to remember?
   - _____ written directions drawn on a map
   - _____ directions that someone has told you

7. You are scheduled to change from the inpatient rotation to the outpatient department. Which supervisor’s plan would be more helpful to you in preparing to treat outpatients?
   - _____ We will meet for an hour each week while you are on the inpatient rotation. During this time, I will review the modalities and manual techniques and give you the articles that you will read. I will assess your performance of the interventions/treatment and quiz you on the content of the articles.
   - _____ Try to spend some time in the outpatient area before you start working here. You should look at the equipment, observe some treatments, and look at our library.

8. The vendor came to demonstrate the use of the new isokinetic equipment while you were on vacation. Which method would you choose to learn to use it for quadriceps femoris muscle strengthening?
   - _____ read the manual
   - _____ it looks similar to other equipment; try to figure it out while strengthening your own knee

9. Soft tissue techniques might lessen your patient’s lumbar pain. To determine whether this intervention would be effective, you would
   - _____ try the techniques and continue to use them if the patient improves
   - _____ review the theoretical basis for soft tissue techniques to determine whether this intervention is appropriate for this patient.
### Activity 6

#### Learning Styles (cont’d)

10. What have your responses on the previous page told you about your learning preferences in these areas? Circle the term that correlates with your response.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. Environmental</strong></td>
<td><strong>quiet</strong></td>
<td><strong>noise</strong></td>
</tr>
<tr>
<td><strong>b. Time of day</strong></td>
<td><strong>early</strong></td>
<td><strong>late</strong></td>
</tr>
<tr>
<td><strong>c. Sociological</strong></td>
<td><strong>alone</strong></td>
<td><strong>in groups</strong></td>
</tr>
</tbody>
</table>
| **d. Psychological** | **short bursts** | **long stretches of time**
|   | **of learning** | **spent learning**
|   | **analytical** | **trial-and-error; reasoner** |
| **e. Visual/auditory/kinesthetic/tactile preference** | **tactile/kinesthetic** | **auditory** |
| **f. Visual/auditory/kinesthetic/tactile preference** | **visual** | **auditory** |
| **g. Organization** | **structured experiences** | **create own structure experiences** |
| **h. Learning style** | **concrete experience** | **observation** |
| **i. Learning style** | **experimentation** | **conceptualization** |

11. In what ways are your learning preferences reflected in your teaching style?

12. Do you think a CI’s learning style should be the same as the student’s?

13. In what ways can you match your teaching style to your student’s learning style?

Instructor’s note: If time allows, consider questions 11-13 at the end of Activity 6. Discuss the value of similar and different learning styles between students and CIs. One learning style is not necessarily better than another.

Recognizing the influence of different learning styles in a clinical instruction situation may be helpful as student performance is assessed. Explore this possibility using examples, if appropriate.
G. Learning Style

1. Characteristic manner of learning or problem solving

Most people have a predominant learning style. It is the approach to learning with which they have had the most experience or success or with which they are the most comfortable. This learning style is the preferred style when they are learning something in a stressful environment (perhaps the clinical education setting!) or otherwise feel threatened. Although typically an individual will have skills in several styles of learning, he/she often prefers and is most comfortable with one. Are you one who likes to observe, reflect on, or discuss a new skill before trying to perform it, or are you one who likes to jump right in and experiment with the skill until you get it right? If you have a strong preference, this would suggest a preferred learning style.
2. **May vary for different situations**

   By necessity, we have skills in several learning approaches, although one may be the most comfortable. For example, in the scenario above, if you are an “active experimenter”, you may modify that approach to be more reflective and questioning before experimenting if the task is learning how to attach a new electrical circuit to your fuse box (experimentation may have too many risks in this situation).

3. **Individuals vary in their strengths and weaknesses in acquiring new information or material**

   Different learning styles and the degree to which one is comfortable in one, two, or several styles help to determine our unique strengths and weaknesses as a learner. A person who is comfortable with many styles may be a particularly effective learner, because of his/her comfort with a variety of approaches to learning. Our goal is to help students be flexible learners, comfortable and effective in various types of learning (experimenting, reflective observation, abstract thinking, learning from concrete experiences, and observation).

4. **Learning style affects how you prefer to receive information**

   a. visual
   b. auditory
   c. kinesthetic
   d. tactile

   Information can be received in different ways. Often, it is helpful to receive the same information in several forms (eg, thinking about a PNF pattern done on you and feeling a PNF pattern performed on you). Your preferred method(s) of receiving information provides insight into your learning style. Did you prefer this form? Are there others you would have liked better? Did you reinforce this learning with another form of this same information (eg, read and think about something that you had observed). Answers to these questions provide insight into your learning style.

   As we understand our students’ learning styles, we can consider the methods of receiving information in which they will be most successful, OR we may challenge them to “stretch” themselves by using an approach to learning with which they are less comfortable.
Learning Style (cont’d)

6. Is more pronounced when learning new material.
7. Teaching style parallels learning style.
8. Can change over time.

5. Learning style affects your preferred method of problem solving

   a. experimenting
   b. conceptualizing
   c. experiencing
   d. reflective observation

Because we use information (new and old learning) to solve problems, our learning style influences our approach to problem solving. We may prefer trial-and-error problem solving (experimenting), thinking through the solutions and the best possible choice first (conceptualizing), using our past experience as our guide to new problems (experiencing), or observing the problem and thinking about the problem and solutions (reflective observation). It is the student’s approach to problem solving that you may first observe as a sign of his/her learning style. Use questions and examples with your student to understand and help him/her understand his/her problem solving approach. We are aware that preferred approaches and the demands of the clinic may not always match (eg, in a patient who has a sudden change in physiological state, rapid action may be needed). Conceptualizing options and discussing them may be time consuming in this emergency situation.

6. Learning style is more pronounced when learning new material

Under new and stressful situations, we tend to use what we know to be comfortable and successful approaches. New learning is continually occurring in the clinic. Allow students the opportunity to use what they are comfortable with in new and stressful situations.
7. Teaching style parallels learning style

a. CIs and student’s learning styles need not be identical.
b. Effective teachers consider a student’s learning style when developing learning experiences.
c. CIs must encourage students to learn to use a variety of learning styles.
d. CIs can facilitate the development of other learning styles through questioning and in the design of other learning experiences.

This is a rich area for discussion. We know this statement to be generally true. We will go about teaching others in a way that we are most comfortable learning ourselves. This can become an unnoticed bias for us as CIs, for which we must be on guard. Are you willing (and able!) to shift your teaching style to allow a student to learn in a style with which he/she is more comfortable? (For example, if the student is most comfortable experimenting, can you serve as the experimental subject when it is not appropriate to practice on a patient? Can you supervise in such a fashion as to allow the student reasonable trial-and-error, but also have you feel comfortable stepping in on the treatment if necessary? Can you allow the learning experience to be more spontaneous than rigidly planned?)

8. Learning styles can change over time

Our learning styles are a product of ourselves and our experience. The setting we are in, the type of work that we do (patient care, research, teaching, administration, etc) contribute to our evolving learning styles. Recognize that your style and your students’ style will change over time. This signifies growth and flexibility, both of which are positive aspects of learning. Recognize and encourage changing learning styles. Avoid having learning styles become rigid, restrictive, or overly predictive of an individual. Learning styles are not “fingerprints,” they are a snapshot in time and will shift.

In summary, as we consider these points in the context of clinical education, it is important to keep several points in mind:

- A learning style is not a “fingerprint,” rigid and fixed, it changes with time and suggests only a preferred or most comfortable approach to learning.
- Our goal with learning styles is to help students develop their ability with all learning styles, while recognizing that they may be most comfortable with one style, and use that preferred style in stressful, new, or very challenging situations (eg, clinical education). We therefore need to challenge them to use behaviors from less comfortable learning styles in appropriate circumstances.
H. Learning Style Resources

Additional Information About Learning Styles

1. Kolb Learning Style Inventory

2. Myers Briggs

3. Emotional Intelligence

4. True Colors
Activity 7
The Case of Raj
(Labeled a Lazy Learner by Lorraine, his CI)

Instructor’s Note: This case might raise questions about cultural differences based on gender, ethnicity, or other diversity issues. The case does not include any information on the cultural background or beliefs of the “players”. If participants raise problems or changes that might be related to cultural differences, it is an opportunity to note that one cannot make assumptions based solely on an individual’s name. The Trainer may ask how cultural differences as a source of the problem were identified. Cultural differences and bias in clinical education will be discussed later in Sections IV and V.
The Case of Raj

- What problems can you identify in this case?
- What changes should Lorraine make?
Activity 7

The Case of Raj
(Labeled a Lazy Learner by Lorraine, His CI)

It is Thursday of the first week of Raj’s second clinical experience. We are listening to his CI, Lorraine, as she speaks with Cheryl, the CCCE.

L: “He never finishes his notes on time. When he is in the staff room, he seems distracted by the conversation and does not write anything down. When we have 5 minutes free between patients, he never bothers to write any notes or use that time to look things up.”

C: “I assume that you have made that one of your objectives for the student for this clinical experience?”

L: “Yes. Objectives are another problem. Ever since I attended the CI workshop, I have found it very effective for the student and CI to set objectives. Every day I have asked Raj to write objectives and he still has not completed them.”

C: “Do you think he is overwhelmed and is forgetting to do things?”

L: “I don’t think so. He has no problem doing anything I tell him, even though he never writes anything down.”

C: “How is Raj doing with designing and writing a plan of care for patients?”

L: “What plan of care? He never seems to plan, but just goes ahead and treats the patients. His motto seems to be treat first, then write a plan that fits with what you have done.”

C: “Are the interventions appropriate and effective?”

L: “Usually. I don’t know how he generates them. You know how the physical therapists from our unit usually get together to discuss patients and brainstorm about possible interventions? Raj never participates in these conversations. I feel like he does not want to be there.”

1. What problems can you identify in this case?

Notes are not completed on time. He does not use his free time well. He has not written learning objectives. Patients’ plans of care are not clearly defined and written. He does not participate in staff discussions on patient problem solving. A broader problem may be that Raj and Lorraine approach learning differently with different learning styles.

2. What changes would you make in Lorraine’s method of instructing Raj?

Consider strategies that allow Raj to use his predominant learning style (ie, discuss with Raj when it is appropriate to be “experimental” in his clinical learning). Consider strategies that push Raj to use less dominate learning styles (ie, develop a series of alternative plans of care in advance, identifying why they are indicated). Clarify for Raj those responsibilities that are “non-negotiable” regardless of learning style (ie, notes written in a timely fashion).
Instructor’s note: Allow 5-7 minutes or enough time for participants to complete this activity.

Ask for participants’ responses to the questions and guide a discussion of these.

The primary problem between Raj and Lorraine is that they each have a different learning style. Raj seems to be an active experimenter and hands-on learner; Lorraine appears to be a planner and organizer.

It appears that Raj gets reasonable results and has reasonable ideas for treatment, although these are not well organized in advance. On the other hand, there are some imperatives of clinical practice (eg, notes must be written and submitted on time; plans of care must be documented and thorough, regardless of learning style).

Discuss with participants the ways in which each of these learning styles can be recognized and valued between Raj and Lorraine.

Consider strategies that allow Raj to use the learning behaviors in his predominant learning style (eg, to experiment with confidence and think on his feet), while attempting to enhance those learning behaviors which may be less comfortable (eg, developing a series of alternative plans for treatment, in advance). Ultimately, this strategy will round out his learning abilities (and Lorraine's) in the most comprehensive way.

As noted in the Case of Raj, recognizing the influence of different learning styles in a clinical instruction situation may be helpful as student performance is assessed. Explore this possibility using examples, if appropriate.
Does anyone have any questions before we wrap up Section II? We've given you a lot of information in a very short time, and we expect that some of you may be struggling with system overload. But your workbooks are inclusive of what we've discussed and will be a good reference for you after the workshop concludes. For this section, we've also provided some additional practice in looking at objectives and domains that you can do at your leisure. It can be found on page 53, Activity 8.
Activity 8

Additional Practice

Examine each of the following behavioral objectives for correctness. a) Does each contain the necessary components? b) Does each meet the requirements (possess the characteristics) of a well-written objective? c) Correct any poorly written objective. d) Identify each component. e) Identify the domain of each objective.

1. The student will distinguish between motor planning problems and weakness in a patient with hemiplegia.

2. By seeking out appropriate guidance from the CI, the student will demonstrate acceptance of limited knowledge and experience.

3. The student will prepare treatment space for an established plan of care for a child with hyperactivity.

4. The student will list appropriate tests and measures for the examination of a patient complaining of knee pain.

5. The student will describe the necessary tests and measures for identification of a torn meniscus and explain the purpose of each test and measure.

6. The student will correctly reproduce a neurodevelopmental treatment program after observing the program two times with the same patient.

7. The student will demonstrate professional behavior.

8. The student will demonstrate the ability to objectively identify manipulative behavior and maintain an appropriate helping relationship.

9. The student will demonstrate the ability to set appropriate priorities by completing assigned responsibilities on time.

10. The student will defend his/her choice of neurodevelopment treatment or proprioceptive neuromuscular facilitation technique in the management of a patient with traumatic brain injury.

11. The student will research the effects of hydrotherapy.

12. The student will be motivated.

13. The student will design a plan of care for a child with cerebral palsy using an integrated program of therapeutic exercise.

14. The student will assess his/her performance following delivery of physical therapy interventions and critically analyze that performance for completeness, effectiveness, and efficiency.

15. The student will document the results of an initial examination thoroughly, concisely, and within 1 hour.
Instructor's note: If time allows, you may want to run through a few of the additional practice items. Those selected below provide a range of domains and problems. If pressed for time a few remarks to bring closure to the section are appropriate, followed by break or introduction to the next section.

Additional practice in looking at objectives and domains can be found on page 25 after the taxonomies. Refer to the following questions for the items below: a) Does each contain the necessary components? b) Does each meet the requirements (possess the characteristics) of a well-written objective? c) Correct any poorly written objective. d) Identify each component. e) Identify the domain and the level within the domain of each objective.

Let's just look at a couple for practice.

4. The student/will list <appropriate> tests and measures/for full examination of a patient complaining of knee pain.
   a) yes               d) audience = the student       e) cognitive
   b) yes               behavior = will list
   c) no corrections    condition = “test and measures….pain”
                        degree = appropriate

6. The student/will <correctly> reproduce a neurodevelopmental treatment program/after observing the treatment two times with the same patient.
   a) yes               d) audience = the student       e) psychomotor
   b) yes               behavior = will reproduce
   c) no corrections    condition = “NDT treatment…same patient”
                        degree = correctly

9. The student/will demonstrate the ability to set appropriate priorities/by completing assigned responsibilities on time.
   a) yes, condition implied d) a = the student       e) affective
   b) yes               b = will demonstrate
   c) no corrections    c = “set appropriate priorities…responsibilities”
                        d = on time

12. The student/will be motivated.
   a) no; no condition, no degree
   b) no; not measurable except by virtue of some other observable behavior
   c & d) In the clinic setting, the student will demonstrate motivation by asking to observe how other therapists provide treatment.
   e) affective
TAXONOMY OF EDUCATIONAL OBJECTIVES FOR LEARNING

The Cognitive Domain (Bloom, from Ford)

Knowledge
- cite
- count
- define
- draw
- list
- name
- record
- relate
- repeat
- underline

Comprehension
- apply
- calculate
- demonstrate
- dramatize
- employ
- examine
- illustrate
- interpret
- operate
- practice
- schedule
- sketch
- solve
- use

Application
- analyze
- appraise
- calculate
- categorize
- compare
- contrast
- debate
- diagram
- differentiate
- examine
- inventory
- question
- test

Analysis
- arrange
- assemble
- collect
- compose
- construct
- create
- design
- formulate
- integrate
- manage
- organize
- plan
- prescribe
- propose

Synthesis
- appraise
- assess
- choose
- compare
- criticize
- estimate
- evaluate
- judge
- measure
- rank
- rate
- revise
- score
- select

Evaluation

Cognitive Domain: Classification of Behavioral Objectives

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Remembering by recognition or recall facts, ideas, material, or phenomena</td>
</tr>
<tr>
<td>Comprehension</td>
<td>Understanding the literal message contained in a communication by translation, interpretation, or extrapolation</td>
</tr>
<tr>
<td>Application</td>
<td>Selecting and using technical principles, ideas, or theories in a problem-solving situation</td>
</tr>
<tr>
<td>Analysis</td>
<td>Breaking down material into constituent parts and relating how the parts are organized</td>
</tr>
<tr>
<td>Synthesis</td>
<td>Putting together elements and parts to form a whole that constitutes a new structure or pattern</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Making qualitative and quantitative judgments in terms of meeting criteria</td>
</tr>
</tbody>
</table>

Instructor Note: Loren Anderson and colleagues\(^{11}\) have reorganized and updated Bloom’s Cognitive Domain with a new format, but we chose to keep the initial format in order to remain consistent with the Psychomotor and Affective Domains. If anyone would like information about the updated taxonomy, refer them to the reference list.
TAXONOMY OF EDUCATIONAL OBJECTIVES FOR LEARNING

The Psychomotor Domain (Simpson, from Ford)

Perception
- distinguish
- hear
- see
- smell
- taste
- touch

Set
- adjust
- approach
- locate
- place
- position
- prepare

Guided Response
- copy
- determine
- discover
- duplicate
- imitate
- inject
- repeat

Mechanism
- adjust
- build
- coordinate
- demonstrate
- manipulate
- mix
- set up

Complex Overt Response
- calibrate
- coordinate
- demonstrate
- maintain
- operate

Adaptation
- adapt
- build
- change
- develop
- supply

Origination
- construct
- create
- design
- produce

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception</td>
<td>Being aware of objects, qualities, or relations through the senses: selecting relevant cues, and relating the cues to motor acts</td>
</tr>
<tr>
<td>Set</td>
<td>Being ready for response to through mental, physical, and/or emotional set</td>
</tr>
<tr>
<td>Guided Response</td>
<td>Imitating the performance of another person and/or repeating performance until correct (trial and error)</td>
</tr>
<tr>
<td>Mechanism</td>
<td>Responding to the demands of a situation with confidence and a degree of proficiency</td>
</tr>
<tr>
<td>Complex Overt Response</td>
<td>Performing without hesitating and with coordinated muscle control</td>
</tr>
<tr>
<td>Adaptation</td>
<td>Altering basic motor responses to enact demands of new situations</td>
</tr>
<tr>
<td>Origination</td>
<td>Creating new motor acts or ways of manipulating materials</td>
</tr>
</tbody>
</table>
TAXONOMY OF EDUCATIONAL OBJECTIVES FOR LEARNING

The Affective Domain (Krathwohl, from Ford)

### Affective Domain: Classification of Behavioral Objectives

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving</td>
<td>Being aware of phenomena and stimuli and willing to control and direct attention</td>
</tr>
<tr>
<td>Responding</td>
<td>Complying with a suggestion, being willing to respond, and responding with satisfaction</td>
</tr>
<tr>
<td>Value</td>
<td>Accepting a value as a belief, preferring the value, and pursuing the value.</td>
</tr>
<tr>
<td>Organizing</td>
<td>Conceptualizing a value and organizing a value system into an ordered relationship</td>
</tr>
<tr>
<td>Characterizing an Internally Consistent Value System</td>
<td>Acting with consistency in accordance with values that are integrated into a total philosophy or world view</td>
</tr>
</tbody>
</table>
References

11. Website Bibliography on Learning Styles and Adult Learning; http://www.cyg.net/~jblackmo/diglib/bibl.html
Section III

Facilitating Learning in the Clinical Environment
Introduction

Section III takes the elements of learning, levels of domains, stages, qualities of the adult learner, and learning styles and applies them to the development of the clinical learning environment. Emphasis is on using a learning assessment for designing learning experiences. The section begins with developing a learning diagnosis and considering the available resources of the facility. From that point, the clinical instructor and student will develop mutually agreeable objectives, plan for weekly learning opportunities and ways to develop adult learning, create learning opportunities, and determine the appropriate teaching and supervisory techniques. The clinical instructor skills of ensuring practice, judicious questioning, effective feedback, and active listening lead to effective assessment, which is the focus of Section IV. Your presence at this course signifies a level of readiness and focuses on another important aspect: the CI’s preparation for teaching in the clinical environment.

Instructor's note: Where possible throughout this section, refer back to the first 2 components of the learning experience – the CI and the student. The purpose of this is to draw connections between each of these 3 components so that the participants recognize them and understand how they interrelate in the student's learning experience.
Objectives

Following the completion of Section III, the participant will be able to:

1. Recognize the resources available to facilitate clinical education.
2. Identify supervisory techniques conducive to effective learning.
3. Apply supervisory techniques for questioning students in a manner that facilitates problem solving.
4. Describe how clinical instruction can be designed to support the development of an adult learner.

5. Recognize the value of feedback in promoting change in student behavior.
6. Recognize the importance of practice in designing appropriate learning experiences.
7. Apply teaching and learning methods to achieve learning goals in the clinical setting.
8. Develop a quality learning experience for a given situation using a systematic process.
6. Recognize the importance of practice in designing appropriate learning experiences.

The clinical environment offers opportunities and places demands on the learning experience. These opportunities include (1) actual clinical problems around which to ask questions, apply knowledge, and consider appropriate interventions, (2) practice for the purpose of mastery of skills, and (3) a context in which to synthesize information, skills, and values as they apply to clinical problems.

7. Apply teaching and learning methods to achieve learning goals in the clinical setting.

8. Develop a quality learning experience for a given situation using a systematic process.

The demands include (1) the necessity of supervision to ensure effective and safe interventions and treatment, (2) a level of student readiness that is appropriate to the demands of the clinical setting, and (3) a level of teaching effectiveness that enables the CI to use the learning opportunities of the clinical environment effectively and efficiently.

The objectives of this section address those skills of the CI that are necessary to optimize the use of the clinical environment while ensuring that the demands of the setting are respected and satisfied.
Assumptions

1. Effective learning is planned.
2. Effective learning only takes place in a setting that is conducive to learning.
3. The process of clinical education should foster characteristics of adult learning.
4. Feedback is a key ingredient for effective learning.

The clinical environment offers many spontaneous learning opportunities; a "teachable moment" that just comes along without being planned by the CI or the student. The experienced CI can often seize this opportunity and create a unique and valuable experience for the student.

Despite these "teachable moments," however, our goal is to plan learning for our students. This is necessary to ensure that the student learns adequately and completely, as well as to optimize the efficiency of the learning experience in a complex and demanding setting.

Our goal is to move students from a recognized starting point to an adequate entry-level performance in a reasonable amount of time. This can be done most effectively only when a plan is in place. Your plan may need to change...but it is much easier to modify something than it is to create it initially. Students will progress through the stages of learning noted earlier, requiring feedback at each of these stages to progress to the next stage.
Assumptions (cont’d)

5. Learning is most effective when the student is an active participant in planning and progressing learning experiences.

6. Practice is essential to effective learning.

7. Effective learning experiences can be many and varied.

We expect students to take on the characteristics of an adult learner in this environment because the CI has a responsibility to many: the patient, the profession, the institution, and the student.

No environment will offer students a more realistic setting in which to practice skills toward mastery than the clinical environment.

Instructor’s note: Ask participants to think of a skill that they have recently learned in the clinical setting and to think about how the environment contributed to or challenged this learning experience. It may be useful for the participant to jot this example down for future reference.
Instructor’s note: Ask participants to consider what these expectations mean to them. Have them create examples to share with the group. Comment as necessary to ensure that key points below are identified.

You may wish to use guiding questions such as those listed below to introduce the process steps in designing an effective learning experience.

Identify 3 skills a student can learn in your setting. Ask yourself, “What can I, in this setting, make available for this student to learn?”

- How do you begin to teach this skill to a student with little or no clinical experience?
- How would you teach this skill differently to a student who has some clinical experience?
- How can you make this skill more challenging for a very experienced student?
- What are the expertise of staff (Activity 1 will address this further)?
A. Process for Designing Learning Experiences

Process for Designing Learning Experiences

1. Define a “learning diagnosis”
   a. Determine the student’s stage of learning
   b. Determine the student’s level of learning within a domain
   c. Determine the student’s learning style(s)
   d. Determine the student’s adult learning qualities
      i. Display all of the characteristics of an adult learner
      ii. Take appropriate risks in providing patient/client care
      iii. Demonstrates the ability to analyze the learning situation correctly

In Section II, we discussed the characteristics of the adult learner. In creating an effective environment, it is important that the student understands your expectations of him/her. This is his/her part of the “contract” in this learning experience.

Make it clear that you expect these behaviors!

Students should be active in making their learning needs and interests known. They should help in identifying learning opportunities that exist in the clinical setting that would be useful for them. Once necessary learning experiences have been identified, the student can work on implementing and evaluating the experience. The student is a PARTNER in, not just a recipient of, the learning process.

What questions can you ask to help your students analyze a situation? How do you fit time for these questions into your daily schedule?

Learning experiences are continually being evaluated, modified, and reevaluated. Students should be expected to participate in this analysis. Students should be part of assessing their own performance, but can be involved in more than that. Students can offer suggestions regarding how to improve a learning experience, how they might better prepare for the learning experiences, and how learning experiences can be sequenced more effectively. An opportunity to assess the learning experience with the students should be built into your schedule whenever possible.
Give me some examples of how to set up situations for students that are “safe risks.”

Students must stretch themselves, their abilities, and their expectations. Students should be encouraged to put themselves in increasingly challenging situations, perform with less restrictive supervision and guidance once safe and able to demonstrate clinical competence, and ultimately be able to think and make patient decisions for themselves. Students should understand that this kind of growth is expected of them in the clinical setting. Students can participate in this advancement of their clinical performance through challenging themselves with appropriate CI guidance and communication.

What are some ways to develop a student's ability to reassess his/her performance? How do you fit these activities into your schedule?

Every learning experience has been only partially utilized until it has been reassessed after the fact. What worked and what did not work? What was learned, not learned, expected, unexpected? What is the next step? Thinking about these questions helps students to reflect on and learn from their past experiences. By reinforcing this kind of reflection, students will become thoughtful in their experiences, not just experience them. Students should be expected to participate in this reflective process with the CI or independently.

Make these expectations of the student clear! AND make it clear to students that THEY have a responsibility in creating the best learning environment for themselves; it is not just your responsibility. Use opportunities such as the initial orientation, weekly meetings, and informal feedback sessions to reiterate them.

Remember that the student's ability to assume these expectations will relate to his/her “readiness.” Therefore, performance among students may vary considerably.

Your expectations should remain the same. How you support the student in reaching your expectations will vary with each student.
2. Consider the Available Resources
   There are 2 general categories of resources for consideration.

   Process for Designing Learning Experiences (cont’d)

2. Consider the available resources
   a. Departmental facility/facility resources (ie, breadth of experiences and resources)
   b. Clinical education resources (ie, depth of resources)
   c. APTA Guidelines for Clinical Education Sites

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a. *Departmental/facility resources*: These resources allow you to provide a breadth of experiences for your students to broaden their exposure.

b. *Clinical education resources*: These resources allow you to focus the clinical education experience to provide some depth to the experience. They can also be thought of as your clinical education support system.

1. Facility-based resources
2. Professional organization resources (eg, educational program, consortia, APTA)

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Some of the resources you may want to consider are included in your workbook on page 65.
The next activity (Activity 1) can be a useful activity to do at a staff meeting. Use some of these ideas as a basis for discussion with your department.

Activity 1
Recognizing Resources at Your Facility
Activity 1

Recognizing the Resources at Your Facility

- Consider the resources at your facility.
- Use a “+” to indicate those that you feel are strongly represented in your facility.
- Place a “-” next to those that are present but that could benefit from further development.
- Leave blank those that are not present or that do not occur in your facility.

*This activity may be used to stimulate departmental discussion and help you to identify plans for change within your department.*

A. Departmental/Facility Resources

Resources in this category assist you in developing the breadth of your clinical education program.

- patient variety/types
- physical environment (consider available space, equipment)
- expertise of clinical staff
- interdisciplinary/team approach
- community involvement
- opportunity to interact with physicians/other disciplines
- in-service programs (departmental, facility-wide)
- opportunity to observe other services (eg, surgery, cardiac lab).
- grand rounds
- opportunity for students to practice patient care
- opportunity to interact with other students in physical therapy; in other disciplines
- opportunity to experience relationship between rehab services and other support departments (ie, risk management department)

B. Clinical Education Resources

These resources allow you to focus the clinical education experience for an individual student. They allow you to provide depth to the experience and to modify the student experience as necessary.

- atmosphere receptive to students
- staff interested/invested in the clinical education process
- staff willing to share expertise
- experienced/skilled educator as CCCE
- administrative support/commitment to clinical education
- written program of expectations for student performance
- clinical education policy/procedure manual
- support for CI training
- staff trained in clinical supervision
- mechanism exists to effectively and efficiently manage communication between the clinical site, academic program, and student should a problem arise
- staff has an ongoing relationship with the ACCE of the student’s academic program (ie, opportunities for interaction, sharing of information, etc.)
2. Consider the available resources

APTA Guidelines for Clinical Education Sites

“The intent of these guidelines is to provide academic and clinical educators direction and guidance in the development and enhancement of clinical education sites and physical therapist and physical therapist assistants CIs and CCCEs. These documents reflect the nature of current policies and also reflect the future of physical therapy clinical education…”

Instructor’s note: The depth of the clinical education resources include facility resources, as well as the wealth of APTA resources. For example: Inform the participants that APTA Guidelines for Clinical Education Sites is available to members as a download or a bound copy that includes the clinical instructor, center coordinator of clinical education, and clinical site guidelines.

You can show the yellow bound copy (APTA E-48; Guidelines and Self-Assessments for Clinical Education) that can be purchased from the APTA online store.

http://iweb.apta.org/Purchase/CatalogSearchResults.aspx?Option=2&Topic=Clinical+Education

In planning for any learning experience, part of the process includes defining a “learning diagnosis” by considering each of the aspects of learning previously discussed in Sections I and II. Consider the student's:

- **stage of learning** (exposure, acquisition, and integration/mastery) in a particular skill.
- **type of learning** (cognitive, psychomotor, and affective) needed.
- **level of learning** as described in the taxonomies of each of the domains, and
- **adult learning qualities** (self-directed, prior learning experiences, problem-centered, readiness to learn, seeks relevant concepts, and recognizes there is more than one answer) of the learner.

All of these items, considered together, provide you with the starting point for the student.
Activity 1 provided an opportunity for participants to explore their facility’s departmental and clinical resources.

Ask yourself this question, “What can I, in this setting, make available for this particular student to learn?”

The components of the answer to this question are on the slide: the resources of the facility, the stage of learning the student is prepared for, and the levels of performance that describe the student's starting point and desired end point.

These factors determine how the environment can be used for the learning benefit of the student.

Any environment can be made effective, although admittedly some lend themselves to students better than others. This is where the planned aspect of a learning experience becomes critical. The resources of the environment must fit with the needs of the student. The effectiveness of the environment is determined by how well the resources are suited to a particular student's needs.

Instructor’s note: Use examples to illustrate this point of combining environmental resources with student needs. For example: A student on his/her first clinical experience in a general hospital with you on a neurological rotation: appropriate experiences may include observing a history and initial examination or asking the student to make a list of appropriate interview questions and to describe the components of the initial examination (not detailed). Although this combination of student needs (first-clinical experience) and clinical resources (neurological rotation) initially may not appear to fit well, this example demonstrates how these resources and needs can be combined in a reasonable manner.
3. Develop mutually agreeable behavioral objectives

**Process for Designing Learning Experiences (cont’d)**

3. Develop mutually agreeable behavioral objectives (Refer to Section II for developing behavioral objectives)

4. Plan for weekly learning opportunities
   a. Document student progress, weekly behavioral objectives, and learning activities.
   b. Use the Weekly Planning Form

The process of developing mutual objectives should be shared by the CI and the student. For the student who is inexperienced with writing objectives, the CI might "guide" the student by providing some "sample objectives," and by describing the components of a well-written objective. For the student who is already comfortable with the composition of objectives, the CI might help the student focus on the appropriate content areas and levels (of learning) for his/her objectives. The final list of objectives should be acceptable to both the student and the CI.

Let's apply what we've just been talking about. This next activity gives you a chance to think about the student's preparation for learning by asking you to consider what he/she must know or be able to do in order to successfully complete a particular objective.
4. Plan for weekly learning opportunities

Use of the Weekly Planning Form

Use of the Weekly Planning Form

Use of the weekly planning form allows the CI to:

i. provide regular written feedback

ii. encourage student self-assessment

iii. track student progress

iv. modify weekly goals with student input

v. provide feedback in a supportive environment

vi. promote collegial planning of learning activities
Use the Weekly Planning Form (cont’d)

vii. provide an opportunity to review the past week and assess how closely the student is approaching achievement of the learning objectives

viii. revise plans to meet student needs in the following weeks

ix. assess the accuracy of the initial learning diagnosis

x. assess the effectiveness of the facility resources

xi. assess student progress toward achievement of behavioral objectives

Instructor’s note: The Weekly Planning Forum is a bit different in that it is proactive rather than reactive. It is very useful in planning the clinical experience and helping to keep the learning experience on track. We recommend that this form, or something similar, be used as a matter of course for every student on every clinical experience.

This form gives the opportunity to review the past week and assess how closely this student is approaching achievement of the objectives. Likewise, the form provides the opportunity to revise plans for subsequent weeks.

Of special note is the opportunity for the student to add his/her input. This makes the student an active participant in the process and helps to maintain the dialogue.
## Weekly Planning Form

| Dates: ______________________ | Week Number: ______________________ |

### STUDENTS REVIEW OF THE WEEK
When completing this form consider the five (5) performance dimensions: quality of care, supervision/guidance, consistency of performance, complexity of tasks/environment, and efficiency of performance.

### CI’S REVIEW OF THE WEEK
When completing this form consider the five (5) performance dimensions: quality of care, supervision/guidance required, consistency of performance, complexity of tasks/environment, and efficiency of performance.

### GOALS FOR THE UPCOMING WEEK OF ________________

| Student’s Signature ________________ | CI Signature ________________ |

next slide/page
Activity 2

Matching Student's Level of Preparation to the Objectives
Activity 2

Matching Student's Level of Preparation to the Objectives

This activity is to practice designing a learning experience by determining a learning diagnosis, considering the facility resources, and developing mutually agreed upon behavioral objectives. Each group will work as a clinical instructor and student who are working together in a supportive environment.

For each of the situations described below, consider the learning diagnosis, then write a behavioral objective for the task described. Then list the background information and facility resources that would be required for the student to successfully complete the objective you have written.

1. Donna is a mature and persuasive third year PT student on her second full-time clinical education experience. She excelled in her first full-time experience in an outpatient orthopedic practice setting. Consuela, her CI is an experienced clinical instructor at a 75-bed community hospital. Donna believes that additional medical diagnostics, possibly an MRI, are indicated to better assess the patient. Donna consults with Consuela about obtaining an MRI for the patient. Consuela agrees.

   a. **Background information:** Based on academic and clinical experiences, is Donna able to: state the rationale for medical diagnostic testing and use of MRI, relate to previous experience with physician therapist interaction, and explain the patient’s medical background?

      What were her previous clinical education experiences? What evidence does Donna have to support her opinion? What has been Donna’s previous interactions with physicians? Is this patient's physician receptive to requests from a Physical Therapist?

   b. **Facility resources:** a. Interdisciplinary/team approach; b. Opportunity to interact with physicians/other disciplines, c. Have physicians receptive to Physical Therapists’ requests for testing; d. Experience/skilled clinical educator

   c. **Behavioral goal:**

      Donna will provide a persuasive, clear and concise consultation with the physician for the necessity of an MRI for this patient, by the end of this week. *(Donna may be persuasive and correct, but the MD will not agree)*

2. Juan is an organized PTA student in his second clinical education experience. Ivan, a novice clinical instructor, is his CI at a large teaching hospital. The physical therapy department regularly teaches a class on safe patient handling techniques to the nursing assistants at the hospital, and the PT director asked Juan to teach the next upcoming class.

   a. **Background information:** Based on academic and clinical experiences, is Juan about to: demonstrate knowledge of safe patient handling techniques, perform body mechanics, use teaching skills, prepare (including completing required content) materials, provide appropriate pacing, and assess participants understanding of the information?

   b. **Facility resources:** a. Appropriate space; b. Outline of course content; c. CI who is willing to share expertise.

   c. **Behavioral goal:**

      Juan will instruct the nurse’s aide body mechanics workshop, scheduled for 3 weeks from today, independently, addressing the required content and skills.
Activity 2 (cont’d)

Matching Student's Level of Preparation to the Objectives

This activity is to practice designing a learning experience by determining a learning diagnosis, considering the facility resources, and developing mutually agreed upon behavioral objectives. Each group will work as a clinical instructor and student who are working together in a supportive environment.

For each of the situations described below, consider the learning diagnosis, then write a behavioral objective for the task described. Then list the background information and facility resources that would be required for the student to successfully complete the objective you have written.

3. Suzanne is a PT student on her second clinical education experience. Marc is her CI in a skilled nursing facility. Marc is also the CI for Dianna, a PTA student on her final clinical education experience. Suzanne has been working on supervising support personnel. Marc asks Suzanne to direct and supervise Dianna in the intervention of a patient, who Suzanne just examined and evaluated.

a. Background information: Based on academic and clinical experiences is Suzanne able to: demonstrate knowledge of the roles and responsibilities of a PTA, of adult learner characteristics, and of effective personal interactive skills?

b. Facility resources: a. Opportunity to practice patient care; b. Opportunity to interact with other students in physical therapy; c. Atmosphere receptive to students; d. An experienced/skilled CI; and e. Valuable resources related to direct supervision, best practice, state laws and regulations, and Medicare requirements for supervision of support personnel.

c. Behavioral goal: By the end of the week, Suzanne will appropriately direct and supervise Dianna’s work with a patient assigned by the CI.

Instructor's note: Allow 5-10 minutes for completion of Activity 2. Ask participants to share their responses and discuss as a group. Use these examples to explore the inter-relatedness of the learning need, the learning environment, and the student's readiness for successful completion. This activity serves to reinforce this interaction.

NOTE: The examples above are in no way exhaustive of all the possible responses. This activity can be done alone, in pairs, or in triads.
5. Promote Adult Learning

Activity 3
5. Promote Adult Learning

The characteristics on the left side are taken from the work of Malcolm Knowles, as he investigated adults learning new skills in the working environment. Garrett McAuliffe proposed that the guidelines on the right could be integrated into learning opportunities in order to facilitate development of adult learning.

Recognize that students may already be adult learners in some ways, and not so characteristic of adult learners in others. For example, they may be highly self-directed and demonstrate a readiness to learn, but they may have little experience to bring to bear on a new learning experience; or they may fail to use what experience they have to assist them in the new learning experience.

You will see students mature as adult learners through the clinical education process, but anything the Clinical Instructor can do to facilitate that development will benefit the student, the CI, the patient, and the profession. Which of McAuliffe’s guidelines on the right do you think could be used in the clinic to develop each specific characteristic on the left?

Instructor note: Divide participants into small groups and have each group work on one Adult Learning Characteristic from the left side, using Guidelines from the right side to develop example(s) of how that characteristic could be fostered in the clinic. Limit time to 10 minutes. Emphasis on using this as a resource. Do not need to spend a lot of time going through each individual guideline. The rest of the content in this section will help to reinforce the information here.
Activity 3

Adult Learning

For each of the items on the left, select all of the guidelines on the right which you feel would assist in promoting that specific characteristic, and provide an example. (You may use each guideline more than once.)

<table>
<thead>
<tr>
<th>Characteristics of the Adult Learner</th>
<th>Guidelines for Promoting Adult Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is self-directed</td>
<td>1. Links new concepts to what students already know</td>
</tr>
<tr>
<td>2. Brings experience to learning</td>
<td>2. Varies teaching methods</td>
</tr>
<tr>
<td>3. Is problem-centered</td>
<td>3. Encourages active learning</td>
</tr>
<tr>
<td>4. Demonstrates readiness to learn</td>
<td>4. Highlights alternative viewpoints</td>
</tr>
<tr>
<td>5. Seeks relevant concepts</td>
<td>5. Models and encourages reflection, not only on performance, but also on interactions with others.</td>
</tr>
<tr>
<td>6. Recognizes there is more than 1 answer</td>
<td>6. Questions assumptions</td>
</tr>
<tr>
<td></td>
<td>7. Acknowledges tension when foreign/new concepts are introduced</td>
</tr>
<tr>
<td></td>
<td>8. Is open to other answers as students move forward</td>
</tr>
</tbody>
</table>
6. **Create learning opportunities**

**Process for Designing Learning Experiences (cont’d)**

6. Create learning opportunities
   a. Provide multiple opportunities for practice
   b. Meet more than 1 behavioral objective
   c. Integrate a variety of learning experiences
   d. Minimize negative learning
   e. Consider a variety of teaching/learning methods

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**Section III, Slide 103**

**a. Provide multiple opportunities for practice.**

How do you manage to provide opportunities for practice in your clinical setting? How do you arrange time to intersperse these opportunities?

**b. Meet more than 1 behavioral objective for the student.**

Once you have determined what needs to be learned and then what can be learned, consider how this can be accomplished. Look for patients or patient experiences in which several learning needs of the student can be addressed. Learning comes to life in the clinic because it can be wrapped around real patient circumstances. Take advantage of this by looking for patients that suit the student's needs.

Patients are unlikely to match exactly with the needs of your student (eg, the learning need may be to complete, an inpatient history and initial examination of or selected intervention (PTA student) for a patient with a simple musculoskeletal problem; however, you only have patients with acute multiple orthopedic trauma). Consider having the student doing the portions of the history and initial examination or selected interventions that are appropriate, but also consider having the student practice range of motion (ROM) or manual muscle testing (MMT) with this patient (or practice ROM or MMT prior to and following an intervention if a PTA student), if that is also a goal for the student. Don't wait for the "perfect patient." Students need to understand that all patients provide a learning opportunity.
d. Minimize negative learning

How do you manage the situation when the student makes a mistake?

As a learning environment is harnessed to provide opportunities in each of these steps, the CI must also provide correction and reinforcement of correct performance. This involves supervision of the student, effective feedback to the student, and the opportunity to practice.

**Practice must reinforce correct performance not the repetition of errors.** Therefore, be sure that the environment allows for correction before reinforcement of a new skill.

e. Consider a variety of teaching/learning methods

We have already discussed styles of learning and their effect on teaching. Consider what you know about the student's learning style. Consider also what you know about your own style(s) of teaching. Now consider what it is you are trying to teach. Is there a particular teaching method or technique that is best suited to these particular objectives? To help you determine this, we will soon be presenting a variety of teaching methods that you might consider.

Instructor's note: Use an example or story of learning correct performance rather than incorrect performance (e.g., the piano teacher often plays for the student so that he/she may hear and see the correct performance, not just his/her own errors).
7. Use a variety of teaching methods to structure effective learning experiences

**Process for Designing Learning Experiences (cont’d)**

7. Use a variety of teaching methods to structure effective learning experiences
   a. Demonstration and practice
   b. Research
   c. “Paper” patients
   d. Patient simulation
   e. Media resources
   f. Journals (reflective)
   g. Observation
   h. Collaborative learning
   i. Mental imagery

Many teaching/learning activities exist that serve to stimulate and reinforce learning. These are only a few, but ones that have been used successfully in clinical education experiences.

a. Demonstration and practice

The importance of practice to successful learning cannot be overly stressed. Using it as a teaching technique usually means supervised practice situations in which the CI can provide immediate feedback, offer demonstration, and ensure correct performance from the beginning. Limitations on this technique may exist in the clinical setting, but opportunities should be sought as this is a rich learning experience.

b. Research

Research in the clinical environment may include formal research activities but more often involve students doing case-specific inquiry of the literature, experts, and other information sources to answer clinical questions. This problem-based inquiry is a good skill for students to master as they will continue this kind of scholarship well into their practice career.
c. “Paper” patients

“Paper” patients offer an opportunity to step back from the necessity to problem solve with actual patients and use the paper case just as a learning tool. This is particularly effective early on when students need more time to reflect or research information that a real patient situation may not allow.

d. Patient simulation (role play)

Simulation and role-plays are excellent tools to assist students to integrate skills and information in a “safe” environment, not yet applying them to patients. Again, this is good for new skills or complex situations in which the student (or the CI) may feel hesitant about the student's performance.

e. Media resources

Media resources lend themselves to independent study, including the use of technology resources, which may be helpful in the clinical setting, as well as for visual learners.

f. Journals (reflective)

Journals are particularly well suited for reflective learners and to provide evidence for learning that occurs over long periods. Students can look back and observe their own progress, not just in their performance but in their thinking.

g. Observation

The value of “observing” as a teaching method is highly underrated. The observer has the advantage of being able to "take in" what is occurring without being required to react or interact. This is an excellent way for an individual to learn through "modeling" behavior or to conclude that, if given the opportunity, he/she would handle the situation differently. Observation is a valuable teaching method and one that occurs naturally in collaborative learning models.
h. Collaborative learning

Collaborative or peer learning occurs with more than one learner working together on a mutual goal. The advantage in collaborating is to have the input of more than one person; to be able to draw from the strengths of each of the participants and to strengthen each individual's knowledge and skill in the process. Collaborative learning is a natural by-product of some of the alternative supervisory models in clinical education, such as the 2 students:1 CI or 3 students or more: 1 CI supervisor model. For the student, it can be a less stressful method of learning in that it fosters discussion and problem solving with a peer rather than with a supervisor or superior who is vested with the role of performance evaluator and where the risks may appear greater to the student not to know specific information. For example, two students may brainstorm a plan of care for a particular patient or discuss discharge arrangements. Collaborative learning in some settings has also been found to enhance the efficiency and productivity of a practitioner depending upon whether or not the individual continues to carry a patient load. Ideally, the CI in the situation of supervising and managing more than one student simultaneously is more effective when carrying a limited or no patient caseload (Ladyshewsky, Ladyshewsky, Healy).


Ladyshewsky, RK. Healey E. *The 2:1 Teaching Model in Clinical Education: A Manual for Clinical Instructors*. Toronto, Ontario, Canada: Department of Rehabilitation Medicine, Division of Physical Therapy, University of Toronto, 1990.

i. Mental imagery

Mental imagery can be very useful in reducing the stress associated with new situations by guiding the student through a mental visualization of what to expect or what is to occur. For example, a student who has never been to the intensive care unit may benefit from the opportunity to mentally imagine, as the CI describes it, the layout of the unit, the sounds of the monitors, amount and types of equipment, etc. The impact of walking into the unit for the first time can be significantly reduced. Mental imagery is also a useful practice technique while in the early stages of skill acquisition.
8. **Maintain a supportive environment**

A supportive environment is achieved through clarity of expectations on a professional level and unconditional positive regard (Section I) on a personal level.

Define with the student his/her starting point. Set weekly goals with the student for performance. **Plan** to provide feedback to the student on a regular basis. Recognize how your role as CI changes as the student makes progress.

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**Instructor's note:** The point should be made and emphasized that "practice" is the key to the success of any teaching method that may be selected. Practice must be planned for in designing effective learning experiences. Because of its importance, it is dealt with separately in a later section.
9. Use teaching supervisory techniques

Now, we put these components of the learning experience in motion: the learner, the instructor, and the learning environment. The student's needs and abilities, the patient's problems, and the constraints and resources of the environment all come together now--and you as the CI must orchestrate the symphony!

Teaching/Supervisory Techniques

- a. Coaching
- b. Time management
- c. Pacing
- d. Role delineation

Coaching students effectively requires sensing when to step in and then tactfully stepping back. If the student has assumed some responsibility (and control) for a patient situation, this may be particularly delicate as you want the student to continue to play that primary role with the patient after your coaching intervention. Remember that there are different learning styles that may influence student performance and your interpretation of performance. Communicate with the student that you know they can “do it”. They have the knowledge and skills, and need to learn how to put this all together in providing patient care services. Coaching relates directly to the role of the CI as the student moves through the stages of learning.
b. Time management

Time management is a very real pressure in the clinic today. Work with the student to stay within realistic time-management guidelines for the clinical setting. It is important to recognize, however, that the student will (and should) achieve efficiency last, following thoroughness, accuracy, and good clinical reasoning. After all, to be efficient but not thorough, accurate, or analytically sound is not good patient care.

c. Pacing

Pacing of student workload should be a balance, providing challenge without overwhelming the student. It is important to get regular student feedback on this.

d. Role delineation

Role delineation requires good ground rules. Identify for students how your role and theirs will change during the clinical experience (eg, as they become more skilled, confident) and how the role will not change (eg, patient safety and effectiveness of treatment will always be your responsibility). Remember that you may find some roles with students more difficult than others (eg, when they are ready to assume primary relationship with the patients). Be prepared to adjust your role and understand your own anxiety in this adjustment. Remember to also be cognizant of the different roles relative to physical therapy practice as related to the responsibilities for direction and supervision by the physical therapist and communication and follow-through by the PTA with the supervising physical therapist. The CI’s role with regard with role delineation changes as the student moves through the stages of learning (Section II).

Instructor’s note: You can relate issues associated with student supervision and students managing patients with Medicare. This issue will be addressed comprehensively in Section V.
Teaching/Supervisory Techniques (cont’d)

e. Practice

i. When learning a concept or generalization, offer a specific example and direct practice activities toward achieving the concept or related skill.

ii. Allow students to practice new material soon after it has been presented.

iii. Schedule practice sessions with intervals sufficient to allow the student to absorb new material or skill, but not so great as to affect the student’s ability to retain the material.

Begin practice activities by being very specific in performance and in application of the practice skill to a situation. You can become more general as the skill is mastered and applied correctly to specific situations.

Be sure that students see the link between what is being practiced and the desired learning goal. This makes practice understandable and establishes motivation, as in a problem-based learning experience.

Recognize that practice and learning should be commingled. Regular and immediate practice of newly learned skills helps to reinforce the accuracy of these new skills.
iii. Practice sessions should be scheduled with intervals sufficient to allow the student to absorb the new material or skill, but not so great as to affect the student's ability to retain the material.

Practicing new skills is like an interval-training event; too much intensity or too little intensity can each be detrimental. Determining an effective intensity for practice is important. This will facilitate moving from the acquisition stage (practice) to integration (mastery) and produce student confidence in the process.

Teaching/Supervisory Techniques (cont’d)

e. Practice (cont’d)

iv. Number and level of difficulty of tasks required in a given practice session should be challenging to the student, but not so great as to be overwhelming. Allow students to practice new material soon after it has been presented.

v. Sequencing of practice builds from simple to more complex activities.

iv. The number of tasks and level of difficulty of the task(s) required in a given practice session should be challenging to the student, but not so great as to become overwhelming.

v. The sequencing of practice should build from simple to more complex activities.

Using student confidence as an indicator, build practice opportunities in intensity; greater efficiency, more complex patients, and new situations to apply learned skills.
Teaching/Supervisory Techniques (cont’d)

f. Questioning

i. Grouped by function
      • to gain information
      • to sort out facts
   b. Application questions: “How?”
      • apply knowledge in clinical setting
Questioning, when done effectively, builds along 2 continuums: the function of questions and the complexity of questions.

When we think about building questions from simple to complex or general to specific, the use of the taxonomies within the domains of learning can be helpful.

Knowledge questions seek answers regarding the "what," "when," and "where" of the topic. Application questions challenge the student to explain the "how" of processes and systems. Analysis and evaluation questions require explanation of concepts and principles that explain "why" something occurs. This order of questioning, although seemingly changing the function of the questions, also builds logically within the cognitive domain from simple to complex.

Make it clear to the student how the questions build in complexity and are easier at first; otherwise, he/she may feel that you just keep asking questions until the student gets stuck—a rather futile feeling for the student. For example, can you think of two drugs that would be appropriate for your patient with rheumatoid arthritis? (knowledge) Tell me about these types of drugs. (knowledge) Why would your patient with arthritis be taking these drugs? (application) What effects should the drug have? (knowledge) How would you know whether they were being effective? (application) What effects, if any, would these drugs have on the rehabilitation program that you have planned? (analysis)

Instructor's note: Indicate to participants how questioning can be threatening. Think of such experiences that you have had in which the questioning was not productive, and share this with the group.
Teaching/Supervisory Techniques (cont’d)

f. Questioning (cont’d)
   i. Grouped by function
      c. Analysis and evaluation questions:
         “Why?”
         • how parts relate to the whole
         • how parts relate to each other
   ii. Grouped by level of complexity
       • Number of possible correct answers
       • Hierarchy of domains
   iii. Types of Questions

The other continuum of questions is the complexity of the questions and answers sought. Is there a right answer to the question? Is the answer known? Is there more than one right answer? How does one justify an answer? These questions are used for discussion and exploration more than for diagnostic reasons or to establish a student's level of knowledge.

Whenever questioning is used, its purpose should be made clear to the student. Is this diagnostic--to clarify some misunderstanding the student has? Or is it evaluative--to assess what the student knows? Or is the question simply to challenge the student's thinking and encourage discussion?

Clarity in the purpose of questioning will help to produce the desired outcome. Often, if you don't get the answer you want, it's because you haven't asked the right question.
### c. Types of Questions

#### Types of Questions

<table>
<thead>
<tr>
<th>Category of Question</th>
<th>Information to be Assessed</th>
<th>Sample Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>broadening</td>
<td>knowledge</td>
<td>What are other causes of joint pain?</td>
</tr>
<tr>
<td>reasoning</td>
<td>clinical decisions</td>
<td>How did you arrive at this diagnosis?</td>
</tr>
<tr>
<td>justifying</td>
<td>rationale, evidence</td>
<td>What about this patient suggests joint pain vs other problems?</td>
</tr>
<tr>
<td>hypothetical</td>
<td>synthesis</td>
<td>If this patient were known to be HIV-positive, how might interventions change?</td>
</tr>
<tr>
<td>alternative</td>
<td>integration, evaluation</td>
<td>How might interventions change using current findings versus waiting for an x-ray?</td>
</tr>
</tbody>
</table>

Instructor's note: The table above describes five categories of question that can be posed of students to assess information that is at different hierarchical levels. Sample questions are posed to illustrate how questions would change to pose questions that challenge the learner at higher levels.
g. Reinforcement and feedback

Teaching/Supervisory Techniques (cont’d)

<table>
<thead>
<tr>
<th>Section III, Slide 112</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are some of the greatest difficulties in giving feedback?</td>
</tr>
</tbody>
</table>

Instructor’s note: The purpose of this next activity is to introduce participants to the form on Guidelines for Providing Feedback to allow participants to practice providing effective feedback through a practice session situation.

When introducing the practice session, consider the individual participants and the group dynamics. Some group participants may be employed by the same be from the same facility and comfortable with one another in a large group practice session, while other groups may include individuals from different facilities that exhibit greater discomfort when acting out a role in front of a group of individuals they do not know. Remember you can do the practice session as a role play of 2 persons in front of the entire group, tag team where participants go in and out of the interaction, or small groups of 3 or 4 where 1 or 2 individuals act as observers and two persons practice the role. Use your judgment as to which option will work best for a particular group.

To conduct the practice session, show the video to participant as an entire group.
Activity 4 – Video Session
Guidelines for Giving Feedback

Activity 4
Guidelines for Providing Feedback

Featuring
Jack the CI
Michael the student

Scene 1
Scene 2

Section III, Slide 113

Ineffective Feedback Video Script
Activity 4

*Guidelines for Providing Feedback Video Script*

**Ineffective Feedback**

**Setting:** Clinic office, 5 minutes before the first patient is scheduled.

Jack (CI): Michael, I know our weekly meetings have been rushed because we get behind, but I’ve needed to talk to you about some specific behaviors for a week. This seems to be a good time. You really are not meeting my expectations. (*Jack has a coffee cup and is eating a donut. He appears distracted.*)

Michael (student): I thought everything was going fine. Can you give me some specifics?

Jack: (*Jack takes a drink of coffee and crosses both arms as he looks at Michael.*) Both you and your school have objectives that you are to only observe the use of physical agents, because you’ve not been taught that. However, we use a lot of ultrasound and electrical stimulation in this clinic, and I need you to administer these agents to the patients in an efficient manner. (*Someone is sitting in the room and leaves while they talk.*)

Michael: Can you or some of the staff teach me how to use the equipment and do a check off to make sure I’m safe?

Jack: (*Jack picks up a patient folder and begins to glance at it…he begins to talk.*) Well, safety is another issue. Someone told me that you forgot to get the stepstool out for a patient to get off the plinth.

Michael: I don’t remember such an episode. When was that?

Jack: (*Jack is now irritated. He turns to look at Michael.*) I don’t know for sure. I had several meetings last week and wasn’t with you when that occurred. Being a CI is such a time-consuming commitment. I don’t think I’m going to take students from your program anymore; there are just too many problems. (*Jack looks at the clock.*) Well, I have a patient scheduled who does not like students. I’ll be checking to see what you do while I’m working with her. You really need to improve over the next 2 weeks when we have to do a mid-term evaluation. (*Jack walks out of the office with a donut in his hand.*)
Effective Feedback
(Cl and student walk into clinic/PT department together.)

Jack (CI): So How was lunch?

Michael (student): Great! It’s nice to have a break before the afternoon. It looks like a busy schedule today.

Jack: It is, so let’s take a couple minutes to reflect on how the morning went and to get ready for the afternoon.

Jack: (Cl and student enter office, Cl closes door; they sit across the table facing each other.)

Jack continues: So, how do you feel your session with Ms Alhambra went this morning?

Michael: I think it went fine. Hmm. (pauses) Well, maybe I rushed things a little bit in order to be done before noon.

Jack: Well, as I was observing, I noticed you did not ask for Ms Alhambra’s permission to expose and drape her shoulder, so that’s why I intervened. Why do you think I intervened as you were exposing her shoulder for the exam?

Michael: Well, after you intervened, I realized I forgot to ask her permission to expose and drape for the examination. It’s difficult to remember everything to do for a shoulder evaluation.

Jack: I understand. It takes a lot of practice to become good at doing a safe, thorough shoulder evaluation. You did remember to ask her permission to apply the electrical stimulation, and you clearly explained what she should feel during the treatment. Can you recall 1 safety measure that you needed to do before you left Ms Alhambra in the room with the E-stim unit on? Something to improve your risk management?

Michael: Hmm, well I probably should have given her a bell to ring in case she needed help.

Jack: Yes, and instructing her on how to use the E-stim unit’s emergency shut-off switch, in case she became uncomfortable or if her pain increased.

Michael: Well, I did go back in the room 10 minutes later to check and see how she was doing.

Jack: That is 1 critical behavior for safety. Your midterm goal is to practice safely 100% of the time. Share with me what you can do to improve your interaction and safety with Ms Alhambra when you see her again.

Michael: Hmm. (pauses) Well, would I be able to write a note to myself on her folder to remember to get her consent to drape her shoulder and to give her the emergency safety switch for the E-stim unit?

Jack: Yes, if you use a sticky note. Also, would it help you to recall safety behaviors if you described to me the steps you will perform for Ms Alhambra before you see her?

Student: Yes, I think that will help me recall safety behaviors and hopefully help me recognize any behaviors I may have missed.

Jack: Great. Sounds like we have a plan!
You have been in clinical practice for nearly seven years now. You are a confident and experienced practitioner, with a focus on the general practice of acute care. You enjoy working with the people and have never really noticed that the bulk of your practice consists of performing transfers, gait training for distances of 25 ft or less, and basic bedside exercise programs. Your main focus in patient management is on function, at the highest level of safety and independence possible for each patient.

You are also an excellent CI, having supervised more than six students at different levels and from different programs. You educate your students to practice in a patient-centered manner, with examinations and plans of care focused on increasing safety and independence for all basic mobility skills. Therefore, measurements and protocols are useful, but each examination and each intervention really need to reflect the current individual patient’s functional level and needs for discharge.

You have a sharp logical mind and you are proud of it.

You find physical therapy an interesting course of study. Your original plan was to go to medical school but once you investigated it, you decided you did not want to put in that much time and effort. Physical therapy is the closest thing to medicine for you.

You like to attack problems by examining them closely, considering even the smallest of details. You have the greatest possible confidence in your ability to solve any problem with which you are presented. One of the things that irritate you most is when people interfere with your ability to solve problems by giving you insufficient information, or by insisting that you resolve the problem the way they tell you to.
Activity 4

Guidelines for Providing Feedback

Information
This activity is to help participants evaluate 2 feedback sessions between a CI and a student. One session portrays ineffective feedback and the other portrays effective feedback. You will observe both feedback sessions in preparation for completing the activity below.

Guidelines for Providing Feedback
After observing the Jack and Michael video, identify the feedback characteristics, both ineffective and effective.

<table>
<thead>
<tr>
<th>Feedback is most helpful when it is ...</th>
<th>Feedback is least helpful when it is...</th>
<th>Practice Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>specific</td>
<td>global</td>
<td></td>
</tr>
<tr>
<td>positive</td>
<td>negative</td>
<td></td>
</tr>
<tr>
<td>useful</td>
<td>directed towards situations that cannot be changed</td>
<td></td>
</tr>
<tr>
<td>supportive</td>
<td>judgmental or evaluative</td>
<td></td>
</tr>
<tr>
<td>given in private</td>
<td>given in front of others</td>
<td></td>
</tr>
<tr>
<td>based on firsthand information</td>
<td>based on &quot;hearsay&quot; or conjecture</td>
<td></td>
</tr>
<tr>
<td>fair</td>
<td>based on only one incident; not a general trend</td>
<td></td>
</tr>
<tr>
<td>honest</td>
<td>obscured by attempts to protect feelings</td>
<td></td>
</tr>
<tr>
<td>constructive</td>
<td>given without suggestions for improvement</td>
<td></td>
</tr>
<tr>
<td>current or timely</td>
<td>delayed by several days or weeks</td>
<td></td>
</tr>
<tr>
<td>focused on behavior, not personality traits</td>
<td>likely to be perceived as a personal attack</td>
<td></td>
</tr>
<tr>
<td>checked for clarity</td>
<td>vague; improperly understood</td>
<td></td>
</tr>
</tbody>
</table>

next slide/page
Activity 4
Reinforcement and Feedback

Feedback is most helpful when it is...
- specific
- positive
- useful
- supportive

Feedback is least helpful when it is...
- global
- negative
- directed toward situations that cannot be changed
- judgmental or evaluative

Activity 4
Reinforcement and Feedback (cont’d)

Most helpful when...
- given in private
- based on firsthand information
- fair
- honest

Least helpful when...
- given in front of others
- based on hearsay or conjecture
- based on only one incident; not a general trend
- obscured by attempts to protect feelings
Activity 4
Reinforcement and Feedback (cont’d)

Most helpful when...
• constructive
• current or timely
• focused on behavior, not personality traits
• checked for clarity

Least helpful when...
• given without suggestions for improvement
• delayed by several days or weeks
• perceived as an attack
• vague; improperly understood

Do we think about the feedback that we provide, or are we just so anxious to “feedback” that we just talk?

Feedback should be aimed at a behavioral change or outcome. This will make it clear to the recipient why he/she is hearing this. If the recipient cannot use the feedback in a constructive way (which should be apparent in the feedback given), the feedback can appear to be unhelpful, offensive, and painful.

How we deliver feedback often determines how much of our message actually gets received. If the method of giving feedback is too painful, embarrassing, emotionally charged, or unclear to the participant, the message of the feedback is likely to be lost.

Integrity in providing feedback is critical. The recipient judges all feedback. To the degree that it is judged to be accurate and constructive, it will be considered.

It is always wise to get feedback on your feedback. Was it understood? What reactions did it create? Were those the desired reactions? Are there misunderstandings?

Feedback is powerful in both a positive and a negative sense. It should be used purposefully and skillfully, particularly in clinical education in which an inequality between the student and the CI is already perceived.
8. Active Listening

Instructor’s note: This practice session situation could also be used to illustrate/analyze:

- Clinical instructor questioning technique
- Clinical instructor and student active listening
- Student demonstration of adult learning qualities

Instructor's note: Use the following guiding questions to introduce the concept of active listening.

What are some of the characteristics of a good listener?
- What do you see that indicates to you that someone is listening?
- What do you NOT see?
- How does a good active listener make you feel?

Discuss examples of Jack’s use of active listening in the video.

Teaching/Supervisory Techniques (cont’d)

h. Active Listening
   i. Skill of becoming involved with what the other person is saying.
   ii. Attend so closely to what the other person is saying, that his/her response generates your next question.
i. The skill of becoming involved with what the other person is saying.

To listen without thinking about the next question(s) until we have heard thoroughly the response to the present one. Often, we are formulating our next questions based on OUR thoughts rather than on the speaker's thoughts. Listen to, think about, and understand the speaker's thoughts BEFORE moving on to the next questions.

ii. Ability to attend so closely to what the other person is saying, that his/her response generates your next question.

The goal here is empathy; understanding what the speaker is saying FROM HIS/HER PERSPECTIVE. That is, can you understand how it feels or appears to HIM/HER, not you? Can you understand what that person is saying by seeing it from his/her vantage point? This requires setting aside your own biases, values, and beliefs so that you do not filter or edit what the person is saying. If we can leave our own point of view, and listen to the speaker as if we were sharing that person's point of view, then we will become involved in what the other person is saying. This may also require us to ask clarifying questions, confirm what we are hearing by restating what we heard, and summarize what we have heard from time to time.

Teaching/Supervisory Techniques (cont’d)

h. Active Listening (cont’d)
   iii. Wait patiently for a thoughtful response.
   iv. Attend to the speaker’s emotional status.
   v. Create an atmosphere where the other person feels his/her contributions are valued.
iii. Ability to wait patiently for a thoughtful response.

Time in which neither person speaks is not necessarily wasted time. In this pause, the student may be reflecting on what was last said, formulating the next statement or question, or trying to clarify in his/her mind what he/she wants to say. If pauses between statements are not respected and made to be comfortable, then we are always rushing to fill them with conversation that is not thoughtful or useful.

iv. Ability to attend to the speaker's emotional status.\(^{(Davis)}\)

Previously, we discussed "unconditional positive regard" as caring about a person as a person before anything else. Attending to the emotional status of the speaker means being aware that emotion exists, recognizing that it may interfere with communication, and allowing the necessary emotional "time outs," where necessary, so that the communication can continue. This signals to the individual that you are aware of his/her emotions and that the emotions are respected, if not understood in the communications (eg, "I know you're going to cry. But after you are finished, I want to respond to your question."). Allow time for the emotions to be expressed, and then continue.

You must also listen for the emotion that is not expressed. Carol Davis has regarded this as listening with the "third ear." That is, listening to a person speak and considering the emotion that person might feel in this speaking role and anticipating it (eg, anger, fear, embarrassment). This is important with students, since they may have a different perspective and feel very differently in a situation than you do as the CI.


v. Ability to create an atmosphere in which the other person feels his/her contributions are valuable.
Listening imparts an inherent sense of valuing of the person being listened to. Providing the time to listen, the privacy to listen, and where the concern is listening, all contribute to the speaker's sense of self-worth. With students, we do not always have to respond. We simply need to listen and let them be heard. As they speak, they often resolve their own conflicts, and find solutions or remedies to their own dilemmas. What was needed was the respect of being listened to, which allowed them to find their own solutions.

Listening is often referred to as the better part of communication. Listening is at least as critical as speaking, but is often treated as simply the time spent waiting until one can speak again!!

Active listening is a level of attentiveness that causes the listener to formulate what he/she says next from what he/she heard.

Students often allow the stress or anxiety of clinical education to interfere with their communications. Listening carefully to students is important because they may not make their points clearly, succinctly, or logically. Only the active listener will be able to get the clearest message under these circumstances.

Use pauses in speaking to reflect. Allow students to do the same. Sometimes, students need more time to formulate a clearer statement. Don't be afraid to wait in silence.

Finally, listen for the message below the message. Try to understand not only what is being said but from whence it is coming. Empathy is an important tool for an instructor. To see from the perspective of the speaker is to understand better what it is that he/she is trying to say. Ask for clarification if necessary.
10. Plan for practice, feedback, and assessment of performance

Process for Designing Learning Experiences (cont’d)

10. Plan for practice, feedback, and assessment of performance
   
a. Consider the type of feedback to be given.
   b. Consider the amount and timing of feedback.
   c. Consider how practice can be provided effectively.
   d. Review guidelines for maintaining open discussions, constructive dialogue, and managing defensiveness.
   e. document the plan, using the weekly planning form and/or the Student Program Planning Flow Chart.

Define with the student his/her starting point. Set weekly goals with the student for performance. Plan to provide feedback to the student on a regular basis. Recognize how your role as CI changes as the student makes progress.
Student Program Planning Flow Chart

The Student Program Planning Flow Chart is a collaborative planning tool that identifies targeted behaviors from the learning diagnosis, states essential goals, creates related objectives and correlates designed learning experiences utilizing available facility resources. Goals and objectives change as the student progresses through the clinical rotation.

Use of the Student Program Planning Flow Chart:

- Allows for personalized planned learning experiences.
- Creates an environment that is conducive to learning.
- Allows for student participation in planning and progressing learning experiences.
- Targets appropriate objects needed to accomplish the goal.
- Promotes learning experiences that are varied and relate to appropriate objectives.
- Allows change as the student progress thru the clinical rotation.
- Clarifies and encourages the student to complete goals identified for that rotation.
Illustration of the Student Program Planning Flow Chart

**Student Program Planning Flow Chart**

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Targeted Behaviors</td>
<td>Long-term Goals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Instructor(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Date of Clinical Experience:</td>
</tr>
</tbody>
</table>

next slide/page
B. Reassess Student Learning – Closing the Loop

Reassess Student Learning – Closing the Loop

1. Hands-on care delivery or skill in manipulating the environment
2. Level of questions asked
3. Ability to respond to questions
4. Ability to self-assess
5. Response to feedback
6. Initiative
7. Risk-taking

These opportunities (noted on the slide) for observation identify the observational role of the CI, and how observation of these parameters contributes to student supervision and student performance evaluation. Again, we may experience limits on our time in the clinic to engage in these observations, but we should consider how we can incorporate these into student instruction.

Observation may become more indirect as students become more skillful and require less direct supervision. “Observation” through chart review, student reporting, and feedback from other observers are examples of such indirect observation. As your student becomes more skillful and you need to become more distant, these skills can be useful.

Instructor’s note: Remember how your mom had eyes in the back of her head? That is what indirect observational skills are similar to. Experienced CI’s become very effective at this.

Ask participants for other examples of indirect supervision that may be helpful.
Activity 5
Additional Practice
The Case of Roger
(Completing his rehabilitation experience)

Instructor's note: If time allows, have participants complete Activity 5 and then discuss their response. This is a summary activity for this section on designing the learning environment and will use many of the points made in this presentation. This activity also draws upon concepts introduced in Sections I and II. This is a good opportunity to tie all 3 sections together before moving on to discuss performance assessment.
Activity 5

The Case of Roger
(Completing His Rehabilitation Experience)

Roger is a physical therapy student on his final clinical internship who is 3 weeks into a 12-week acute rehabilitation clinical experience. You have been noticing that he continues to have difficulty in working with patients with a CVA who have atypical movement patterns. This occurs with patients he is currently treating as well as with new referrals. He is able to correctly explain the physiological and physical aspects of the movement patterns. He has come to you, obviously concerned about the situation.

a. Identify Roger’s learning diagnosis with an emphasis on the domains of learning and his stage of learning.

b. Using the form provided on the previous page, complete a “Program Planning Flow Chart” for Roger. Your answers to the questions below will help you complete the sections of the Program Planning Flow Chart.

1. Which behavior needs to improve?

2. What long-term goal can be attained by the midterm?

3. What behavioral objective can be identified and if completed in 1 week will advance Roger closer to his goal?

4. What learning experiences (including teaching/learning methods) would be beneficial for the identified behavior to improve?

5. Which resources can be identified in the clinical environment to accomplish Roger’s goal?

see answer key Section VII

end slides
## Student Program Planning Flow Chart

**Student’s Name:** Roger  
**Instructor(s):**  
**School:**  
**Date of Clinical Experience:** Add date of conference, which experience, what week of the experience

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific Targeted Behaviors</strong></td>
<td><strong>Long-term Goals</strong></td>
</tr>
</tbody>
</table>
| Patient handling for patients with CVA and atypical movement patterns. | By mid-evaluation, Roger will be able to correctly control patients with CVAs and atypical movement patterns during intervention. | By the end of the week, Roger will be able to correctly adjust patient contact with 2 patients with CVA. | Roger will observe a PT working with a patient with atypical movement patterns, and then repeat the same handling techniques, with feedback from the PT.  
Roger will demonstrate handling techniques on the CI who will simulate a patient with atypical movement patterns. | Patient population  
Expertise of clinical staff  
Opportunity for student to practice patient care  
Staff willing to share expertise |
References


Additional Recommended Readings


Section IV

Performance Assessment - The Clinical Environment

Performance Assessment—The Clinical Environment
Think back to the parallels in the roles:

**Q:** How do you decide when it's time to change a patient's program? How do you know whether the patient has achieved short-term goals or not? What process do you use?

**A:** You examine the patient; based on the examination findings and your evaluation a diagnosis is established. This is the final piece in the loop. You determine the patient's prognosis, establish a plan of care that includes long-term and short-term goals and outcomes, and specific interventions to be used, implement your plan of care, and then evaluate the outcomes.

It is the same thing in clinical education. How do we know when it's time to progress the student? We assess his/her performance. Has the student met the short-term goals that we established?

Evaluation drives our decision making. We should be noting change, or lack of change, in the student's performance every time we observe the student...just as we do with patients each time we provide physical therapy.

**Introduction**

Section IV describes **Evaluation Principles** and a variety of evaluative methods. Formative and summative evaluations are discussed, including use of anecdotal records, critical incident reports, and weekly Planning Forms summaries. Guidelines for effective evaluation are presented. The importance of accurate, objective documentation of student performance is stressed.

We’re going to take a closer look at the process of evaluation in clinical education. This is going to include a brief discussion of **Evaluation Principles**, different types of instruments, what they're used for, and how to use them objectively. It is most important to understand the strengths and limitations of your evaluation instrument.

**We’re also going to take a closer look at some of the rules that govern evaluation.** Our interest is in being as objective as possible in our evaluation of students...so we need to be aware of these rules. We also need to be aware of the typical, common errors that can be made.
Rather than review these objectives individually, I'll let you read them on your own. They are all in your workbook. So let's move on and look at some of the assumptions that we will be using as a foundation in this section.

Objectives

Following the completion of this section, the participant will be able to:

1. Describe the evaluation process as it is applied in the clinical setting.
2. Describe 2 types of evaluation: formative and summative.
3. Identify selected tools used in providing evaluative feedback to students.
4. Describe common rater errors in performance evaluation.
5. Describe the use of the ratings for summative evaluation instruments.
Objectives (cont’d)

6. Describe how the different raters in clinical and academic settings interpret the evaluations.

7. Recognize one’s own evaluative skills.

8. Discuss the importance of the student to be able to self-assess his or her clinical performance.

9. Apply performance evaluation as it relates to the student’s academic growth.
Assumptions

1. Decisions in clinical education are based on evaluation. Objective evaluation of student performance drives decision making.

2. Evaluation is an ongoing process with 2 complementary components: formative and summative.

Assumptions (cont’d)

3. Being an effective evaluator requires skill in 3 competency areas:
   1) supervision,
   2) evaluation, and
   3) communication.

4. The ability to self-assess is an important component of the clinical education process.

5. Clinical education is NOT an evaluative process. Rather, evaluation is a tool used in the clinical education experience.
We talked about assumption #1 just a minute ago. The only other assumption that I will draw your attention to is #5. “Clinical education is NOT an evaluative process. Rather, it is a tool used in the clinical education experience.”

Why have I singled this assumption out? Some CIs mistakenly feel that the clinical experience should be viewed as an opportunity to test the student...to fire questions at him/her. Did any of you have an experience like that? As if this were your 6, 7, or 8, week-long opportunity to prove everything that you knew?

How did this make your feel? Was it a pleasant experience? Most would opt to change this approach if they could. Often, situations like this arise when the CI persists in asking low-level questions: What? Where? and, When? These questions are essential early in a clinical experience to establish a baseline of student performance. But as soon as possible, the level of questioning should be raised...to application or analysis questions (Why?). This feels more like learning to the student, and the experience will not be perceived as a test of didactic knowledge.

Sometimes, it feels like a testing situation because the only information our CI gives back to us is negative. I’d suggest that the CI could have given you the same input, and had you feel a lot better about your performance, if he/she had practiced some of the rules, especially of formative evaluation...better known sometimes as “feedback.”

Instructor note: The types of evaluation differ in purpose, use, timing, and audience. The chart on slide 132 will help to identify those differences!
A. Types of Evaluation: Formative/Summative

1. Purposes of Evaluation

   a. To determine how students are changing.
   b. To identify additional learning needed for mastery.
   c. To provide feedback on performance in cognitive, psychomotor, and affective domains. (Hayes, Huber, Rogers, Sanders)
   d. To evaluate the overall effectiveness of a clinical course.

   c. To provide feedback to students regarding performance in cognitive, psychomotor, and affective domains

   next slide/page
Purposes Of Evaluation (cont’d)

d. To determine whether a student is competent in a procedure.

e. To evaluate the final achievement of objectives.

f. To gather data for determining grades.

g. To assist in the development of self-assessment skills.

TYPES OF EVALUATION

<table>
<thead>
<tr>
<th>PURPOSE</th>
<th>Formative</th>
<th>Summative</th>
</tr>
</thead>
<tbody>
<tr>
<td>USE</td>
<td>Promotes Learning</td>
<td>Grading</td>
</tr>
<tr>
<td>TIMING</td>
<td>During</td>
<td>After</td>
</tr>
<tr>
<td>AUDIENCE</td>
<td>Internal</td>
<td>External</td>
</tr>
<tr>
<td>FUNCTION</td>
<td>Predicts Summative</td>
<td>Sets Standards for Formative</td>
</tr>
</tbody>
</table>
2. Formative Evaluation

You’ve just completed documenting an initial examination, and you give me your report to review. I make a few notations about grammar, spelling, and the use of medical terminology and anticipate that on the next examination, you will make certain to include a section that addresses the mental state of the patient.

I am providing you with feedback about your performance in writing a note. As your CI, I do expect that you will remember this information and integrate it the next time you write a note. So formative evaluation is:

a. Used to provide feedback to students during the clinical experience.

b. Used to further learning or modify behavior.

c. Provided during the learning experience.

d. Internal – critical audience is the student.

e. Predictive of summative results.

If we keep track of the formative evaluation we’ve provided to the student, we can predict what the final evaluation is going to be.
3. **Summative Evaluation**

**Summative Evaluation**

a. Used to summarize performance outcomes.

b. Used for grading or certification.

c. Provided at the end of the clinical experience.

d. External – critical audience is the academic program in addition to the student.

e. Used to set the standards for formative feedback.

We actually perform a summative evaluation **twice** in physical therapy clinical education; formally at midterm, to provide the student with a chance to modify his/her performance, and then again at the end of the clinical experience.

d. Critical audience is external, the academic program, in addition to the student

e. Sets the standards for formative feedback

Based on the expectations that have been set for student performance, provided by the academic program and those that are set by the clinical site, we are cognizant of areas that are going to require an evaluation eventually. We therefore have an outline of areas that need to be attended to, during the clinical experience, so that the student can successfully meet the desired outcomes.
4. Timing of Evaluation

Timing of Evaluation

a. Begins at once, as soon as the student starts the clinical experience.
b. Continues throughout the experience.
c. Important to evaluate all aspects of student performance so there are no surprises at mid-evaluation and at the end of the clinical experience.

Instructor’s note: The emphasis here is on the need for the CI to be constantly and consistently assessing the student’s performance. Each time the CI observes the student doing something, the CI should make a mental note to himself/herself as to whether the performance was better than, the same as, or worse than previous opportunities. This is particularly useful during summative evaluation, when numerous examples will need to be provided, especially for any performance that is below the expected level.
B. Formative Evaluation—Guidelines and Tools

1. Guidelines for Formative Evaluation

These guidelines resemble what you have previously seen labeled as feedback. Feedback is considered a form of formative evaluation.

Guidelines For Formative Evaluation

- Individualized
- Goal related
- Diagnostic
- Remedial
- Collegial
- Positive
- Liberative
- Selective
- Timely
- Reciprocal

Section IV, Slide 136

a. Individualized - tell each student how he/she is doing rather than spending time discussing how “most” students do, or even comparing this student’s performance with that of a group.

ex: __________________________________________________________________________

b. Goal related - focus the discussion on the student’s progress toward clearly specified performance objectives. Be sure the student understands what those objectives are and how his or her performance is being judged.

ex: __________________________________________________________________________

It is important to talk about how closely the student's performance is approaching achievement of the objectives. This keeps the discussion focused on performance and not on personal aspects.
c. **Diagnostic** - identify specific strengths and weaknesses rather than simply making global comments about overall performance. Anecdotal comments or examples often help to clarify. When problems arise in mastery of complex skills, work with the student to analyze his/her performance to determine where the difficulty lies.  
   ex:  

   d. **Remedial** - before the session ends, try to work out with the student a practical plan for future activity that will help to maintain present strengths and remedy weaknesses.  
   ex:  

A plan for action should be in place at the end of the session. 

   e. **Collegial** - collaborate with the student in reaching conclusions and planning future action. Listen, be flexible, and give the student time to put his/her thoughts into words. Recognize that the student knows things about himself/herself that you do not know. Both your verbal and nonverbal behaviors, and the setting in which you meet with the student will have an important influence on your success.  
   ex:  

   Need to be respectful of the student as an individual; friendly, but not “friends.”  
   f. **Positive** - be sure to mention the things that the student is doing right. You may also need to identify errors, but be certain that is NOT the only thing you do.  
   ex:  

   Even a student with major, global problems is doing something correctly. It is important to make sure that you provide positive feedback on those areas, so that the student isn’t totally deflated and hopeless.  
   g. **Liberative** - help the student learn to assess his/her own performance and to want to do so.  
   ex:  

   “What would you do differently next time? How did the intervention(s) (examination) go? Would you change anything if you could do it over again?”  
   h. **Selective** - do not try to cover everything in one session.  
   ex:  

   It will be impossible for the student to absorb it all. System overload goes into effect.
i. **Timely** - try to arrange your schedule so advising can be done soon after the event(s) that need to be discussed. Plan some conferences early so that there is still time to carry out the remedial plan you and the student develop. Remember, several short sessions carried out at a time when they seem really relevant and fresh may be more valuable than a long, formal session scheduled at some arbitrary time.

ex: ______________________________________________________________________

Shorter, but more frequent, feedback sessions are especially useful to students on early clinical experiences, or early in any clinical experience where the student has not been in your type of setting before. The more experienced student can more easily handle feedback sessions that may be less frequent. It's important to combine being **selective**, as described above, with timeliness.

j. **Reciprocal** - use these conferences to get ideas about your own strengths and weaknesses as a CI. Remember that if a student is having problems, you may need to make changes in what you are doing to help him or her improve.

ex: ______________________________________________________________________

Asking for feedback about your performance reinforces that this is a dialogue, keeps the lines of communication open, and reinforces the fact that students are expected to provide input/feedback to students to assist in shaping and taking responsibility for their learning.

next slide/page
2. Useful Formative Evaluation Tools

### Useful Formative Evaluation Tools

- Professional Behaviors (Kontney, May, Iglarsh; May, Straker, Foord-May)
- Weekly Planning Form
- The Anecdotal Record
- The Critical Incident Report (Shea, Boyum, Spanke)

Instructor Note: Discuss the importance of using Formative evaluation tools. The CI should consider including these tools routinely in providing clinical education. We will look at these four (4) formative evaluation tools more closely.
a. Professional Behaviors$^{3,4}$

1. **Critical Thinking.** The ability to question logically; identify, generate and evaluate elements of logical argument; recognize and differentiate facts, appropriate or faulty inferences, and assumptions; and distinguish relevant from irrelevant information. The ability to appropriately use, analyze, and critically evaluate scientific evidence to develop a logical argument, and to identify and determine the impact of bias on the decision-making process.

2. **Communication.** The ability to communicate effectively (ie, verbal, non-verbal, reading, writing, and listening) for varied audiences and purposes.

3. **Problem Solving.** The ability to recognize and define problems, analyze data, develop and implement solutions, and evaluate outcomes.

4. **Interpersonal Skills.** The ability to interact effectively with patients, families, colleagues, other health care professionals, and the community in a culturally aware manner.

5. **Responsibility.** The ability to be accountable for the outcomes of personal and professional actions and to follow through on commitments that encompass the profession within the scope of work, community and social responsibilities.
Professional Behaviors (cont’d)

6. **Professionalism.** The ability to exhibit appropriate professional conduct and to represent the profession effectively while promoting the growth and development of the physical therapy profession.

7. **Use of Constructive Feedback.** The ability to seek out and identify quality sources of feedback, reflect on and integrate the feedback, and provide meaningful feedback to others.

8. **Effective Use of Time and Resources.** The ability to manage time and resources effectively to obtain the maximum possible benefit.

9. **Stress Management.** The ability to identify sources of stress and to develop and implement effective coping behaviors; this applies for interactions for: self, patient/clients and their families, members of the health care team, and in work/life scenarios.

10. **Commitment to Learning.** The ability to self direct learning to include the identification of needs and sources of learning, and to continually seek and apply new knowledge, behaviors, and skills.

The issue is to convey to CIs that the practice of physical therapy consists of both cognitive (knowledge and psychomotor skills) and non-cognitive (professional and communication) behaviors, which requires that the CI identify and evaluate (formative and summative) both sets of skills in student performance.
In a study by Hayes et al\(^1\), the authors found that more than half of student performance problems in clinical education were in the affective domain; however CIs did not directly address them. If students do not receive feedback they will not change. We have some resources available to look at the affective area. We previously looked at APTA’s core values in Section I that reflect professionalism. Likewise, there are also Professional Behaviors that are integral to student performance that have been incorporated into APTA’s Clinical Performance Instrument.

b. Weekly Planning Form
   i. **Adjunct** to summative evaluation, but does not stand alone well
   ii. Promotes program assessment
   iii. Promotes program planning
   iv. Allows for ongoing dialogue between the student and CI
   v. Allows for and promotes student self-assessment

### Weekly Planning Form

Refer to Section III (CCIP Manual; pp 66-67) for information about the Weekly Planning Form.

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Instructor’s Note: The Weekly Planning Form was discussed in Section III, Participant Manual p 67. You may want to refer back to that section for review. This form is a bit different in that it is **proactive** rather than reactive. It is very useful in planning the clinical experience and helping to keep the learning experience on track. We recommend that this form, or something similar, be used, as a matter of course, for every student, on every clinical experience.

This form gives the opportunity to review the past week and assess how closely this student is approaching achievement of the objectives; it also provides the opportunity to revise plans for subsequent weeks.

Of special note is the opportunity for the student to add his/her input. This makes the student an active participant in the process and helps to maintain the dialogue.

next slide/page
c. Anecdotal Record (CCIP Participant Manual, p84)

Anecdotal Record

1. Useful as an adjunct to summative evaluation but does not stand alone well.
2. Can be used to document positive or negative behaviors.
3. Useful in supporting ratings/scores, especially for students with poor affective behaviors and for students who excel.
   • Supports grades (especially affective)
4. Separates interpretation from student action.
5. Requires student signature.

The reality is that it is used almost exclusively for negative behaviors, especially in the affective domain, but can be used for positive behavior especially with longer clinical rotations.

1. Separates interpretation from student action
2. Requires student signature

Student signature indicates only that the student has seen this report. It does not imply that the student agrees with the contents. But it is also a reminder to us that we must share this information with the student. Due process requires that the student be adequately informed.

Many schools are including a copy of the anecdotal record, critical incident, or weekly planning form in the information packets. All forms are very useful in making a paper trail, especially when there is a serious concern about the student passing the clinical experience.

Instructor’s note: The choice of the activity should be based on the assessed need or interest of the participants as well as time constraints. A group activity can include both Activity 1 (Anecdotal Record) and Activity 2 (Critical Incident Report) by dividing the participants into A and B groups followed by group presentation of results of the group’s activity.
<table>
<thead>
<tr>
<th>Anecdotal Record</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student:</strong></td>
</tr>
<tr>
<td><strong>Evaluator/Observer:</strong></td>
</tr>
<tr>
<td><strong>Setting (place, people involved, atmosphere, etc.)</strong></td>
</tr>
<tr>
<td><strong>Student’s Actions or Behavior:</strong></td>
</tr>
<tr>
<td><strong>Evaluator’s Interpretation:</strong></td>
</tr>
<tr>
<td><strong>Student’s Signature</strong></td>
</tr>
<tr>
<td><strong>Student’s Comments:</strong></td>
</tr>
</tbody>
</table>
Activity 1
The Anecdotal Record
Activity 1
The Anecdotal Record

Directions: Using the information in the narrative below, complete the blank Anecdotal Record on the next page as if you were planning to share it with your student. First record what happened. You may then add your own interpretation, however avoid combining your judgment with the facts.

Jane is beginning week 3 of her second clinical experience in a subacute rehabilitation facility in her hometown. Her first experience was in an outpatient orthopedic private practice. Jane readily admits that she needs a lot of assistance at first in maintaining control of the therapist-patient interaction, especially with some of the more aggressive patients and those who challenge her every word. This has improved as she has become more familiar with the facility, the caseload, and her clinical instructor.

Mrs J is an 86-year-old woman admitted from the acute care facility after having slipped on an area rug in her home (where she lives alone) and fracturing her hip. Her history of diabetes has complicated her rehabilitation somewhat. Mrs J is viewing her stay in this subacute facility as the opportunity to take a little vacation, catch up on her phone calls to friends, and play a little cribbage with the woman in the next bed.

In this subacute setting, the therapy staff actively involves the patients in deciding their therapy times. They then inform the nursing staff of the therapy schedule for the next day to ensure that patients are up and ready. However, twice within the last week, Mrs J has adamantly refused therapy. Jane is not sure how reliable Mrs J's complaints/refusals are.

Today, Robert, Jane's clinical instructor, is interested in observing Jane's interaction with Mrs J. So as not to disrupt the session, Robert arrives just after Jane, but remains in the hallway, within easy listening distance.

Jane enters Mrs J's room, to find her on the telephone with one of her neighbors from home. Jane briefly interrupts Mrs J to tell her that it is time for her scheduled appointment. When Mrs J makes no move to end her conversation, Jane again interrupts Mrs J to say that she will return in a minute and expects to see that the conversation has ended. When Jane returns a few minutes later, she again interrupts Mrs J and firmly, but politely, asks her to hang up because she has agreed to have her treatment at this time. Mrs J looks somewhat surprised, but appropriately hangs up.

(See answer key in Section VII.)
### Anecdotal Record

*The CI simply records the facts of “what happened,” offering no judgments mixed with facts.*

<table>
<thead>
<tr>
<th>Student's Name: Jane</th>
<th>Date: ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluator/Observer: Robert</td>
<td></td>
</tr>
</tbody>
</table>

#### Setting:
(Place, persons involved, atmosphere, etc)

Jane had made an appointment with Mrs J, who in the past week has refused physical therapy twice. When Jane arrived, the patient was on the telephone. Jane told the patient that she would return in a minute and asked the patient to end the conversation. When Jane returned, the patient was still on the phone and made no move to end the conversation.

#### Student Action or Behavior:

Jane interrupted Mrs J and firmly, but politely, asked her to end the conversation, since she had agreed to have her treatment at this time.

#### Evaluator Interpretation:

Jane demonstrated appropriate and assertive intervention to set limits on the patient's behavior. Assertiveness has been a challenge for her, and this is a good example of an appropriate application of the skill.

**Jane Student**

**Robert Clinical Instructor**

#### Student's Comments:

It's difficult for me to feel like I'm being rude, but I can see the importance of setting limits on the patient's behavior.
d. Critical Incident Report

Critical Incident Report

1. Useful *adjunct* to summative evaluation, but not useful alone
2. Can be used to document a series of related behaviors, usually problem behaviors
3. No interpretation by observer; just states facts
4. Includes *clearly stated consequences* for the behaviors
5. Requires student signature

This form provides additional information about consequences. It makes it very clear to the student how serious you are about his/her attending to a particular behavior.

The use of the Critical Incident Report is strongly suggested for the student who demonstrates problem behaviors or may be having significant difficulties in the clinic. As the CI, you must be prepared to carry out the consequences or this becomes simply an exercise.

This form is also particularly useful with students with affective/attitudinal problems.
# The Critical Incident Report

*Directions: Record each entry clearly and concisely without reflecting any biases.*

**Student’s Name:**

**Evaluator/Observer:**

<table>
<thead>
<tr>
<th>Date (Time)</th>
<th>Antecedents</th>
<th>Behaviors</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student’s Initials:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evaluator’s Initials:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Student’s Initials:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evaluator’s Initials:</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Student’s Initials:</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Evaluator’s Initials:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Student’s Signature:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evaluator’s Signature:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Activity 2
The Critical Incident Report
Activity 2
The Critical Incident Report

Directions: Given the information in the narrative, complete the Critical Incident Report on the next page as if you were planning to share it with your student. Disregard the “specific times.” Create your own consequences.

Bruce is completing the fourth week of his second full-time clinical experience on an inpatient rotation at St. John’s Hospital. He previously completed an 8-week experience in an outpatient private practice. His previous clinical experience was uneventful except for frequent reminders to adjust the aggressiveness of interventions. He required reminders to consider the entire patient and the patient’s response to interventions, not just the single joint on which he was working.

During the first week of this clinical experience, Bruce’s clinical instructor, Karen, became concerned with Bruce’s lack of attention to detail as it related to total patient care and lack of respect for the patient and their needs. She mentally noted a number of instances, such as failure to use a gait belt, lack of attention to setting up the environment in the patient’s room prior to providing interventions, lack of attentiveness to the patient’s needs or asking about level of pain. As incidents were identified and discussed, they did not recur. However, Karen was concerned that new examples of this failure to attend to detail and lack of respect for the patient and his or her needs continued to surface. She wanted to find a way to emphasize the seriousness of these incidents to Bruce, let him know that he was jeopardizing his patients’ welfare by failing to look at the big picture and being sensitive to their needs, and inform him in no uncertain terms that a change in his approach was required. She decided to use the Critical Incident Report format to document the following additional instances.

During the first week of the clinical experience, having observed Karen treat a similar case the day before, Bruce successfully instructed a 76-year-old woman with a total hip replacement, in non-weight bearing with a walker. This was the first time ambulating since her surgery, and Bruce did a nice job with patient instructions and demonstration. Bruce appeared to be in control of the situation, as Karen stopped briefly to fill in one of the nurses about another patient. When she glanced down the hallway a few moments later, she was appalled to see that Bruce let go of the gait belt and was apparently texting a message on his phone. He did not notice the incorrect gait pattern or the visible signs of distress on the face of his patient.

During the second week of this acute clinical experience, Bruce was transferring a patient from wheelchair to bed, a task he had performed many times in the last couple of weeks. As he assisted the patient to standing, the wheelchair began to move. Rather than sit the patient down to correct the error, Bruce continued with the transfer.

Bruce’s third and fourth weeks have been spent on the cardiopulmonary unit at St. John’s. Very strict protocols, policies, and procedures are adhered to on this unit. Karen thoroughly reviewed all pertinent policies and procedures with Bruce, and the importance of each was discussed. However, Karen has frequently noted a troubling lack of detail in the notes Bruce has written and that pertinent information about the patient’s needs was absent. Important information is missing. It is discovered, upon questioning, that Bruce has only sporadically done a thorough chart review and patient interview.

(See answer key in Section VII.)
Instructor’s note: the “case of Bruce” is used again for Activity 3. It is suggested that all participants complete the Critical Incident Report and also Activity 3 at this time.

**Critical Incident Report**

*Directions: Record each entry clearly and concisely without reflecting any biases.*

<table>
<thead>
<tr>
<th>Date (time)</th>
<th>Antecedents</th>
<th>Behaviors</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/2 at 9:30 am</td>
<td>Bruce was assisting a 76-year-old patient with a total hip replacement during her first attempt at ambulation, non-weighting bearing, with a walker.</td>
<td>Bruce was text messaging on his cell phone while assisting the patient during ambulation. Bruce was not paying attention to the patient. Bruce did not note level of pain evidenced by the patient the patient’s incorrect gait pattern and distress.</td>
<td>If unsafe behavior such as this continues to occur, it will be written on his permanent evaluation.</td>
</tr>
<tr>
<td>10/15 at 2:00 pm</td>
<td>Bruce was assisting a patient in transferring from wheelchair to bed.</td>
<td>Bruce did not lock the wheelchair prior to assisting the patient to a standing position.</td>
<td>This behavior will be recorded on Bruce’s permanent evaluation. If behavior such as this continues, his mid-evaluation rating on “Safety” will be lowered and the ACCE/DCE will be contacted.</td>
</tr>
<tr>
<td>10/22 at 11:00 am</td>
<td>On the cardiopulmonary unit: Documentation following treatment session.</td>
<td>Documentation poor due to lack of thorough chart review and patient interview.</td>
<td>ACCE/DCE will be called to address repeated issues of safety, lack of concern for patient welfare, and interpersonal skills.</td>
</tr>
</tbody>
</table>

**Student’s Signature:** Bruce Student  
**Evaluator’s Signature:** Karen Clinical Instructor
So now that we know a little bit more about feedback/formative evaluation, let's take a look at some of the most frequent comments that we hear about student performance and assess whether or not they're appropriate.

C. Summative Evaluation

1. Guidelines for Effective Summative Evaluation

Guidelines For Summative Evaluation\(^{(Watts)}\)

General Principles

- Any rating method will be somewhat subjective given professional judgment.
- Following accepted principles of evaluation will make rating as objective as possible.

General Principles:

Careful evaluation should be used as a mechanism for determining strengths and weaknesses of the individual student, as well as the effectiveness of the academic and clinical programs. Although any rating method will be somewhat subjective given professional judgment, every precaution should be taken to make it as objective as possible by following these accepted principles of rating.

Typically physical therapy evaluation instruments are observational in nature. We don't use paper-and-pencil tests in the clinic (some disciplines do...medical technology for example, which is very objective). Inherent in observational instruments is their tendency to be subjective...unless one attends carefully to some of the established rules.
Guidelines For Summative Evaluation: The Rating Process

i. Ratings are based on definite observations made of the student’s work.

ii. Ratings are based on typical and frequent manner of performance (not isolated instances)

iii. Do not “average” performance (assess performance at a point in time; use comments to indicate a change in performance)

The rater should not guess! If you have had insufficient opportunity to observe the objective in question, and consultation with others is not helpful, your response should be “N/O” or “not observed enough to evaluate”. Most instruments will provide this option. In some cases, you may wish to indicate in a comment section that you have begun to discuss this objective with the student, even though you have not had an opportunity to actually observe the student relative to the objective in question.

Instructor's note: Only the next 3 items are addressed on this slide. The remaining guidelines are addressed on the next slide.
ii. On the basis of **typical and frequent** manner of performance rather than on isolated instances. **Do not rate based on one observation only.** This should be "N/O" or "not observed enough to evaluate."

This is a common error among CIs. If you have only observed the performance only one time, you cannot rate it objectively. A series of N/Os will indicate where you need to spend time during the second half of the clinical experience. The only **caveat** to the "typical and frequent" rule is when it comes to issues of **safety.** Even one instance of unsafe behavior can destroy the trust you have in the student; it should be addressed immediately.

iii. On the basis of typical and frequent manner of performance at **this point in time.** Do not average performance over the first half of the clinical experience. **Use the comment section** to indicate that change in performance has occurred.

---

**Guidelines For Summative Evaluation:**

**The Rating Process (cont’d)**

iv. Become “rating conscious”

v. Avoid rater “errors” and maintain rater objectivity

vi. Do not average rating scores within a section

vii. Use comment section to make specific explanatory remarks

viii. Use CPI Performance Dimensions to rate performance and guide comments (CCIP; p 38)

1. Quality
2. Supervision/guidance
3. Consistency
4. Complexity
5. Efficiency
iv. Become "rating conscious" by familiarizing yourself with the rating form in advance so you know what you are asked to observe. Look for concrete instances in the daily work of the student that will assist you in formulating your professional judgments. The more instances you can cite, the better able you will be to support your rating in discussions with the student.

Before the student arrives, the CI should become "rating conscious". This means that you should familiarize yourself with the evaluation instrument in advance so you know what you’re going to be asked to observe. You should know the expectations of the academic institution, and you should be clear about the interpretation of the rating scale.

v. Become knowledgeable about common types of rater error. Awareness of typical errors will increase the objectivity of your assessment.

We’ll address this specifically a little later.

vi. Unless instructed to do so, do not average ratings/scores within a section or make extraneous markings. Follow the specific directions provided with the evaluation instrument.

You immediately invalidate the document by doing so.

vii. Use the comment section to document and clarify ratings (score, rating, markings) that are below the norm or expectations and those ratings that are above the norm or expectations. Use of the comment section is crucial for any evaluation tool, but especially for the CPI, to support and be consistent with the mark on the VAS or categorical scale.

Accompanied by an anecdotal record or critical incident report, this becomes very powerful documentation.

viii. Use the CPI Performance Dimensions to rate performance and guide comments. expectations.

1. Quality
2. Supervision/Guidance
3. Consistency
4. Complexity
5. Efficiency
Using The Summative Evaluation Report

i. Midpoint evaluation
   - Provide assurance
   - Offer constructive criticism
   - Discuss areas for improvement
   - Plan for improvement

b. Using the report
   i. It is **suggested** that the student's performance be evaluated at midpoint. If the student is doing well, give him or her this assurance as well as constructive criticism that may guide him or her to even better performance. If there are areas that need improvement, indicate this and give positive suggestions for improvement.

   Suggested and required by most schools.

next slide/page
Using The Summative Evaluation Report (cont’d)

ii. Final evaluation
   – Summarize performance
   – Plan for future clinical experiences
   – Plan for entry into practice

iii. CI and student sign and return summative evaluation to academic program

Strategies for Conducting an Evaluation Session

a. Clearly establish goals and objectives
b. Be consistent about expectations and open to sharing observations in a timely manner
c. Be specific - use examples
d. Engage the learner in self-evaluation
e. Listen actively
f. Practice assertiveness and cooperation
2. **Guidelines for Successful Student Evaluation**

   a. Clearly establish the goals you are working toward and the objectives that describe those goals.

   Establish good communication early in the experience and keep the lines of communication open.

   b. Be consistent with your expectations of the student and be open about sharing your observations with the student in a timely manner.

   Use the principles of formative evaluation that we spoke of earlier. Be careful not to overload the student with so much information that he/she is unable to absorb it all.

   c. Use examples and be as specific as possible with your critiques.

   This is especially critical for any areas that are below the norm. Base your comments on how close the student is to achieving the established objective(s).

   d. Engage the student in both evaluating himself/herself and reacting to your evaluation.

   Self-assessment is a critical area of student evaluation. Many programs begin students early by having them complete Student Data Forms, which require that they assess their exposure as well as their comfort in a variety of areas of physical therapy practice and patient management. NOTE: The skillful CI will effectively incorporate the student’s self-assessment results in the overall evaluation process.

   The ability to accurately self-assess is highly dependent, however on the feedback that has been received. We must be honest with students, so they develop a keen ability to self-assess. Once they graduate, they will be responsible for determining whether they have done a good job and they must be able to do this **honestly** and **accurately**.

   e. Be sure to listen as well as to speak.

   f. Try to practice a combination of assertiveness and cooperation when dealing with a potential or actual problem situation.

   And I'll add one more to this list, and that is to be acutely aware of common errors that evaluators (CIs) may make in assessing student performance.
<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>CRITIQUE</th>
<th>IMPROVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “This is hard to evaluate for the student's level.”</td>
<td>Evaluation scores address observable behavior, not a subjective assessment of progress.</td>
<td>The student should receive a rating/score based on the criteria outlined in the evaluation form, regardless of his or her level.</td>
</tr>
<tr>
<td>Next Slide (151)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. “With more experience, she hopefully will improve in...”</td>
<td>This is conjecture, not fact. We hope that the student will improve with more experience, but we cannot allow this subjective “hope” for future student performance to color our assessment of his/her performance at this point in time.</td>
<td>Student should receive an objective rating/score, based on the criteria outlined in the evaluation form.</td>
</tr>
<tr>
<td>Next Slide (152)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. “His performance was OK, but could have been better.”</td>
<td>This is not useful feedback, as it is much too vague. Any student would have difficulty deciding what he or she was supposed to change.</td>
<td>Be specific about what needs to be modified.</td>
</tr>
<tr>
<td>Next Slide (153)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. “This problem dates back to his first week of clinical experience.”</td>
<td>If this is the case, the expectation is that it has been addressed in a variety of ways since that time. If there has been no attempt at remediating the “problem,” why not?</td>
<td>You should be able to provide documentation of all attempted remediation techniques and the outcomes of all techniques used using formative feedback tools.</td>
</tr>
<tr>
<td>Next Slide (154)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. “She needs a better attitude toward patients, as evidenced by her performance during bedside care.”</td>
<td>Attitudes are difficult to assess. This statement does not make it clear to the student what her behavior is that is a problem.</td>
<td>Be objective and specific by noting observable behaviors. Use anecdotal records to document/describe specific situations.</td>
</tr>
<tr>
<td>Next Slide (155)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Instructor’s note: The above content emphasizes the need to be precise in assessing the student’s performance. Therefore, this can easily be reviewed rather quickly, depending on participants’ levels of experience. There is a series of 5 slides with each of the 5 statements in the left column.

next slide/page
Slides 151-155 follow
“This is hard to evaluate for the student’s level.”

“With more experience, she hopefully will improve in...”
“His performance was OK, but could have been better.”

“This problem dates back to his first week of clinical experience.”
“She needs a better attitude toward patients, as evidenced by her performance during bedside care.”

**Common Rater Errors in Performance Evaluation**

a. Halo or reverse-halo effect  
b. Rater mood or memory  
c. Error of central tendency  
d. Proximity error  
e. Error of leniency  
f. Initial impressions  
g. Logical error  
h. Contrast effect  
i. Similarity of background and issues of diversity* (Haskins, Rose-St Prix, Elbaum)
3. Common Rater Errors in Performance Evaluation

a. **Halo or reverse-halo effect**
   Allowing the value of 1 item to positively (or negatively) influence your grade in another item.

b. **Rater mood or memory**
   Allowing your mood to affect the grades you assign to a student. Making professional judgments of student’s performance based on unclear recollections.

c. **Error of central tendency**
   The tendency for raters to grade toward the center of the scale, whatever the scale might be. The entire scale should be considered, and used if appropriate. Failure to use the whole scale when appropriate does not adequately discriminate between a student's or students' abilities.

d. **Proximity error**
   Allowing 1 item to affect your score on the next item, simply because of each item’s proximity to the other.

e. **Error of leniency**
   The tendency to be more lenient in rating the student you know well, or going disproportionately out of your ways to avoid leniency.

f. **Initial impressions**
   Allowing the first impression left by a student to affect your later judgments about performance of a specific skill.

g. **Logical error**
   The tendency to rate items similarly simply because some traits are logically quite similar to others, without making the necessary distinctions between traits.

h. **Contrast effect**
   The quality where the previously rated student will often affect judgment about the student being rated.

i. **Similarity of background and issues of diversity**
   Allowing your judgment to be affected by the degree of similarity between you and the student being assessed with respect to background, attitudes, and ethnic group. It has been shown that greater similarity tends to produce more favorable decisions. Diversity describes the many differences and similarities that exist between people. Some of these are apparent such as race and gender. Some of these differences are less obvious—cultural background, religious morals and values, education, social status, age, lifestyle, and political views. All of these dimensions may influence evaluation of performance. Covert bias due to race and ethnicity was shown to exist in evaluating student performance in a study by Haskins et al.⁶
Instructor Note: The emphasis of discussing rater errors should be on awareness. Just being aware that these types of errors can help us to become more objective in our assessment of student performance and can easily occur with observational instruments. Important discussion points with regard to issues of diversity.

* Treat everyone with respect
* Be aware of one’s own beliefs
* Learn about other cultures
* Do not assume others will have similar values, backgrounds, or standards

This is a topic that is too broad to address completely in this program. Emphasize the need for awareness and where to go to obtain more information about this topic. There are several modules in the APTA Learning Center on cultural competence that participants may wish to explore. We will discuss implications of diversity in the cases in Section VI.
4. Summative Rating Scales and Their Use

Rating Scales

Summative Rating Scales and Their Use

- a. Checklist
- b. Numeric rating scale
- c. Visual analog scale
- d. Categorical rating scale

1. Checklist
2. Numeric ratings
3. Visual analog scales
4. Categorical Rating Scale (EX: PT CPI)

This section is intended to present various rating scales, however the primary emphasis should be on understanding the rating scale including the limitations and strengths of each tool. In addition, it is important to emphasize the evaluation tools are used by different stakeholders for different purposes. Students are interested in the grade reflected by the rating; academic institutions use ratings to measure outcomes, and researchers use ratings for yet a different purpose. The important key is helping participants understand the use of any evaluation tool and use it in the manner in which it was intended. This session is not intended to provide training on any of the tools where the rating scales are identified.
Checklist

i. Rating absence/presence (yes/no) only
ii. Often in task analysis format—useful in remediation of challenging student situations
iii. Least subjective of all tools
iv. Most difficult to use correctly
v. Does not allow for nuances in performance ratings

a. Checklist
   i. Rating absence/presence (yes/no) only
   Not being asked to “qualify” student performance.
   ii. Often in task analysis format—useful in remediation of challenging student situations
   Presents a nice task analysis of skills and can be useful in remediation.
   iii. Least subjective of all tools
   iv. Most difficult to use correctly
   Inherently have a need to qualify our responses.
Example 1
Checklist

The following rating scale has been developed for use with the PT MACS:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>Above entry-level. Surpasses entry-level standards for this setting by meeting all applicable objectives; practices the skill safely, effectively, consistently, and efficiently.</td>
</tr>
<tr>
<td>✔</td>
<td>Entry-level. Meets entry-level standards for this setting by meeting all applicable objectives; practices the skill safely and effectively.</td>
</tr>
<tr>
<td>NI</td>
<td>Not Independent. Below entry-level standards for this setting; does not meet all applicable objectives; practices the skill with supervision or assistance from the CI, requiring guidance and/or correction. Requires comment by CI.</td>
</tr>
<tr>
<td>U</td>
<td>Unacceptable. Well below entry-level standards for this setting; does not meet applicable objectives even with repeated assistance from CI to correct deficits; practices the skill in an unsafe and/or ineffective manner even with repeated guidance from CI. Requires comment by CI citing incidents/reasons for the rating; CI or CCCE must call DCE or ACCE as soon as possible once the student earns this rating.</td>
</tr>
<tr>
<td></td>
<td>Blank. Student has had no opportunity to practice the skill in this setting.</td>
</tr>
</tbody>
</table>

A. Basis for the Rating Scale
   1. The PT MACS is designed so that the skills can be completed in a variety of practice settings.
   2. The student may encounter facilities where certain objectives for the skill are not performed routinely by the physical therapist.
      - If this is the case, then the student should be rated based only on the objectives that are applicable for that facility.
      - The student should not be expected to fulfill an objective if that objective is not applicable to the facility.
      - At the beginning of the internship, the CI should identify:
         - Objectives applicable to the setting
         - Expectations of the student in order to earn an entry-level (✔) rating

Note: Ratings should be based only on the objectives applicable at the facility in which the student is completing the internship.
Example 1
Checklist† (Cont’d)

B. Explanation of the NI and U Ratings

1. **NI** rating: The student is not independent because of 1 or more of the following:
   - Student requires cueing, prompting, reminding, instructing, guiding, or correcting to perform applicable objectives for the skill.
   - Student is not safe in performing the skill.
   - Student demonstrates errors in performance of the skill.

   *Note: CI must document specific behaviors that need improvement, referring to the objectives of the skill when applicable.*

2. **U** rating: The student’s performance is unacceptable because of 1 or more of the following:
   - Student engages in a single grievous incident that demonstrates gross unprofessional, unsafe illegal, or unethical behavior
   - Student continues to perform the skill in an unsafe or ineffective manner *even after* receiving repeated guidance from the CI including written documentation of the incident(s) or problem(s).
   - Guidelines for Documenting the U Rating:
     - Document the specific behavior(s) that resulted in the U rating objective(s) that apply to the rating.
     - Document the extent and type of guidance, instruction, or counseling provided to the student leading up to the U rating.
     - If the documentation exceeds the space available for comments in the PT MACS, the CI must sign and date all additional documentation.
Numeric Rating Scales

i. Report quality of performance
ii. Descriptive, numeric, or graphic formats
iii. Easy to use
iv. Use in conjunction with formative tools
v. Can be subjective and must follow summative evaluation principles to avoid bias (rating errors)

b. Numeric Rating Scales
   i. Rater able to qualify response; not only can the student perform something, but also how well is it performed
   ii. Can appear as descriptive–numeric format (Example 2), or graphic (Examples 3 and 4)
   iii. Easy to use
   iv. Can be subjective and must follow summative evaluation to avoid bias (i.e., typical rating errors)
      • each objective operationally defined (Example 2)
      • visual analog scale (Example 3)

APTA’s 1997 and 1998 PT and PTA student performance evaluation instruments previously used a visual analog scale (VAS). We will see what this scale looks like and the dimensions used to assist the rater in marking the scale shortly.
Example 2  
**Numeric Rating Scale**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Consistently meets the stated objective. The student seeks <strong>confirmation</strong> from the CI.</td>
<td><em>Confirmation</em>. Student confers with the CI prior to or following an activity for the purpose of sharing information and/or validating decision making. The student is capable of functioning safely and independently.</td>
</tr>
<tr>
<td>3</td>
<td>Consistently meets the stated objective. The student needs <strong>guidance</strong> from the CI.</td>
<td><em>Guidance</em>. Student needs advice from the CI to expand knowledge or skills. The presence of the CI in the immediate vicinity is not necessary.</td>
</tr>
<tr>
<td>2</td>
<td>Meets the stated objective with inconsistencies. The student requires <strong>supervision</strong> from the clinical instructor.</td>
<td><em>Supervision</em>. The student needs verbal cuing or physical assistance from the clinical instructor. The presence of the clinical instructor in the immediate vicinity is necessary.</td>
</tr>
<tr>
<td>1</td>
<td>Does not meet the stated objective. The student requires <strong>constant supervision</strong> from the clinical instructor.</td>
<td><em>Constant Supervision</em>. The student requires continuous verbal cuing or continuous physical assistance from the clinical instructor.</td>
</tr>
<tr>
<td>N/A</td>
<td>Not Applicable. Objective not applicable to this clinical situation.</td>
<td></td>
</tr>
<tr>
<td>N/O</td>
<td>Not Observed. Objective not observed to the extent that a rating is <strong>appropriate</strong>.</td>
<td></td>
</tr>
</tbody>
</table>

Some evaluation tools also include critical areas or essential areas; selected areas that have been weighted more heavily than others. The student must successfully pass these areas or risk failure of the experience.
Visual Analog Scale (VAS)

i. Reports student performance along a visual continuum with 2 clearly defined anchors that progress from novice to entry-level; assesses student performance in relation to entry-level.

ii. More difficult to use to qualify performance with only 2 anchors.

iii. Ratings triangulate with qualitative comments: internal consistency check.

iv. Used in conjunction with formative tools.

v. Must follow summative evaluation principles to avoid bias.

vi. Visually can represent a small degree of change in student performance; however those small changes may not necessarily be statistically significant in terms of grading.

c. Numeric Rating Scales – Visual Analog Scale

i. Reports student performance along a visual continuum with 2 defined anchors that progress from novice to entry-level; assesses student performance in relation to PTA entry-level.

ii. More difficult to use to qualify performance with only 2 anchors.

iii. Ratings triangulate with qualitative comments: internal consistency check.

iv. Used in conjunction with formative tools.

v. Must follow summative evaluation principles to avoid bias.

vi. Visually can represent a small degree of change in student performance; however those small changes may not necessarily be statistically significant in terms of grading.
EXAMPLE 3
Visual Analog Scale: APTA Clinical Performance Instrument (PTA CPI)\(^9\)

| Performs in a safe manner that minimizes risk to patient, self, and others. |
|-----------------|-----------------|-----------------|
| M | F |

<table>
<thead>
<tr>
<th>Not Observed</th>
<th>Novice Clinical Performance</th>
<th>Entry-Level Performance</th>
<th>With Distinction</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

**Significant Concerns:** Check below if performance on this criterion places student at risk for failure of this clinical experience.

Key:  
M = Midterm; F = Final

The PTA CPI: Version 1998 allowed the rater to assess student performance based on outcome performance criteria. The rater indicates on the *visual analog scale (VAS)*, using a vertical line that intersects the scale, where the student’s performance falls on the continuum from novice clinical performance to entry-level performance at both mid- and final evaluations. *Sample behaviors* accompany each performance criterion to guide the assessment of the student’s competence relative to the performance criterion. In addition, the rater has the option of checking the “With Distinction” box indicating that the student’s performance on the criterion exceeds expectations for that specific clinical experience. Note that this scale allows the rater to indicate that the performance was not observed. The rater may also check the “Significant Concerns” box if the student’s performance is problematic such that the student is at risk of failing. This provides for an *early warning signal* (to be discussed further in Section V) to student and the academic program. When this box is checked, it warrants a call to the ACCE/DCE to discuss the student’s performance problems as early as possible and to develop an action plan to address any performance issues.

**Instructor Note:** Note that this scale allows the rater to indicate any performance criterion that was not observed. The rater may also check the “significant concerns - at risk” box if the student’s performance on a criterion is problematic such that the student is at risk of failing. This box provides for an *early warning signal* (to be discussed further in Section V) to the student and the academic program. When this box is checked, it warrants a call to the ACCE/DCE to discuss the student’s performance problems as early as possible and to develop an action plan to address any performance issues.
Instructor's note: Consistency in the use of a visual analog scale is enhanced by clearly defined anchors and performance dimensions that augment the rater's understanding of the continuum being used.

In the PTA CPI, **novice clinical performance** indicates a student who provides quality care only with uncomplicated patients and a high degree of supervision. Without close supervision, the student's performance and judgment are inconsistent and require constant monitoring and feedback. This is typically a student who is inexperienced in the clinical environment or who performs as though he or she has had limited or no opportunity to apply academic knowledge or clinical skills.

In the PTA CPI, **entry-level performance** indicates a student who consistently and efficiently provides quality care with simple or complex patients and in a variety of clinical environments under the supervision of a physical therapist. The student usually needs no further guidance or supervision except when addressing new or complex situations.
Categorical Rating Scale

i. Uses 6 well defined anchors that provide specific conditions under which all must be met to mark on or above an anchor or in an interval.

ii. Ratings triangulate with qualitative comments to check for internal consistency.

iii. May be more difficult to use given specific anchor definitions.

iv. Enables subtle changes in student performance to be recorded, however statistically significant changes exist only between 2 intervals or anchors for the purpose of grading.

v. Used in conjunction with formative tools.

vi. Must follow summative evaluation principles to avoid bias.

vii. In the case of the PT and PTA CPI, requires successful completion of an online training prior to use.

d. Numeric Rating Scales – Categorical Rating Scale

i. 6 well defined anchors provide specific conditions under which all must be met to mark on or above an anchor or in an interval.

ii. Ratings triangulate with qualitative comments to enable a check for internal consistency.

iii. May be more difficult to use given specific anchor definitions.

iv. Enables subtle changes in student performance to be recorded, however statistically significant changes exist only between 2 intervals or anchors for the purpose of grading.

v. Used in conjunction with formative tools.

vi. Must follow summative evaluation principles to avoid bias.

vii. In the case of the PT and PTA CPI, requires successful completion of an online training through the APTA Learning Center prior to use.
EXAMPLE 4
Categorical Scale: APTA Clinical Performance Instrument (PT CPI)\(^{10}\)

Professional Practice

SAFETY

1. Practices in a safe manner that minimizes the risk to patient, self, and others.

SAMPLE BEHAVIORS

a. Establishes and maintains safe working environment.
b. Recognizes physiological and psychological changes in patients* and adjusts patient interventions* accordingly.
c. Demonstrates awareness of contraindications and precautions of patient intervention.
d. Ensures the safety of self, patient, and others throughout the clinical interaction (eg, universal precautions, responding and reporting emergency situations, etc).
e. Requests assistance when necessary.
f. Uses acceptable techniques for safe handling of patients (eg, body mechanics, guarding, level of assistance, etc.).
g. Demonstrates knowledge of facility safety policies and procedures.

*Words denoted with an asterisk are defined in the PT CPI glossary.

MIDTERM COMMENTS: (Provide comments based on the performance dimensions including supervision/guidance*, quality*, complexity*, consistency*, and efficiency*.)

FINAL COMMENTS: (Provide comments based on the performance dimensions including supervision/guidance*, quality*, complexity*, consistency*, and efficiency*.)

Rate this student's clinical performance based on the sample behaviors and comments above:

Beginning Performance* Advanced Beginner Performance* Intermediate Performance* Advanced Intermediate Performance* Entry-level Performance* Beyond Entry-level Performance*

Significant Concerns: If performance on this criterion is unacceptable, check the box and call the ACCE/DCE.
EXAMPLE 4 (Cont’d)

The PT CPI: Version 2006 allows the rater to assess student performance for 18 outcome performance criteria. All 18 performance criteria are to be rated for all levels of student clinical education experience. Prior to marking the rating scale, the rater reviews the Sample Behaviors that accompany each performance criterion. Using the sample behaviors and the 5 Performance Dimensions (Participant Manual, p 38), comments are provided to guide the assessment of students’ competence relative to the performance criterion.

The rating scale consists of 6 well-defined anchors designed to reflect a continuum of performance ranging from “Beginning Performance” to “Beyond Entry-Level Performance.” Student performance is described in relation to one or more of these 6 well-defined anchors. This rating scale is not designed to be a visual analog scale. The vertical mark indicates that the student has exceeded the anchor definition of “intermediate performance”; however the student has yet to satisfy the definition associated with “advanced intermediate performance.” In order to place the rating on an anchor, all of the conditions of that level of the rating must be satisfied as provided in the description for each of the 6 anchors. The rater may also check the “Significant Concerns” box indicating that the student’s performance on this criterion is unacceptable for this clinical experience. The significant concerns box provides an early warning system to identify student performance problems thereby enabling the CI, student, and ACCE/DCE to determine a mechanism for remediation, if appropriate.

The PT CPI: Version 2006 requires that all users (CIs, CCCEs, ACCEs/DCEs, and students) complete an online training program and assessment program and achieve a passing score of 70% or higher. This training program is offered through the APTA Learning Center (http://learningcenter.apta.org/) and consists of 5 modules that include all of the essential information to accurately and consistently use this instrument. The PT CPI: Version 2006 is only available as a Web-based instrument (PT CPI Web) to those individuals that have successfully completed the online training and assessment. Physical therapist academic programs purchase an annual subscription through Academic Software Plus to access the PT CPI Web, which allows students, CIs, CCCEs, and ACCEs/DCEs to use the customized software (www.apta.org/ptcpi). Contact the physical therapist program’s ACCE/DCE for specific questions about using the PT CPI Version: 2006 or the PTA CPI Version: 2009.
Now that we have discussed different types of rating scales and their strengths and limitations, let’s take a quick look at the different perspectives of the raters that are using these different scales. The 4 different raters–students, CIs, CCCEs, and the academic program (ACCE/DCE) may all use the same student performance evaluations, however their perspectives about the purpose and use of these instruments differs. Let’s explore each of the rater users to see what they desire in these tools.
Rater Perspectives

• Students
  – Seek clear and objective performance information.
  – Seek indications of performance change from mid-to final evaluations and details about those changes.
  – No surprises! Should know how they are performing through summative and formative mid- and final evaluations.

Students seek clarity about their performance and how they have changed over the duration of the clinical experience. They also are interested in how they have improved from mid- to final evaluations, recognizing that there is a possibility that they may not have improved on a criterion or in fact become less capable.

One of the most important concepts is that the student should know how they are performing throughout the experience through summative feedback and comments as well as formative evaluations. There should be NO surprises for the student given that most tools provide for an early warning system to notify the student, CCCE, and academic program of a student whose performance is at risk or of significant concerns.
Rater Perspectives

- CIs
  - Seek clarity in how to use the specific performance assessment accurately.
  - Prefer assessments that can show small degree of change in student performance.
  - Seek systematic and objective tools that can be used consistently.
  - Must provide comments that support and explain ratings.
  - Need to feel comfortable in their role to objectively assess the student and the academic program to assign a grade based on the performance assessment and other program requirements.

CIs seek clarity in how to accurately, systematically, and consistently use a rating scale and a student performance instrument to be as objective as possible, recognizing issues of rater bias. CIs prefer instruments that enable them to convey small changes in performance to students to demonstrate that they are making progress in relation to specific criterion or skills. CIs need to feel comfortable in their role as the assessor of student performance through patient/client observation, demonstration, education, and communication and need to recognize the importance and value of providing objective and honest performance assessment based on established skills or criteria.

As a part of their role it is imperative to use the comments section provided in evaluation tools to describe specific cognitive, psychomotor, and affective performance and specific examples of how the comments provided support the rating. Finally, the CI needs assurance that they provide the objective student assessment while the academic program uses the performance evaluation with other requirements for clinical education to determine a grade for the student,
Rater Perspectives

- CCCEs
  - Review CI performance assessment of the student as a part of CI professional development.
  - Attest that the CI performance assessment of the student was completed and reviewed.

The role of the CCCE in student performance is primarily through the CI at the practice setting. The CCCE may or may not be a physical therapist or physical therapist assistant and therefore, may not be directly involved in assessing the student’s performance.

The CCCE, however is vested with 2 primary responsibilities relate to student assessment. The CCCE may review the CI’s performance assessment of the student as a part of the CI’s professional development to ensure that the assessment is completed thoroughly and objectively. The CCCE may inquire as to how the CI was able to provide a rating on a particularly criterion based on the student’s learning experience. The CCCE may also inquire of the CI how the learning experience could be improved for students and what the CCCE could do to contribute to that outcome.

The CCCE may be required to sign off on a student performance assessment to ensure that the student and CI reviewed and signed both mid- and final evaluations. In some cases, the CCCE may be invited or requested to be present during a student performance evaluation, especially in the case of a student with significant concerns or at risk performance.
Rater Perspectives

• Academic Program
  – Important that CIs and students use performance assessments consistently and objectively.
  – Basis decisions on student clinical performance on the CI’s objective performance evaluations.
  – Compares student performance self-assessment with CI performance assessment of the student for degree of agreement and/or variance.
  – Grading of student performance based on CI performance ratings and other program requirements.
  – Conducts research on student clinical performance over time to make modifications in curriculum.

The academic programs’ perspective, typically represented by the ACCE/DCE in physical therapy, is concerned with student performance assessment from the perspective of meeting clinical education learning objectives, progression throughout the curriculum with demonstrated competence, and readiness to enter practice upon graduation. Academic programs invest in resources to ensure that CIs and student use the performance assessments correctly, consistently, and accurately so decisions that are based on the CIs assessment are valid. Programs compare the CIs assessment of the student’s performance to the student’s self-assessment to determine overall consistency in the ratings and student’s ability to self-assess. Self-assessment is a part of the student’s development as a professional where clinical education provides one opportunity, among others, for self-appraisal. Decisions regarding a grade for the clinical education course are a part of the ACCE/DCE responsibility. Grading decisions are based on the student performance assessment as well as other clinical education requirements that may be required of the specific course (eg, keeping a journal, in-service requirement, case study, research, etc).

The ACCE/DCE also tracks longitudinal student performance data from clinical education to inform decisions regarding curriculum design and revision. Clinical education research may also be conducted by compiling and analyzing aggregate student clinical performance data with respect to admissions requirements, licensure pass rates, predicting students with clinical performance difficulties, and Credentialed CIs vs. non-Credentialed CIs.
Summary

Section IV highlighted the following information about performance assessment:

Summary: Evaluation

- Includes timely and specific feedback
- Promotes student self-assessment
- Documents performance using formative and summative evaluation tools
- Raters know how to use the evaluation tools.
- Raters are aware of rater errors
- Contact ACCE/DCE early with student performance issues!

**FINAL QUESTION**

What 1 thing will you change in the future as you evaluate student performance?
References


Additional Reference

Section V

Legal, Regulatory, and ADA Issues in Clinical Education

Acknowledgment

Some of the information contained in this section is used with permission and taken from the presentation “Legal Context for Evaluating and Dismissing Physical Therapy Students” by Steve Milam, Senior Counsel and Assistant Attorney General, Health Sciences and Medical Centers, University of Washington, Seattle, WA.¹
Introduction

Section V reviews the legal context in which the evaluation and dismissal of physical therapist and physical therapist assistant students are viewed. The discussion includes the view of the courts regarding intervening in academic matters, as well as the legal principles and processes involved when a legal decision is required. References are made to actual case outcomes. Documentation of the student’s performance is discussed. Discussion also addresses the responsibilities of the clinic when a student requires reasonable accommodations consistent with the American with Disabilities Act (ADA). In addition, student supervisory issues are addressed in relation to federal regulations and APTA policy, positions, and guidelines.

This discussion is not to be construed as legal advice or counsel. All participants are directed to consult legal counsel for actual situations that occur related to clinical education.

Within the context of a case situation, we will be considering four principles that influence how the courts make decisions about legal challenges in educational situations.

We will look at the decisions made in some actual cases.
We will consider your responsibilities.

We will also use a hypothetical case situation to look at the "Americans With Disabilities Act" and the definitions that define disability and discrimination and will consider your role and responsibilities with respect to students with disabilities.

Lastly, we will discuss information about student supervision based on federal regulations and APTA policy and positions.
Objectives

Following the completion of this section, the participant will be able to:

1. Identify the legal requirements for a high-quality educational experience, including a clinical affiliation agreement.
2. Apply documentation formats to maintain a clear academic record.
3. Discuss how courts view litigation of academic issues.

Objectives (cont’d)

4. Examine issues related to students with disabilities and implications for clinical education.
5. Discuss the legal and supervisory responsibilities of the clinical educator.
6. Locate references and resources associated with legal, regulatory, payor, employer, and profession-based supervisory responsibilities in clinical education.
Assumptions

1. Educators have legal as well as ethical responsibilities to students, to the academic institution, to the clinical facility, and ultimately to patients or clients.

2. Documentation of the clinical education process must be sufficiently clear, accurate, and thorough to demonstrate the quality and consistency of the educational experience.
**A. Clinical Affiliation Agreement**

The clinical affiliation agreement is a contractual document that is legally binding. The agreement specifies the roles and responsibilities of the involved parties, in this case the academic institution and clinical facility. Although duly authorized individuals are required to sign this document, it is still the responsibility of those parties who will carry out the contract to have read the document and to be in full compliance with the conditions specified therein.

Clinical affiliation agreements are generally reviewed and negotiated by legal counsel or other duly authorized individual within higher education and the clinical facility. The parties that are involved in the contract are also delineated. Although language used in clinical affiliation agreements vary between academic institutions and clinical facilities, essential elements required include:

1. **Specific responsibilities of the academic institution, clinical facility, and student in providing a clinical placement.**

As a part of the specified responsibilities, the items below are to be addressed:

- The nature of the relationship of the student to the clinical facility (ie, trainee, employee, independent contractor).
- Rights of the clinical facility in supervising the student (ie, direction, hours, discipline, conditions upon which the student may be terminated)
- The obligations of the clinical facility to the student (ie, safe environment, early problem identification, supervision, opportunity to fulfill learning requirements).
- The obligations of the student to the clinical facility (ie, diligent performance of the work, safeguarding the interests of the clinical facility, abiding by clinical facility policies).
- Rights of the academic institution regarding the clinical facility (ie, access to
• evaluate the student, removal of the student from the placement).
• The obligations of the institution to the student (ie, award of credit for satisfactory performance).
• The obligations of the institution to the clinical facility (ie, appropriate student screening and placement, advisement of known limitations, provision of information specific to the learning experience).

2. Specification of the conditions and time frame under which the contract may be broken, including the length of time in which the contract is in effect.

3. Identifies the method and frequency of evaluations.
   a. Includes requirements for the award of student credit and satisfactory course completion.

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**Clinical Affiliation Agreement (cont’d)**

5. Requirements for student malpractice insurance coverage.
6. Liabilities of the involved parties (eg, hold harmless).
7. Required information not in violation of the Buckley Amendment (eg, immunizations, test, health records on file).

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4. The method for resolution of disputes and the authority for and process of termination.
5. Required malpractice insurance coverage of the student.
6. Statement regarding liability of the parties involved in the contract (eg, hold harmless, double indemnity clause).
7. Specification of any information that must be provided about the student, that is not in violation of the Buckley Amendment, such as specific required immunizations or tests, health records on file, etc.
The Case Of A Student Dismissal

next page
Student Dismissal Case
The Case of a Student Dismissal

A student is completing her final 12-week clinical experience at a large inpatient rehabilitation hospital. This student’s performance has successfully met expectations for all classroom and prior clinical education experiences. The student has a slow start and is fearful of this clinical experience because she has not had any prior experience in adult rehabilitation or with patients with complex neurological conditions. She is diligent in preparing for patients that she will be seeing and routinely asks questions about managing complex neurological patients with various conditions.

Clinical Instructor Observations – Week 1
The CI used the Weekly Planning Form for the first week of the clinical experience but did not continue its use in subsequent weeks.

Midterm Performance Evaluation:
- Narrative comments reflect slow progress in all performance criteria.
- Ratings on the categorical scale are in the interval between beginner performance and advanced beginner performance anchors on the CPI.
- The CI has completed no critical incident reports.
- Summative comments by the CI indicate the student’s performance is a little behind expected performance but anticipates that the student will meet expectations in the next 6 weeks
- There is no indication on the CPI that the student is at risk on any performance criterion (mid-evaluation at-risk box is not checked).
- No call is placed to the ACCE/DCE.

Based on this mid-evaluation, the student feels confident that although she got a slow start, she is progressing satisfactorily to successfully meet the performance expectations at the completion of this experience. The student assumes that she is performing in ways that continue to progress and meet expectations. The CI verbally lets the student know that she is still demonstrating problems meeting expected clinical performance.

Final Performance Evaluation:
- Narrative comments indicate that the student is slowly progressing on several performance criteria.
- Ratings on the categorical scale for the performance criteria are at the advanced intermediate level and in the interval between below and well below entry-level performance.
- CI does not mark the at-risk box.
- Summative written comments at the end of the CPI do not reflect the seriousness of the student’s problem.
- CI and student review the completed CPI and sign the evaluation instrument.

The student leaves the experience with the impression that she has successfully passed the clinical experience.

The ACCE/DCE receives the completed CPI and a note from the CI stating that this student’s performance has not met performance expectations. Based on the CI’s CPI evaluation of the student, she should not pass the clinical experience. This is the first time that the ACCE/DCE is aware that there has been any problem with this student and the documentation that is provided does not seem to consistently substantiate the CI’s recommendation. The ACCE/DCE contacts the CI and asks whether the student was informed that her performance was unacceptable. The CI indicates that she had been letting the student know all along that she was progressing more slowly than expected and she was made aware that she needed work. At this point, the ACCE/DCE recognizes that this situation is potentially problematic and litigious.
The following questions should be raised, discussed, and answered during the course of this section.

Discussion Questions

1. What fundamental legal principles may have been violated in this case?
2. Was this student aware of the status of her clinical performance?
3. Was the student provided early notification regarding performance difficulties with an opportunity to successfully remedy her performance?
4. On what basis did this student fail this clinical experience?
5. How was the student’s clinical education performance documented? Was it sufficient to warrant failure?

Instructor’s Note: Allow participants to review this case and then raise the questions above to determine what participants may or may not know about this case with regard to legal issues and academic dismissal. Follow this discussion with the information provided in the manual that discusses legal issues and academic dismissal. Ensure that when you discuss this case that you address the roles and responsibilities of the clinical instructor, academic program, and the student in this situation. It is important that the participant understands the critical role of the CI in this situation and the importance that clear and timely documentation plays in the evaluation of student performance with opportunities for early warning with sufficient time for successful remediation.
B. Principles That Define the Legal Context for Evaluation and Dismissal of Students

Principles That Define the Legal Context for Evaluation and Dismissal of Students

1. The court will not overturn academic decisions.
1. The court will not overturn academic decisions.

   a. Courts recognize 4 essential freedoms of the university:
      
      i. who may teach
      ii. what may be taught
      iii. how it shall be taught
      iv. who may be admitted to study

- The courts are reluctant to interfere in the academic world.
- The court recognizes that it is the duty of the school to recognize and act on evidence that a student cannot meet academic standards.

   “When judges are asked to review the substance of a genuinely academic decision...they should show great respect for the faculty’s professional judgment. Plainly, they may not override it unless it is such a substantial departure from accepted academic norms as to demonstrate that the person or committee responsible did not actually exercise professional judgment.”

   Univ. of Michigan v. Ewing, 106 S. Ct. 507 at 513 (1985)
“Courts are ill-equipped to evaluate academic performance. The factors discussed...warn against any such judicial intrusion into academic decision-making.”

Board of Curators of Univ. of Missouri v. Horowitz,, 435 U.W. 78 (1978)

“Courts are not supposed to be learned in medicine and are not qualified to pass opinions as to the attainments of a student in medicine.”

Connelly v. Univ. of Vermont, 244F. Supp. 156 (1965)
2. Faculty are encouraged to uphold high academic standards.

a. The faculty should use their professional judgment and assess the entire record of the student.

This includes clinical faculty who are considered professionals as clinical educators, having been invested by the academic institution with the responsibility for evaluation and the authority for professional judgment.

next slide/page
Faculty have duties to candidly and critically evaluate a student.

These duties are owed to:

• the student
• patients/the public
• the profession

b. Faculty have duties to candidly and critically evaluate a student. These duties are owed to:

• the student
• patients/the public
• the profession
“Arbitrary and capricious action is willful and unreasoning action without consideration and in disregard of facts or circumstances. When there is room for two opinions, an action is not arbitrary or capricious when exercised honestly and upon due consideration even though it may be believed that an erroneous conclusion has been reached.”

McDonald v. Hogness, 92 Wn.431, at 437 (1979)

c. Faculty decisions will be upheld if they are not arbitrary or capricious.
   i. “Arbitrary and capricious action is willful and unreasoning action without consideration and in disregard of facts or circumstances.”
   ii. “When there is room for two opinions, action is not arbitrary or capricious when exercised honestly and upon due consideration even though it may be believed that an erroneous conclusion has been reached.”

- Clinical evaluation is not a matter of fact so much as a matter of opinion.
- For this reason, the opinion of the evaluator is final; no intervention by the judicial system is required as long as the process is valid. Therefore, challenges will be made on the process.
- Hence, the value of the documentation systems we have discussed.
3. Faculty are encouraged to identify problem students early and to provide assistance.

- It is not necessary to show adverse effects on patient/client care.
- You do not have to wait for the patient/client to die to determine that medical care has suffered.

a. Educators are encouraged to develop an "early warning system"
Early Warning System

1. Identify problems
2. Define what it takes to resolve problems
3. Define performance criteria expectations explicitly
4. Define timelines for improvement

*NOTE: ENSURE THAT THE STUDENT SEES HIS/HER DOCUMENTATION!*

b. The EWS needs to:
   i. identify problems
   ii. define what it will take to resolve problems
   iii. define performance criteria expectations that leave NO questions regarding successful outcome
   iv. define time lines for improvement

c. Be sure that the student sees all documentation about his/her performance, including information reported by other staff.

- In one case, the court specifically addresses the responsibility of the academic program.
Instructor’s Note: Recall that the Clinical Performance Instrument has a component for each performance criterion that asks the evaluator to indicate whether or not the student’s performance is “at-risk” by checking the box provided and contacting the ACCE/DCE (telephone icon). The at-risk box represents an EWS to document student performance that is problematic as well as a reminder to notify the ACCE about the problem. The ACCE will then be able to work with the CI, student, and CCCE in determining appropriate steps for remediation. Remember that evaluation tools such as the Critical Incident Report could also be used to document specific student performance difficulties. In addition, the Weekly Planning Form can be used to define specific areas for remediation of performance based on defined areas of performance deficits.

To ensure that students have been informed about their performance, they should review all performance related documentation and sign the documentation to indicate that they have reviewed the document. Any changes made to any documentation should also be reviewed with the student and initialed wherever changes were made to indicate that the student has seen and reviewed the changes.

Documentation provided by the clinical facility is considered part of a student’s academic record and as such must also ensure student privacy and consent for release to entities other than the academic program, CI of record, and CCCE. The CI is responsible for the student’s performance throughout the entire clinical experience, even if the student is working with another therapist or health care provider. Documentation of student performance should be accurate, thorough, and state observations with the inclusion of professional judgment where harm may be done to the patient/client or others. As in patient-related documentation, if documentation is not provided regarding an aspect of student performance then there is no record of its occurrence and therefore in legal contexts did not occur.
d. The EWS allows objective assessment of the course of the student's progress:

**Outcomes Of Early Problem Identification**

1. Performance improves
2. Student denies problems
3. Student tries to improve and fails

"The real tragedy and perhaps unfairness to the student was the school’s failure to dismiss the student earlier when there was ample evidence of his inability to meet scholastic standards."

Manangen v. Board of Regents, University of Washington, King County Cause #832518, Washington Superior Court, Nn 1977, Seattle, Washington (unreported and not appealed)

e. The time line protects faculty (and the student) from dragging on ineffective remediation unnecessarily.
4. Faculty are encouraged to candidly evaluate a student’s performance and to dismiss a student when dismissal is warranted.

We will see that there are 2 types of dismissal: Disciplinary and Academic.

Disciplinary Dismissal
versus
Academic Dismissal

“Did they do it?”
versus
“Did they do ____ well?”
Disciplinary Dismissal
“Did they do it?”

- **Determination of facts:** Allegations of misconduct; violations of rules
- **Due process:** Formal hearings
- **Burden of proof:** Institution has burden of proof (must show due process for academic and clinical components)

a. Disciplinary dismissal
   I. Determination of facts: allegations of misconduct and/or violation of rules
      ii. Due process is by formal hearing
          a) includes depositions, witnesses, cross-examination, presentation of evidence
      iii. Burden of proof is on the academic institution
          a) must show that due process was provided and that sanctions were appropriate

- Disciplinary dismissal is determination of "Did they do it?" vs "Did they do well?"

- Because this can be a lay person's decision, due process includes a formal hearing with legal representation, with all elements of evidence and testimony (notice of charges, discovery, depositions, cross-examination, etc).
Academic Dismissal

“Did they do _____ well?”

- Determination of facts: Cognitive assessment
- Due process: Informal hearing
- Burden of proof: Student has the burden of proof

b. Academic dismissal

- The law provides that all students must be treated with equality and fairness; this does not mean that all students have to be treated the same.
- If the entire academic record demonstrates that a student is having problems, you can evaluate that student in greater depth than others, based on the entire academic record.
- You can dismiss students for less-than-standard performance: this is considered to be an “academic dismissal” and is considered by the courts to be the educators’ responsibility because it requires a professional opinion.
- Because it is based on a professional opinion, it is not readily subject to judicial review—therefore, the process is informal and attorneys are not generally present.

i. Determination of facts: by professional judgment
   a. cognitive assessment
   b. noncognitive/clinical performance evaluation

ii. Due process is informal
   a. notice of inadequacies and opportunity to improve
   b. careful and deliberate decision making based on entire academic record
   c. informal meeting/discussion

iii. Burden of proof is on the student
   a. must show action to be arbitrary or capricious
   b. must show some other error in decision-making process
c. Defamation alleged from evaluations

**Slander/Libel**

Party is sued for defamation as an outcome of:

- Libel: *Written defamation*
- Slander: *Spoken defamation*

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I. Written defamation: libel
ii. Spoken defamation: slander
iii. To avoid libel charges
   a) candid evaluations made in good faith
   b) made on basis of first hand information vs reported information
   c) not communicated to third parties outside of the academic program
   d) not made with malicious intent

Kraft vs William Alanson White Psychiatric Foundation
“A person who seeks an academic credential and who is on notice that satisfactory performance is a prerequisite to his receipt of that credential consents to frank evaluation by those charged with the responsibility to supervise him.”


- If you are concerned about such charges when you write an assessment of the student’s performance, you should know that in this area, the courts have stated that: “A person who seeks an academic credential and who is on notice….to supervise him.”

iv. Refer to the Buckley Amendment and the Family Rights and Privacy Act — 1974

next slide/page
Buckley Amendment (1974)
Questions often arise about what information the school can share with the clinic. It is a popular conception that we cannot share ANY information with the clinics. This is not entirely accurate.

Information about a student's academic record may not be shared with anyone without the student's permission, unless that person is considered by the academic faculty to have a "need to know." Any information, which is shared, should be shared in such a way to avoid any perception of libel (see above).

Any documentation made by the CI of the student's performance becomes part of the student's academic record. You should feel free to keep your own personal notes, as long as you do not share them. If you share them with any person who is in a position to evaluate the student, they then become part of the student's "academic record" and the student therefore has the right to view and review them.

You should also be aware of the student's rights to see whatever is contained in his/her academic record. In 1974, the Buckley Amendment to The Family Rights and Privacy Act was passed. This amendment allowed students to inspect their academic records and to challenge any facts within the academic record. Be aware that anything that you write about a student, that becomes part of their formal evaluation or is shared with a person in a position of responsibility to evaluate that student, is considered part of that student's academic record.

Furthermore, be aware that anything that you write or say about a student to someone who does not have a "need to know" about that student could be construed as slander or libel, and a violation of confidentiality if it is consistent with the qualities as described above.
v. Refer to Health Insurance Portability and Accountability Act (HIPAA) —1996. For more information about HIPAA refer to:


HIPAA (1996)

• The Health Insurance Portability and Accountability Act
  – Safeguards patient/client information shared electronically or otherwise to protect the patient/client.
  – Students need to protect identities of patients/clients during discussions, journal entries, sharing of information with academic programs, etc.
  – CIs need to protect identities of patients/clients when describing student clinical performance with specific patient conditions.

In addition, any student clinical performance record should not contain personal identification of a patient/client such that the individual could be identified by name or condition, if he or she was the only patient in the facility at that time with that condition. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 safeguards patient/client information shared electronically or otherwise to protect the patient/client. The definition of “health care operations” in the Privacy Rule allows for “conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers.” Covered entities should take reasonable safeguards by encouraging their students to protect the identity of patients during discussion and being mindful of the “minimum necessary” standard, but students and trainees are permitted to have access to patients’ medical information for training purposes. For more information about HIPAA refer to: a) http://www.hhs.gov/ocr/privacy/ and b) www.apta.org/HIPAA/. Trainers may want to check these links and be prepared to show participants how to access the information.
vi. Patient’s/Client’s Rights (HIPAA): care provisions and clinical education

Patient’s/Client’s Rights

• HIPAA
  – Grants patients/clients legal rights when provided health care services.
  – Right to patient privacy when sharing electronic information under covered entities.
  – Right to know who is providing the care, what that care will entail, and the right to refuse care given by any provider (including a student).

Patient’s/Client’s Rights: Care Provision and Clinical Education

We have discussed the student’s rights within a legal context. It should be noted that patients/clients also have legal rights when being provided health care services. HIPAA grants the individual the right to patient privacy when sharing written or electronic information under covered entities. In addition, the patient/client has the right to know who is providing care and the right to refuse that care given by any provider. This is of particular importance when the patient/client is being provided care by the licensed professional, licensed/registered/certified assistant, or by a student under the supervision of a licensed or certified provider. The patient/client has the right to refuse care by any provider. Thus, the patient must be made aware of who will be providing the services and what those services will entail and their consent must be obtained from the patient/client prior to providing services by any health care professional. This is even more critical if that care is to be provided by a student even while supervised by the health care provider.

The patient/client must be made explicitly aware and informed in the person who is intended to provide physical therapy is a student. The patient/client has the right to refuse physical therapy that is provided by a student.

Let’s go back to the case of the student dismissal, what were patients’/clients’ rights when being treated by this student with known performance difficulties? Have participants discuss their response.
d. Memorandum of Agreement

We recommend that you develop (if you haven’t already) a student manual that contains all of the policies and procedures related to the student’s experience, as well as any documentation forms that might be used. This helps both the student and the CI to know in advance what performance is expected, how one’s performance will be evaluated and what steps are taken when the performance does not meet expectations.

We further recommend that each student be asked to sign a memorandum such as the one below to assure that he/she realizes what responsibilities he/she will be held to during the clinical education experience.
Instructor’s note: Revisit the student dismissal case introduced in the beginning of this session. Pose the following questions to tie up loose ends prior to providing a final summary of legal responsibilities to complete this component of Section V.

- Were all of the initial questions answered?
- Were there any issues of libel or slander?
- What should have or could have been done differently in this situation?
- Does this case help you to integrate the concepts provided in this Section?

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e. **Summary of legal responsibilities**

**Summary of Legal Responsibilities**
(Adams, Corleo, DeBlois; Smith)

i. Rules governing student’s performance must be communicated to the student prior to performance evaluation.

ii. The student must be treated fairly and given feedback regarding his/her performance.

iii. CIs must show they have not acted arbitrarily or capriciously.
Summary of Legal Responsibilities (cont’d)

iv. The problem-solving process should be documented, as well as the student’s behavior and response to feedback.

v. DCE/ACCE, CCCE, CI, and student should all be involved in contract negotiations and decision making.

vi. Patients must be informed of and consent to health care services prior to delivery, especially in the case of services provided by students.
C. Students With Disabilities

Students With Disabilities

The Case Of A Student With A Disability
The Case of a Student with a Disability

A student is beginning his second (of 4) clinical experiences at an outpatient orthopedic facility after completing 1/2 of a 3-year DPT program. He has successfully passed all classroom coursework to date. His first 4-week clinical experience was in home health care. The student is provided with an orientation on the first day of the experience with clear weekly expectations set for his performance. The student identifies learning objectives and performance areas that he believes are his strengths and limitations. The Weekly Planning Form is completed for the first week that describes the learning objectives he is expected to achieve.

**Week 1**
- The student becomes flustered when trying to manage situations that require multitasking (ie, checking on a patient completing exercises, setting up another patient on an exercise program, and completing patient documentation in 30 minutes).
- Under stressful situations, the student is unable to control his emotions and may interact with patients inappropriately or lash out at another clinician. When the student is able to complete single tasks at a time, his behavior appears manageable.
- The student becomes defensive and unable to converse when questioned directly about how he arrived at a diagnosis.
- The student is easily distracted in a gym setting with difficulty focusing on the patient.

**Week 2**
- Beginning the 2\(^{nd}\) week, the CI sits in a quiet area to talk with the student about his performance. The CI asks “How do you think you are doing?” The student responds he is doing fine and just needs to work on his time management skills so that multiple activities do not occur simultaneously.
- The CI is concerned with the student’s self-assessment and wonders if something more is going on with this student that is not readily evident.
- The CI further questions the student regarding whether similar situations have happened before. The student denies that this situation has happened before and indicates he just needs more time to accommodate to this clinical environment.
- Learning objectives are set up for the student for the next 2 weeks using some of the sample behaviors from the CPI to focus his ability to multitask, to stay attentive on the care being provided to the patient, and to interact appropriately with patients and others.

**Week 3**
- The student continues to have distractibility problems that appear to be getting worse.
- Episodes continue with raised voices to patients during multitasking situations.
- Errors continue in patient documentation, even within a more structured and controlled learning environment.
- “Significant at-risk” performance is demonstrated on several of the “red flag” items on the CPI. The CI suspects the student has other significant problems.
- The CI asks the student directly if there is anything else that the CI ought to know that would explain his continued performance deficits. The student admits that he does have a known learning disability that has been disclosed only to the academic program. He believed that disclosure of a disability to the CI or CCCE would not be necessary for him to successfully complete the clinical experience. He had not had any prior difficulty in academic or clinical situations and thought he could compensate for his disability. The pace and nature of this clinical environment, however, has made it difficult for him to successfully manage and control his environment.
- The CI recognizes that the student has now disclosed a known learning disability while on this clinical experience.
The following questions should be raised, discussed, and answered during the course of this section.

**Discussion Questions**

1. What should the CI do now that the student has disclosed the presence of a learning disability?
2. What additional information, if any, would the CI want to know from the student to assist him in being successful in this clinical experience?
3. How could the academic program be of assistance to this CI?
4. What is the student’s role in this learning experience?
5. Is the clinic required to provide reasonable accommodation for this student?
6. How could this clinical experience accommodate this student’s learning disability?

**Instructor’s Note:** Allow participants to review this case. Then raise the questions above to determine what participants may or may not know about this case with regard to the ADA and reasonable accommodations. Follow the discussion with the information provided in the manual that discusses the ADA and essential functions required of physical therapy students. Ensure that when you discuss this case that you address the roles and responsibilities of the clinical instructor, academic program, and the student in this situation. It is important that the participant understands the critical role of the CI in this situation and the importance that clear and timely documentation and communication plays in the evaluation of this student’s performance. To access the American with Disabilities Act updated September 15, 2010 refer to: [http://www.ada.gov/regs2010/ADAreqs2010.htm](http://www.ada.gov/regs2010/ADAreqs2010.htm) and to stay current with other ADA updates refer to: [http://www.ada.gov/](http://www.ada.gov/).
1. **Purpose of the Americans with Disabilities Act (ADA) [P.L.101-336]**

   The purpose of the ADA (P.L. 101-336) is to provide a “clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”

   - It is estimated that 11% of the population qualifies as having a disability.
   - The Americans with Disabilities Act was signed into law July 26, 1990. The act prohibits discrimination based on disabilities in the areas of employment, public services, transportation, public accommodations and telecommunications. It requires all affected entities (businesses) to provide “reasonable accommodation” to persons with disabilities.
2. **Proof of Disability**

“**Proof Of Disability**

“A physical or mental impairment that substantially limits one or more of the major life activities of an individual.”
3. **Proof of Discrimination**

**Proof Of Discrimination On The Basis Of A Disability**

Failure to “make reasonable accommodations to known physical or mental limitations.”

- The law requires that an individual analysis be made with every request for accommodations, and the determination of reasonableness must be made on a case-by-case basis.

- You should expect to work with the school to understand and develop reasonable accommodations for the student.

- If a student with a disability does not come forward, it cannot be shown that you should have known; therefore, you are not subject to ADA requirements.
3. Proof of Discrimination (cont’d)

Proof Of Discrimination (cont’d)

Plaintiff shows:
– that he/she is disabled
– that his/her requests for accommodations are reasonable
– that those requests have been denied

The ADA was not meant to give people with disabilities advantages over other applicants.

The purpose is to place those with disabilities on an equal footing and not to give them an unfair advantage.

next slide/page
5. There are several other important components to include or consider with respect to the ADA.

Additional ADA Considerations

a. Academic program and the clinical facility identify in writing, essential functions required to perform specific tasks/position of the profession. Essential functions should address cognitive, psychomotor, and affective components.\(^7\)\(^ -\)\(^9\)

b. Academic and clinical faculties, with the student, determine whether or not the student with reasonable accommodations can meet the essential functions.

next slide/page
5. There are several other important components to include or consider with respect to the ADA. (cont’d)

**Additional ADA Considerations**

a. Academic program and the clinical facility identify in writing, essential functions required to perform specific tasks/position of the profession. Essential functions should address cognitive, psychomotor, and affective components. (Ingram; Rangel, Wittry, Boucher, et al; AASIG)

b. Academic and clinical faculties, with the student, determine whether or not the student with reasonable accommodations can meet the essential functions.

c. The student must meet the required performance competencies and essential functions for entry into practice and the profession. Accommodations allow the student to modify the manner and time frame for meeting the competencies, however, this does not permit the student to matriculate into or graduate from the academic program if the established competencies are not met. 10-11

A 2004 court ruling illustrates in one case, the importance of essential functions in professions.

“The US District Court for the Eastern District of Pennsylvania held that a hospital could terminate an orthopedic surgery resident, who, because of a disability could not perform orthopedic surgery. The court ruled that he did not qualify for protection under the Americans with Disabilities Act because he was unable to perform the essential functions of his position, with or without a reasonable accommodation.”


IMPORTANT NOTE: When it comes to case law, ADA decisions are made on a case-by-case basis. In contrast with the previous section on academic discrimination and dismissal, case law is set at the appellate court level or higher. These decisions do set a precedent for future legal decisions.

Instructor’s note: Before moving on to the final component of Section V, revisit the case of a student with a disability introduced at the beginning of the section on ADA. Pose the questions below to tie up loose ends prior to addressing student supervisory issues, final component of Section V.

- Were all of the initial questions answered?
- What should have or could have been done differently in this situation?
- Does this case help you to integrate concepts associated with the ADA, reasonable accommodation, and essential functions?

NOTE: You may wish to refer to the work of Francis NJ, Salzman A, Polomsky D, Huffman E (Reference #10) that is about a case report describing accommodations made in clinical practice for a student with a disability.
D. Student Supervisory Issues

Note: Please refer to the APTA website for the most current information.
- federal and state regulatory standards (http://www.apta.org/Payment)
- practice acts (www.fsbpt.org)
- licensure information (http://www.apta.org/Licensure/)

Guidelines For Supervision

- Who guides your supervision decisions?
- What are the guidelines?
- Where can you find the guidelines?
- How do they apply in your setting?
Instructor note: In this last section we will address student supervisory issues that are shaped by regulations such as Medicare and APTA policies and positions. These issues influence how students must be supervised, how services can be billed, and who can document in the patient/client record. Two case situations are provided that can be used to illustrate the different conditions that may occur in the supervision of PT and PTA students that are shaped by state practice acts, reimbursement, and APTA policies and positions. References that follow will be helpful to your discussion with participants.

Break participants into small groups and provide them with the case scenarios (some do Case 1 and others Case 2). Let them use the supportive resource materials to answer each of the questions. Then reconvene the group to discuss their responses and supportive rationale. Fill in any additional comments that help to expand the participant’s understanding of the topic and correct any misperceptions or inaccuracies as well.

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### Student Supervisory Issues Affected by Regulations and APTA Policies and Positions

<table>
<thead>
<tr>
<th>Federal Law</th>
<th>State Law</th>
<th>Regulatory Agency</th>
<th>Payer</th>
<th>Employer</th>
<th>APTA/Best Practice (includes patients)</th>
</tr>
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<tbody>
<tr>
<td>Medicare (student supervision; requirement of PTAs)</td>
<td>Practice Acts</td>
<td>Joint Commission</td>
<td>Government</td>
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<tr>
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<tr>
<td>Patient Bill of Rights</td>
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</table>

The table identifies the various entities that guide your decisions regarding supervision. You will need to check the links for these items that follow in this section as they may change over time and were current at the time this manual was published. Tips for using the table.

- Discuss problems that occur when the guidelines from the different entities conflict.
- Discuss the application of these laws and regulations in different clinical settings.
- Use the table as a reference for the cases.
- If you have internet access, show participants how to find the information on the APTA website and others as desired.
- Print out current Medicare supervisory chart to distribute to participants.
**Activity 1**

Student Supervision, Billing, and Documentation for Medicare Part A

An 85-year-old white female is admitted to a SNF in your state for physical therapy after a 3-day qualifying stay at Bethany Nursing Home for a CVA on the left side. She is eligible for skilled benefits under Medicare Part A. She is diagnosed by a physical therapist with impaired motor function and sensory integrity associated with acquired non-progressive disorders of the central nervous system in adulthood (Neuromuscular – Pattern B). The plan of care provides for interventions including patient/client instruction, ADL training (bed mobility and transfer training, gait training), neuromuscular reeducation, balance and coordination training, and motor function retraining. Department staff includes 10 physical therapists, 4 physical therapist assistants, 2 physical therapist students, and 2 physical therapist assistant students. As the supervising therapist you must decide how to properly provide this patient's care by directing and supervising the PT and PTA students according to the state practice act, Medicare Part-A regulations, and APTA guidelines, policies, and positions.
1. What can the PT student perform in this situation? What can be billed? How should the supervising PT handle patient care documentation provided by the PT student? Support your position.

What can the PT student perform in this situation?

Physical therapist students are not required to be in line-of-sight of the professional supervising therapist/assistant (Federal Register, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy.

The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:

- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.) (RAI Version 3.0 Manual, October 2011).

What can be billed?

Actually the term billing is a misnomer. In the SNF setting if the PT or PTA student provides the service while in line-of-sight of the PT or PTA CI, then Medicare Part A permits the minutes can count toward the Minimal Data Set (MDS). (Refer to Medicare Student Supervision Chart on page TK).

How should the supervising PT handle patient care documentation provided by the PT student?

All time that the student spends with patients should be documented. APTA recommends that the physical therapist co-sign the note of the physical therapist student and state the level of supervision that the PT determined was appropriate for the student and how/if the therapist was involved in the patient’s care. (Refer to Medicare Student Supervision Chart on pages 112-114. Please see Supervision Under Medicare chart for clarification of students working with Individual, Group, and Concurrent therapy.)
2. What can the PTA student perform in this situation? What can be billed? How should the supervising PT handle patient care documentation provided by the PTA student. Support your position.

What can the PTA student perform in this situation? How should he/she be supervised?

Physical therapist assistant students are not required to be in line-of-sight of the professional supervising therapist/assistant (Federal Register, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. The minutes of student services count on the Minimum Data Set. Medicare no longer requires that the PT/PTA provide line-of-sight supervision of physical therapist assistant (PTA) student services. Rather, the supervising PT/PTA now has the authority to determine the appropriate level of supervision for the student, as appropriate within their state scope of practice. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy.

The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:

- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.) (RAI Version 3.0 Manual, October 2011).

What can be billed?

As with the PT student, under line-of-sight of the PT supervisor, the minutes of PTA student services count on the MDS.

How should the supervising PT handle patient care documentation provided by the PTA student?

APTA recommends that the physical therapist and assistant should co-sign the note of physical therapist assistant student and state the level of appropriate supervision used. Also, the documentation should reflect the requirements as indicated for individual therapy, concurrent therapy, and group therapy the same as for the physical therapist student. (Refer to Medicare Student Supervision Chart on page -TK). Please see Supervision Under Medicare chart for clarification of students working with Individual, Group, and Concurrent therapy.

(See answer key Section VII)

next slide/page
Activity 2

Student Supervision, Billing, And Documentation For Medicare Part B

A 66-year old Hispanic male is being seen in an outpatient orthopedic clinic s/p rotator cuff repair surgery on the left (dominant). The patient is also diabetic. He is diagnosed by a physical therapist with impaired joint mobility, motor function, muscle performance, and range of motion associated with soft tissue surgery (Musculoskeletal - Pattern I). He also complains of mild post surgical pain and tenderness over the incision for which he takes Tylenol extra strength. He is eligible for benefits under Medicare Part B. The physical therapist plan of care indicates interventions including joint mobilization, connective tissue massage, stretching, therapeutic exercise, and cryotherapy. Physical therapy department staff includes 6 physical therapists, 2 physical therapist assistants, one physical therapist student and one physical therapist assistant student. As the supervising therapist you must decide how to properly provide care by directing and supervising the PTA clinician, PT student, and PTA student according to your state practice act, Medicare Part B regulations, and APTA guidelines, policies, and positions. In addition, the student has some strong indicators that this outpatient clinic may be benefiting from a referral for profit situation.
1. What can the PT student perform in this situation? What can be billed? How should the supervising PT handle patient care documentation provided by the PT student? Support your position.

Only the services of the physical therapist can be billed and paid under Medicare Part B. The services performed by a physical therapist student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. For Medicare Part B, the licensed physical therapist with a student cannot be managing two patients at the same time, such as in an open gym to meet the conditions provided below.

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician’s service, not for the student’s services).

APTA recommends that the licensed physical therapist complete documentation when supervising a physical therapist student. Documentation provided by students that is co-signed is a red flag for auditors with regard to whether or not the Medicare Part B regulations were followed.
2. **What can the PTA student perform in this situation? How should he/she be supervised? What can be billed? How should the supervising PT handle patient care documentation provided by the PTA student. Support your position.**

Only the services of the physical therapist can be billed and paid under Medicare Part B. The services performed by a physical therapist student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. For Medicare Part B, the licensed physical therapist with a student cannot be managing two patients at the same time, such as in an open gym to meet the conditions provided below.

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician’s service, not for the student’s services).

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

APTA recommends that the licensed physical therapist complete documentation when supervising a physical therapist student. Documentation provided by students that is co-signed is a red flag for auditors with regard to whether or not the Medicare Part B regulations were followed.

In addition, Medicare supervision regulations with respect to PTAs in a Comprehensive Outpatient Rehabilitation Facility (CORF) state that the services must be furnished by qualified personnel. If the personnel do not meet the qualifications in 485.705, then the qualified staff must be on the premises and must instruct these personnel in appropriate patient care service, techniques, and retain responsibility for their activities. A qualified professional representing each service made available at the facility must be either on the premises of the facility or must be available through direct telecommunications for consultation and assistance during the facility’s operating hours.

However, APTA has a position with regard to the PTA that states that “direct personal supervision requires that the physical therapist, or where allowable by law, the physical therapist assistant, is physically present and immediately available to direct and supervise tasks that are related to patient/client management. The direction and supervision is continuous throughout the time these tasks are performed. Telecommunications does not meet the requirement of direct personal supervision. Note that this position is less liberal than that of Medicare. In addition, care to be delivered must be within the state practice act and scope of the work of the PTA (Refer to Procedural Interventions Performed Exclusively by Physical Therapists [Position](http://www.apta.org/Policies/HOD1/))
3. **What should the student do if he or she finds themselves in a clinical education facility that may be engaged in a referral for profit situation?**

According to APTA policy, Ethical and Legal Considerations for Clinical Education (HOD P06-01-16-18), physical therapist and physical therapist assistant students are obligated to communicate information to their academic program regarding clinical education experiences that appear to be in conflict with these standards, policies, and positions. APTA has a policy, Financial Considerations in Practice (HOD P06-99-13-17) that opposes participation in underutilization or overutilization of services for personal or institutional gain, or participation in services that is in any way linked to the financial gain of the referral source.
## SUPERVISION OF STUDENTS UNDER MEDICARE (CHART)¹² (Last Updated 12/12/2011)

<table>
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<tr>
<th>Practice Setting</th>
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<td>Physical Therapist in Private Practice</td>
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<td>Certified Rehabilitation Agency</td>
<td>N/A</td>
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<td>Comprehensive Outpatient Rehabilitation</td>
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<tr>
<td>Skilled Nursing Facility</td>
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<td>Hospital</td>
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<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>Y⁴</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Key**
- **Y**: Reimbursable
- **X**: Not Reimbursable
- **N/A**: Not Applicable
- **NAR**: Not Addressed in Regulation. Please defer to state law.

**Y¹**: Reimbursable: Therapy students are not required to be in line-of-sight of the professional supervising therapist/assistant (Federal Register, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy. All time that the student spends with patients should be documented.

Medicare Part B—The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:
- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.)

Individual Therapy:
When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals and he/she is able to immediately intervene/assist the student as needed.

Example: A speech therapy graduate student treats Mr. A for 30 minutes. Mr. A.’s therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Mr. A. Mr. A.’s therapy may be coded as 30 minutes of individual therapy on the MDS.

Concurrent Therapy:
When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy; or
- The therapy student is treating 2 residents, regardless of payer source, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

Medicare Part B: The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment.

Example: An Occupational Therapist provides therapy to Mr. K. for 60 minutes. An occupational therapy graduate student, who is supervised by the occupational therapist, is treating Mr. R. at the same time for the same 60 minutes but Mr. K. and Mr. R. are not doing the same or similar activities. Both Mr. K. and Mr. R.’s stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual’s MDS for this day of treatment as follows:
Mr. K. received concurrent therapy for 60 minutes.
Mr. R. received concurrent therapy for 60 minutes.

Group Therapy:
When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.
Medicare Part B: The treatment of 2 or more individuals simultaneously, regardless of payer source, who may or may not be performing the same activity.

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or
- The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.

Documentation: APTA recommends that the physical therapist co-sign the note of the physical therapist student and state the level of supervision that the PT determined was appropriate for the student and how/if the therapist was involved in the patient’s care.

Y2: Reimbursable: The minutes of student services count on the Minimum Data Set. Medicare no longer requires that the PT/PTA provide line-of-sight supervision of physical therapist assistant (PTA) student services. Rather, the supervising PT/PTA now has the authority to determine the appropriate level of supervision for the student, as appropriate within their state scope of practice. See Y1.

Documentation: APTA recommends that the physical therapist and assistant should co-sign the note of physical therapist assistant student and state the level of appropriate supervision used. Also, the documentation should reflect the requirements as indicated for individual therapy, concurrent therapy, and group therapy in Y1.

Y3: This is not specifically addressed in the regulations, therefore, please defer to state law and standards of professional practice. Additionally, the Part A hospital diagnosis related group (DRG) payment system is similar to that of a skilled nursing facility (SNF) and Medicare has indicated very limited and restrictive requirements for student services in the SNF setting.

Documentation: Please refer to documentation guidance provided under Y1.

Y4: This is not specifically addressed in the regulations, therefore, please defer to state law and standards of professional practice. Additionally, the inpatient rehabilitation facility payment system is similar to that of a skilled nursing facility (SNF) and Medicare has indicated very limited and restrictive requirements for student services in the SNF setting.

X 1: B. Therapy Students

1. General

Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable.

EXAMPLES:

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
• The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.

• The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician’s service, not for the student’s services).

2. Therapy Assistants as Clinical Instructors

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

Documentation: APTA recommends that the physical therapist or physical therapist assistant complete documentation.
USE OF STUDENTS UNDER MEDICARE PART B¹⁴

The purpose of this document is to provide clarification on the circumstances under which physical therapy students may participate in the provision of outpatient therapy services to Medicare patients, and whether or not such services are billable under Medicare Part B. Specifically, this document addresses student participation in the provision of services in the following settings: private practice physical therapy offices, rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs) (Part B), outpatient hospital departments, and home health agencies (Part B).

Background

CMS issued a program memorandum, (AB-01-56) on the provision of outpatient therapy services by therapy students on April 11, 2001. In this program memorandum (http://www.cms.hhs.gov/manuals/pm_trans/AB0156.pdf), CMS provided answers to frequently asked questions regarding payment for the services of therapy students under Part B of the Medicare program.

In response to inquiries from the American Speech Language Hearing Association (ASHA), CMS issued a follow-up letter dated November 9, 2001, to ASHA in which they further clarified the policy on payment of student services that they outlined in the Q and A program memorandum. On January 10, 2002 CMS also issued a similar letter to AOTA on the subject. The follow-up letters to ASHA and AOTA were not intended to signify a change in the policy issued in the program memorandum; they were merely intended to provide further clarification.

Specifically, in the program memorandum (AB-01-56), CMS stated, in part, that “services performed by a student are not reimbursed under Medicare Part B. Medicare pays for services of physicians and practitioners (e.g. licensed physical therapists) authorized by statute. Students do not meet the definition of practitioners listed in the statute.” Regarding whether services provided by the student with the supervising therapist “in the room” can be reimbursed, CMS stated that “Only the services of the therapist can be billed to Medicare and be paid. However, the fact that the student is “in the room” would not make the service unbillable. Medicare would pay for the services of the therapist.” In response to another question, CMS stated that “the therapist can bill for the direct services he/she provides to patients under Medicare Part B. Services performed by the therapy student are not payable under Medicare Part B.”

In the letter to ASHA, CMS once again restated, in order to be paid, Medicare Part B services must be provided by practitioners who are acting within the scope of their state licensure. CMS further described circumstances, under which they consider the service as being essentially provided directly by the qualified practitioner, even though the student has some involvement. Such services would be billable. Specifically, CMS states:

"The qualified practitioner is recognized by the Medicare Part B beneficiary as the responsible professional within any session when services are delivered."

"The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment."

"The qualified practitioner is present in the room guiding the student in service delivery when the student is participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time."

"The qualified practitioner is responsible for the services and as such, signs all documentation (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician’s services, not for the student’s services)."

In response to a request from AOTA, CMS issued a summary of their understanding of the typical scenario involving students for which occupational therapists seek payment. The information provided in this letter mirrors what was stated in the letter provided to ASHA.
Acceptable Billing Practices

Based on the information provided by CMS and MedPAC, it is possible for a physical therapist to bill for services only when the services are furnished jointly by the physical therapist and student. APTA recommends that physical therapists consider the following factors in determining whether or not a physical therapist may bill Medicare Part B for a service when the therapy student is participating in the provision of the service.

- Physical therapists should use their professional judgment on whether or not a service is billable, keeping in mind the importance of integrity when billing for services.

- Physical therapists should distinguish between the ability of a student to provide services to a patient/client from the ability to bill for student services provided to Medicare Part B patients. A student may provide services to any patient/client provided it is allowable by state law. This does not mean, however, that the services provided by the student are billable to Medicare, Medicaid, or other private insurance companies.

- As CMS states, only services provided by the licensed physical therapist can be billed to Medicare for payment. Physical therapists should consider whether the service is being essentially provided directly by the physical therapist, even though the student has some involvement in providing the care. In making this determination, the therapist should consider how closely involved he or she is involved in providing the patient’s care when a student is participating. The therapist should be completely and actively engaged in providing the care of the patient. As CMS states in their letter, “the qualified practitioner is present in the room guiding the student in service delivery when the student is participating the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.” The therapist should direct the service, make the skilled judgment, and be responsible for the assessment and treatment. There should be checks and balances provided by the physical therapist throughout the entire time the patient/client is being managed.

- The physical therapist should ask him-or herself whether the billing would be the same whether or not there is a student involved. The therapist should not bill beyond what they would normally bill in the course of managing that patient’s care. The individual therapist or the employer should not benefit financially from having the student involved in the clinical experience in the practice or facility.

Conclusion

It is crucial that physical therapists be aware of and comply with Medicare regulations governing the circumstances in which physical therapy students may participate in the provision of physical therapy services. CMS has clearly stated its policy that student services under Part B are not billable, and that only services provided to Medicare beneficiaries by the PT may be billed. APTA will continue to work to ensure that physical therapy students receiving the clinical training they need in order to provide valuable, high-quality physical therapy services to patients/clients.
Implementing MDS 3.0: Use of Therapy Students

As facilities continue to change their current practices to implement the Minimum Data Set Version 3.0 (better known as MDS 3.0), one of the emerging issues is the manner in which they document and utilize therapy students. Under the new rules, in order to record the minutes as individual therapy when a therapy student is involved in the treatment of a resident, only one resident can be treated by the therapy student and the supervising therapist or assistant (for Medicare Part A and Part B). In addition, the supervising therapist or assistant cannot engage in any other activity or treatment when the resident is receiving treatment under Medicare Part B. However, for those residents whose stay is covered under Medicare Part A, the supervising therapist or assistant cannot be treating or supervising other individuals. Beginning on October 1, 2011, the student and resident no longer need to be within the line-of-sight supervision of the supervising therapist. CMS will allow the supervising therapist to determine the appropriate level of supervision for the student. The student is still treated as an extension of the therapist, and the time the student spends with the patient will continue to be billed as if the supervising therapist alone was providing the services.

Under Medicare Part A, when a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist or assistant is treating another resident and the therapy student is supervised by the therapist at the appropriate level of supervision as determined by the supervising therapist; or
- The therapy student is treating two residents at the appropriate level of supervision as determined by the supervising therapist and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist or assistant is treating two residents at the same time, regardless of payer source

The student would be precluded from treating the resident and recording the minutes as concurrent therapy under Medicare Part B.

Under Medicare Part A, when a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment at the appropriate level of supervision as determined by the supervising therapist and the supervising therapist or assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident.

Under Medicare Part B, when a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing group treatment and the supervising therapist or assistant is present and in the room and is not engaged in any other activity or treatment; or
- The supervising therapist or assistant is providing group treatment and the therapy student is not providing treatment to any resident.
Use of Students under Medicare Part B

The purpose of this document is to provide clarification on the circumstances under which physical therapy students may participate in the provision of outpatient therapy services to Medicare patients, and whether or not such services are billable under Medicare Part B. Specifically, this document addresses student participation in the provision of services in the following settings: private practice physical therapy offices, rehabilitation agencies, comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs) (Part B), outpatient hospital departments, and home health agencies (Part B).

Background

CMS issued a program memorandum, (AB-01-56) on the provision of outpatient therapy services by therapy students on April 11, 2001. In this program memorandum (http://www.cms.hhs.gov/Transmittals/downloads/AB0156.pdf), CMS provided answers to frequently asked questions regarding payment for the services of therapy students under Part B of the Medicare program.

In response to inquiries from the American Speech Language Hearing Association (ASHA), CMS issued a follow-up letter dated November 9, 2001, to ASHA in which they further clarified the policy on payment of student services that they outlined in the Q and A program memorandum. On January 10, 2002 CMS also issued a similar letter to AOTA on the subject. The follow-up letters to ASHA and AOTA were not intended to signify a change in the policy issued in the program memorandum; they were merely intended to provide further clarification.

Specifically, in the program memorandum (AB-01-56), CMS stated, in part, that "services performed by a student are not reimbursed under Medicare Part B. Medicare pays for services of physicians and practitioners (e.g. licensed physical therapists) authorized by statute. Students do not meet the definition of practitioners listed in the statute." Regarding whether services provided by the student with the supervising therapist "in the room" can be reimbursed, CMS stated that "Only the services of the therapist can be billed to Medicare and be paid. However, the fact that the student is "in the room" would not make the service unbillable. Medicare would pay for the services of the therapist." In response to another question, CMS stated that "the therapist can bill for the direct services he/she provides to patients under Medicare Part B. Services performed by the therapy student are not payable under Medicare Part B."

In the letter to ASHA, CMS once again restated, in order to be paid, Medicare Part B services must be provided by practitioners who are acting within the scope of their state licensure. CMS further described circumstances, under which they consider the service as being essentially provided directly by the qualified practitioner, even though the student has some involvement. Such services would be billable. Specifically, CMS states:

"The qualified practitioner is recognized by the Medicare Part B beneficiary as the responsible professional within any session when services are delivered."

"The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment."

"The qualified practitioner is present in the room guiding the student in service delivery when the student is participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time."
"The qualified practitioner is responsible for the services and as such, signs all documentation (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician's services, not for the student's services)."

In response to a request from AOTA, CMS issued a summary of their understanding of the typical scenario involving students for which occupational therapists seek payment. The information provided in this letter mirrors what was stated in the letter provided to ASHA.

**Acceptable Billing Practices**

Based on the information provided by CMS and MedPAC, it is possible for a physical therapist to bill for services only when the services are furnished jointly by the physical therapist and student. APTA recommends that physical therapists consider the following factors in determining whether or not a physical therapist may bill Medicare Part B for a service when the therapy student is participating in the provision of the service.

Physical therapists should use their professional judgment on whether or not a service is billable, keeping in mind the importance of integrity when billing for services.

Physical therapists should distinguish between the ability of a student to provide services to a patient/client from the ability to bill for student services provided to Medicare Part B patients. A student may provide services to any patient/client provided it is allowable by state law. This does not mean, however, that the services provided by the student are billable to Medicare, Medicaid, or other private insurance companies.

As CMS states, only services provided by the licensed physical therapist can be billed to Medicare for payment. Physical therapists should consider whether the service is being essentially provided directly by the physical therapist, even though the student has some involvement in providing the care. In making this determination, the therapist should consider how closely involved he or she is involved in providing the patient's care when a student is participating. The therapist should be completely and actively engaged in providing the care of the patient. As CMS states in their letter, "the qualified practitioner is present in the room guiding the student in service delivery when the student is participating the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time." The therapist should direct the service, make the skilled judgment, and be responsible for the assessment and treatment. There should be checks and balances provided by the physical therapist throughout the entire time the patient/client is being managed.

The physical therapist should ask him-or herself whether the billing would be the same whether or not there is a student involved. The therapist should not bill beyond what they would normally bill in the course of managing that patient's care. The individual therapist or the employer should not benefit financially from having the student involved in the clinical experience in the practice or facility.

**Conclusion**

It is crucial that physical therapists be aware of and comply with Medicare regulations governing the circumstances in which physical therapy students may participate in the provision of physical therapy services. CMS has clearly stated its policy that student services under Part B are not billable, and that only services provided to Medicare beneficiaries by the PT may be billed. APTA will continue to work to ensure that physical therapy students receiving the clinical training they need in order to provide valuable, high-quality physical therapy services to patients/clients.
Use of Physical Therapist Assistants (PTAs) under Medicare

Please note that physical therapists are licensed providers in all states and physical therapist assistants are licensed providers in the majority of states. As licensed providers, the state practice act governs supervision requirements. Some state practice acts mandate more stringent supervision standards than Medicare laws and regulations. In those cases, the physical therapist and physical therapist assistants must comply with their state practice act. For example, in a skilled nursing facility in New Jersey, a physical therapist must be on the premises when services are furnished by a physical therapist assistant despite the fact that Medicare requires general supervision. New Jersey's state practice act requires direct supervision rather than general supervision, and therefore, the physical therapist and physical therapist assistant would have to comply with this requirement.

Certified Rehabilitation Agency (CRA)

CRAs are required to have qualified personnel provide initial direction and periodic observation of the actual performance of the function and/or activity. If the person providing services does not meet the assistant-level practitioner qualifications in 485.705, then the physical therapist must be on the premises.

Comprehensive Outpatient Rehabilitation Facility (CORF)

The services must be furnished by qualified personnel. If the personnel do not meet the qualifications in 485.705, then the qualified staff must be on the premises and must instruct these personnel in appropriate patient care service, techniques, and retain responsibility for their activities. A qualified professional representing each service made available at the facility must be either on the premises of the facility or must be available through direct telecommunications for consultation and assistance during the facility's operating hours.

Home Health Agencies (HHA)

Physical therapy services must be performed safely and/or effectively only by or under the general supervision of a skilled therapist. General supervision has been traditional described in HCFA manuals as requiring the initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Inpatient Hospital Services

Physical therapy services must be those services that can be safely and effectively performed only by or under the supervision of a qualified physical therapist. Because the regulations do not specifically delineate the type of direction required, the provider must defer to his or her physical therapy state practice act.

Outpatient Hospital Services

Physical therapy services must be those services that can be safely and effectively performed only by or under the supervision of a qualified physical therapist. Because the regulations do not specifically delineate the type of direction required, the provider must defer to his or her physical therapy state practice act.
Private Practice

Physical therapy services must be provided by or under the direct supervision of the physical therapist in private practice. CMS has generally defined direct supervision to mean that the supervising private practice therapist must be present in the office suite at the time the service is performed.

Physician's Office

Services must be provided under the direct supervision of a physical therapist who is enrolled as a provider under Medicare. A physician cannot bill for the services provided by a PTA. The services must be billed under the provider number of the supervising physical therapist. CMS has generally defined direct supervision to mean that the physical therapist must be in the office suite when an individual procedure is performed by supportive personnel.

Skilled Nursing Facility (SNF)

Skilled rehabilitation services must be provided directly or under the general supervision of skilled rehabilitation personnel. General Supervision@ is further defined in the manual as requiring the initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.
USE OF PHYSICAL THERAPY AIDES UNDER MEDICARE

Certified Rehabilitation Agency (CRA)

In order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide regardless of level of supervision.

CMS’s policy is that the therapy aide may assist the professional therapist or therapist assistant to perform a specific therapy service. The aide should never be the provider of the service.

Comprehensive Outpatient Rehabilitation Facility (CORF)

In order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide, regardless of level of supervision.

CMS's policy is that the therapy aide may assist the professional therapist or therapist assistant to perform a specific therapy service. The aide should never be the provider of the service.

Home Health Agencies (HHA)

Under Medicare Part A regulations, all therapy services offered by the HHA, either directly or under arrangements, must be provided by a qualified therapist or a qualified therapist assistant under the therapist's supervision and in accordance with the plan of care. The qualified therapist assists the physician in evaluating level of function, helps develop the plan of care (revising as necessary), prepares clinical and progress notes, advises and consults with the family and other agency personnel, and participates in in-service programs. (42 CFR §484.32)

An HHA that wishes to furnish outpatient physical therapy or speech pathology services must meet all the pertinent conditions of this part and also meet the additional health and safety requirements set forth in subpart H of part 485 of this chapter to implement section 1861(p) of the Act. 42 CFR 484.38

Inpatient Hospital Services

Physical therapy services must be those services that can be safely and effectively performed only by or under the supervision of a qualified physical therapist. According to 42 CFR Section 482.56 of the Medicare hospital conditions of participation, "physical therapy, if provided, must be provided by staff who meet the qualifications specified by medical staff, consistent with state law." Because the regulations do not specifically delineate the type of direction required, the provider must defer to his or her physical therapy state practice act.

Outpatient Hospital Services

In order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide regardless of level of supervision.

CMS's policy is that the therapy aide may assist the professional therapist or therapist assistant to perform a specific therapy service. The aide should never be the provider of the service.
Physical Therapist in Private Practice

In order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide, regardless of level of supervision.

CMS's policy is that the therapy aide may assist the professional therapist or therapist assistant to perform a specific therapy service. The aide should never be the provider of the service, however, and employees must be personally supervised by the physical therapist.

Physician's Office/"Incident to" Billing

Effective July 25, 2005, in order for services to be reimbursed under Medicare Part B benefit, they may not be provided by a physical therapy aide, regardless of level of supervision.

Skilled Nursing Facilities

Effective July 30, 1999, "The therapy assistant cannot supervise a therapy aide. It is up to the professional therapist to ensure that the assistant is capable of performing therapy services without the more stringent "line-of-sight" level of supervision required by therapy aides. A therapy aide must be supervised personally by the professional therapist in such a way that the therapist has visual contact with the aide at all times. Therapy aides are not to perform any services without "line-of-sight" supervision. Similarly, a therapy aide must never be responsible for provision of group therapy services, as this is well beyond the scope of services that they are qualified to provide."

Additionally, the rule states that set-up time, as well as time under the therapist's direct supervision, count as reportable therapy minutes on the MDS.

Use of Aides in the Delivery of Skilled Services

Per the RAI manual instructions released on November 9, 2009, aides cannot be used to deliver skilled services. Aides should be used to provide support services and those services cannot be counted towards the minutes on the MDS. This policy is further detailed in the 2010 SNF PPS Final Rule.

From August 2003 through October 1, 2009, the following policy regarding the use of aides in SNFs was in effect. As of October 1, 2009, this policy is no longer effective.

Supervision (Medicare A only): Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist when allowed by state law. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide, while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes.
Recommended Skilled Nursing Facility Therapy Student Supervision Guidelines

(Submitted to CMS by the American Physical Therapy Association (APTA) During the Comment Period for the FY 2012 SNF PPS Final Rule)

Please note: These suggested guidelines would be in addition to the student supervision guidelines outlined in the RAI MDS 3.0 Manual and all relevant Federal Regulations.

- The amount of supervision must be appropriate to the student’s level of knowledge, experience, and competence.
- Students who have been approved by the supervising therapist or assistant to practice independently in selected patient/client situations can perform those selected patient/client services specified by the supervising therapist/assistant.
- The supervising therapist/assistant must be physically present in the facility and immediately available to provide observation, guidance, and feedback as needed when the student is providing services.
- When the supervising therapist/assistant has cleared the student to perform medically necessary patient/client services and the student provides the appropriate level of services, the services will be counted on the MDS as skilled therapy minutes.
- The supervising therapist/assistant is required to review and co-sign all students’ patient/client documentation for all levels of clinical experience and retains full responsibility for the care of the patient/client.
- Therapist assistants can provide instruction and supervision to therapy assistant students so long as the therapist assistant is properly supervised by the therapist.

These changes as well as other changes regarding MDS 3.0 will take effect October 1, 2011. If you have questions regarding this provision or other provisions within MDS 3.0, please contact the APTA at advocacy@apta.org or at 800.999.2782 ext. 8533.
Note: Refer to the APTA Website ([http://www.apta.org/Policies/HOD1](http://www.apta.org/Policies/HOD1)) for the most up-to-date policies, positions, and guidelines as they may change.

**Consumer Protection In The Provision of Physical Therapy Services:**

**Qualifications Of Persons Providing Physical Therapy Services (HOD 06-01-20-20)**

It is the policy of the American Physical Therapy Association (APTA) that:

Protection of the consumer requires that physical therapy services be provided only by, or under the direction and supervision of, duly licensed physical therapists who have successfully completed physical therapist professional education. Physical therapist professional education includes graduates from 1926 to 1959 who have completed physical therapy curricula approved by the appropriate accreditation bodies. It also includes graduates from 1960 to the present who have successfully completed professional physical therapy education programs accredited by the Commission on Accreditation in Physical Therapy Education or determined to be equivalent.

Protection of the consumer further requires that the practice of physical therapists, which includes examination, evaluation, diagnosis, prognosis, and intervention complies with well-defined regulations. In addition, physical therapist assistants, under the direction and supervision of the physical therapist, are the only individuals who assist in the provision of selected physical therapy interventions. The physical therapist assistant is a graduate of a physical therapist assistant program accredited by the Commission on Accreditation in Physical Therapy Education and is licensed or otherwise regulated.

**Levels Of Supervision (HOD 06-00-15-26)**

*The American Physical Therapy Association recognizes the following levels of supervision:*

**General Supervision:** The physical therapist is not required to be on-site for direction and supervision, but must be available at least by telecommunications.

**Direct Supervision:** The physical therapist is physically present and immediately available for direction and supervision. The physical therapist will have direct contact with the patient during each visit that is defined in the *Guide to Physical Therapist Practice* as all encounters with a patient/client in a twenty-four hour period. Telecommunications does not meet the requirement of direct supervision.

**Direct Personal Supervision:** The physical therapist, or where allowable by law, the physical therapist assistant, is physically present and immediately available to direct and supervise tasks that are related to patient/client management. The direction and supervision is continuous throughout the time these tasks are performed. Telecommunications does not meet the requirement of direct personal supervision.
Student Physical Therapist Provision of Services (HOD 06-00-18-30)

It is the position of the American Physical Therapy Association (APTA) that:
Student physical therapists, when participating as part of a physical therapist
professional education curriculum and when acting in accordance with APTA policy and
applicable state laws and regulations, are qualified to provide services only under the
direction and direct supervision of the physical therapist, who is responsible for
patient/client management. Direct supervision means the physical therapist is physically
present and immediately available for direction and supervision. The physical therapist
will have direct contact with the patient during each visit that is defined in the Guide to
Physical Therapist Practice as all encounters with a patient/client in a twenty-four hour
period. Telecommunications does not meet the requirement of direct supervision.

Supervision of Student Physical Therapist Assistants (HOD P06-11-09-17)

It is the position of the American Physical Therapy Association (APTA) that:
Student physical therapist assistants, when participating as part of a physical therapist
assistant education curriculum and when acting in accordance with American Physical
Therapy Association policy and applicable state laws and regulations, are qualified to
perform selected physical therapy interventions under the direction and direct
supervision of either the physical therapist alone or the physical therapist and physical
therapist assistant working as a team. When the student physical therapist assistant is
participating in the delivery of physical therapy services while being supervised by the
physical therapist alone or the physical therapist and physical therapist assistant working
as a team, the physical therapist or the physical therapist assistant is physically present
and immediately available at all times. The physical therapist or the physical therapist
assistant will have direct contact with the patient/client during each visit as defined by
the Guide to Physical Therapist Practice. The physical therapist maintains responsibility
for patient/client management at all times, including appropriate utilization of the physical
therapist assistant as described in Direction and Supervision of the Physical Therapist
Assistant, and for interventions performed by the student physical therapist assistant.

Direction And Supervision Of The Physical Therapist Assistant (P06-05-18-26)

Physical therapists have a responsibility to deliver services in ways that protect the
public safety and maximize the availability of their services. They do this through direct
delivery of services in conjunction with responsible utilization of physical therapist
assistants who assist with selected components of intervention. The physical therapist
assistant is the only individual permitted to assist a physical therapist in selected
interventions under the direction and supervision of a physical therapist.

Direction and supervision are essential in the provision of quality physical therapy
services. The degree of direction and supervision necessary for assuring quality
physical therapy services is dependent upon many factors, including the education,
experiences, and responsibilities of the parties involved, as well as the organizational
structure in which the physical therapy services are provided.

Regardless of the setting in which the physical therapy service is provided, the following
responsibilities must be borne solely by the physical therapist:

1. Interpretation of referrals when available.
2. Initial examination, evaluation, diagnosis, and prognosis.
3. Development or modification of a plan of care which is based on the initial examination or reexamination and which includes the physical therapy goals and outcomes.
4. Determination of when the expertise and decision-making capability of the physical therapist requires the physical therapist to personally render physical therapy interventions and when it may be appropriate to utilize the physical therapist assistant. A physical therapist shall determine the most appropriate utilization of the physical therapist assistant that provides for the delivery of service that is safe, effective, and efficient.
5. Reexamination of the patient/client in light of their goals, and revision of the plan of care when indicated.
6. Establishment of the discharge plan and documentation of discharge summary/status.
7. Oversight of all documentation for services rendered to each patient/client.

The physical therapist remains responsible for the physical therapy services provided when the physical therapist’s plan of care involves the physical therapist assistant to assist with selected interventions. Regardless of the setting in which the service is provided, the determination to utilize physical therapist assistants for selected interventions requires the education, expertise, and professional judgment of a physical therapist as described by the Standards of Practice, Guide to Professional Conduct, and Code of Ethics.

In determining the appropriate extent of assistance from the physical therapist assistant (PTA), the physical therapist considers:

• The PTA’s education, training, experience, and skill level.
• Patient/client criticality, acuity, stability, and complexity.
• The predictability of the consequences.
• The setting in which the care is being delivered.
• Federal and state statutes.
• Liability and risk management concerns.
• The mission of physical therapy services for the setting.
• The needed frequency of reexamination.

**Procedural Interventions Exclusively Performed by Physical Therapists** (HOD 06-00-30-36)

The physical therapist's scope of practice as defined by the Guide to Physical Therapist Practice includes interventions performed by physical therapists. These interventions include procedures performed exclusively by physical therapists and selected procedures that can be performed by the physical therapist assistant under the direction and supervision of the physical therapist. Procedures that require immediate and continuous examination and evaluation throughout the intervention are performed exclusively by the physical therapist. Such direct interventions within the scope of physical therapist practice that are performed exclusively by the physical therapist include, but are not limited to, spinal and peripheral joint mobilization/manipulation, which are components of manual therapy, and selective sharp debridement, which is a component of wound management.
Documentation Authority For Physical Therapy Services (HOD P05-07-09-03)

Physical therapy examination, evaluation, diagnosis, prognosis, and plan of care (including interventions) shall be documented, dated, and authenticated by the physical therapist who performs the service. Interventions provided by the physical therapist or selected interventions provided by the physical therapist assistant under the direction and supervision of the physical therapist are documented, dated, and authenticated by the physical therapist or, when permissible by law, the physical therapist assistant.

Other notations or flow charts are considered a component of the documented record but do not meet the requirements of documentation in or of themselves.

Students in physical therapist or physical therapist assistant programs may document when the record is additionally authenticated by the physical therapist or, when permissible by law, documentation by physical therapist assistant students may be authenticated by a physical therapist assistant.

Distinction Between The Physical Therapist And The Physical Therapist Assistant In Physical Therapy (HOD 06-01-18-19)

It is the position of the American Physical Therapy Association (APTA) that:

The American Physical Therapy Association (APTA) is committed to promoting the physical therapist as the professional practitioner of physical therapy and promoting the physical therapist assistant as the only individual who assists the physical therapist in the provision of selected physical therapy interventions. The APTA is further committed to incorporating this concept into all Association policies, positions and program activities, wherever applicable.

*Professional*: The term, “professional,” when used in reference to physical therapy services, denotes the physical therapist.

*Physical Therapist Assistant*: The physical therapist assistant is an educated individual who works under the direction and supervision of a physical therapist. The physical therapist assistant is the only individual who assists the physical therapist in accordance with APTA’s policies and positions in the delivery of selected physical therapy interventions. The physical therapist assistant is a graduate of a physical therapist assistant education program accredited by the Commission on Accreditation in Physical Therapy Education.

*Practice*: The practice of physical therapy is conducted by the physical therapist.
Ethical And Legal Considerations For Clinical Education (HOD 06-01-16-18)

It is the policy of the American Physical Therapy Association (APTA) that: Physical therapists, physical therapist assistants, and academic programs shall provide clinical education that reflects, supports, and promotes professional development, complies with legal and ethical standards for patient/client management, and is consistent with the policies and positions of the American Physical Therapy Association. Physical therapist and physical therapist assistant students are obligated to communicate information to their academic program regarding clinical education experiences that appear to be in conflict with these standards, policies, and positions.

Financial Considerations In Practice (HOD 06-99-13-17)

It is the policy of the American Physical Therapy Association (APTA) that: The American Physical Therapy Association opposes participation in underutilization or overutilization of services for personal or institutional gain, or participation in services that is in any way linked to the financial gain of the referral source.
References


Internet Resources

AAPC
http://www.aspc.com/

American Health Information Management Association
http://www.ahima.org

American Medical Association
www.ama-assn.org

American Physical Therapy Association Payment Resources
http://www.apta.org/Payment

Buckley Amendment: Family Educational Right to Privacy Act
http://www.cpsr.org/cpsr/privacy/ssn/ferpa.buckley.html

Centers for Medicaid & Medicare Services (CMS)
http://www.cms.gov

Centers for Medicare and Medicaid Services HIPAA Page
http://cms.hhs.gov/hipaa

Centers for Medicaid & Medicare Services Regulations, Guidance, and Standards
http://www.cms.gov/home/regsguidance.asp/

Department of Health and Human Services
http://aspe.hhs.gov/admnsimp

Department of Health and Human Services Office for Civil Rights
http://hhs.gov/ocr/hipaa

Guidance on Privacy Rule Priorities From the HHS Office of Civil Rights
www.hhs.gov/ocr/hipaa/privacy.html

Health Data Management
http://healthdatamanagement.com

Legislative Information
http://thomas.loc.gov

Medicaid HIPAA Compliant Concept Model
http://mhccm.org

National Committee on Vital and Health Statistics
http://ncvhs.hhs.gov

Strategic National Implementation Process (SNIP)
http://snip.wedi.org

Supervision Under Medicare
http://www.apta.org/Payment/Medicare/Supervision

The American Disabilities Act (P.L. 101-336)
http://www.apta.org/rt.cfm/PT_Practice/administrationofphysica/ADA
TRACE Resources and Tools
http://trace.wisc.edu/resources
Section VI

Managing the Exceptional Student in Clinical Education
Introduction

The previous sections instruct how to make a general plan for clinical education, individualizing that plan for your student, and evaluating that student. Section VI prepares you to recognize and work effectively with the student who is exceptional in the clinic; considering not only the student whose performance is lower than expected, but also the student whose performance exceeds expectations. Section VI examines ways to identify the exceptional student and the methods for working effectively with that student.

Review of previous sections

In Section I, you had the opportunity to recognize parallels between clinical practice and clinical teaching.

In Section II, you learned to examine a student's readiness to learn. You explored the basic principles and stages of learning and considered ways to use your own and your student's styles of learning to help the student to develop qualities of the adult learner. You learned to develop behavioral objectives and used the stepwise levels of the taxonomies of cognitive, psychomotor, and affective learning to develop learning experiences in each domain.

In Section III, you learned ways to create an environment that fosters effective clinical learning (in much the same ways that you create an environment that fosters therapeutic intervention with your patients). You learned how to determine a student's learning diagnosis, to create an environment that engages the student in learning, and to design learning experiences that match the student's style of learning, his/her level of preparation, and his/her level of learning. You heard that practice will help the student develop the skills that are defined in the objectives. You know that the skills of observation, questioning, listening, and feedback are necessary to facilitate the student's progress.

In Section IV, you saw how you can use evaluation and assessment instruments to help describe the student's performance and to define the progress that is still to be made.

In Section V, you learned about some of the legal, regulatory, supervisory, and ADA issues and principles that may affect the clinical education process.

So you now have the information and skills you would need to work with the typical student. But few students are really "typical," and no students are typical in all ways.

Therefore, in this section, we will consider how you will work with the student who is exceptional and exceeds performance expectations or the student whose behavior is questionable or does not meet performance expectations.

The objectives for this section describe skills with which you are already familiar; in this section, we will examine how to apply them to the exceptional student.
Objectives

Following the completion of this section, the participant will be able to:

1. Generate appropriate solutions after analyzing a given learning situation.
2. Use a structure or format to sequence the design of learning experiences and to address the problem behavior appropriately.
3. Use communication and conflict management skills to work effectively with the exceptional student.
4. Analyze the effectiveness of the implemented solution.
5. Amend or adapt the planned solution to meet the needs of the learner.
Assumptions

1. The eventual manifestation of problem behaviors can be anticipated through careful and early observation of the student's performance.

2. An organized, structured approach is the most effective way to identify and manage students who manifest behaviors that are inconsistent with effective clinical practice.

Assumptions (cont’d)

3. Management of exceptional learning experiences is most effective when it includes skilled clinical teaching, judicious selection of learning experiences, and effective use of communication skills.

4. The learning plan applied in an exceptional learning situation should be reassessed to evaluate its effectiveness.
Assumptions (cont’d)

5. The CI can make recommendations to the DCE/ACCE regarding the student’s level of performance in the clinical setting.

Instructor’s note: In this section, you are presenting ways to identify and describe the exceptional student. You might wish to add anecdotal illustrations from your experience or participant experiences; however, these should be carefully selected and planned so that you can maintain the focus on the elements of identification and description and stay within the time allotted for this section.
A. Identification of the Exceptional Student

1. Define Exceptional Student

We most often think of the problem student when we think of an exceptional student. However, given the changes in the student body, the educational process, and the profession as a whole, we must consider both the above-average student and the below-average student.

Consider also that it is possible for a student to perform at an above-average level in one area of practice and at a below-average level in another area.

As the CI, you need to be prepared to assess student work at all levels, and to prepare and implement a program that will challenge that student at his/her highest possible level of performance in all areas at all times.

Think about a student’s performance that was above and below expectations. List some indicators of the student whose performance was above expectations and indicators of performance that were below expectations.
2. Observe carefully and note the student’s level of performance.

Identification of the Exceptional Student (cont’d)

2. Observe carefully and note the student’s level of performance.
   a. Note any unusual or unexpected level (higher or lower) of performance
   b. Note any indication of the student’s performance that does not match your expectations for demonstrating:

Identification of the Exceptional Student (cont’d)

b. Note if the student’s performance does not match expectations for:
   i. safe and effective practice
   ii. a level of independence appropriate for your facility
   iii. a level of competence consistent with the student’s educational preparation
3. Observe and note the student’s level of learning

**Identification of the Exceptional Student (cont’d)**

3. Observe and note the student’s level of learning (Hayes, Huber, Rogers, Sanders)
   a. Higher than expected?
      i. The student will move more quickly through behavioral objectives.
   b. Lower than expected?
      i. The student will require smaller steps in the progression of learning experiences to meet the behavioral objectives.
4. Diagnose student professional behaviors\textsuperscript{1,2}

Study conducted by Hayes, Huber, Rogers, and Sanders found that...

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**Identification of the Exceptional Student (cont’d)**

4. Diagnose Student Professional Behaviors (Hayes, Huber, Rogers, Sanders; Jette, Bertoni, Coots, et al)

Behaviors deemed as questionable by supervising CIs were either

1. Cognitive:
   a. Inadequate knowledge and skills

2. Noncognitive
   a. Poor communication
   b. Unprofessional behaviors

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a. Behaviors deemed as “questionable” by supervising clinical instructors fell into one of three categories\textsuperscript{1}:

1. Inadequate knowledge and skills (cognitive behaviors)
2. Poor communication (non-cognitive behaviors)
3. Unprofessional behavior (non-cognitive behaviors)

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next slide/page
b. Conclusion

**Conclusion:**

1. Most unacceptable behaviors were noncognitive, but cognitive behaviors were addressed more often.
2. Students who did not receive feedback were unlikely to change.
3. If behaviors changed, the experience was more successful.
4. CIs used cognitive behaviors more often to recommend a negative outcome.

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1. More than 50% of unacceptable behaviors were non-cognitive in nature, however cognitive behaviors were addressed more by CIs.
2. Students who did not receive feedback about their behavior(s) were unlikely to change.
3. Behaviors that changed were associated with a successful clinical experience.
4. Cognitive behaviors were used more often by CIs to recommend a negative outcome for the clinical experience.

next slide/page
5. Observe and note the student's performance in each domain of learning

Identification of the Exceptional Student (cont’d)

5. Observe and note the student’s performance in each domain of learning.
   a. Be prepared to observe different levels of performance within cognitive, psychomotor, and effective domains.
   b. Example: A student could perform higher than expected in the cognitive domain and lower than expected in the affective domain.

a. Be prepared for different levels (within the taxonomy) of performance in the cognitive, psychomotor, and affective domains.

b. A student who performs at a level higher than expected in the cognitive domain could concurrently perform at a level lower than expected in the affective domain.
6. Consider the student's performance with respect to the expectations of the facility

Identification of the Exceptional Student (cont’d)

6. Consider the student’s performance with respect to the expectations of the facility.
   a. What is the student’s previous clinical experience?
   b. What is the student’s level of academic preparation?
   c. What are the demands of the facility or the specific clinical experience?
7. Consider the student's performance with respect to the academic program’s expectations

Identification of the Exceptional Student (cont’d)

7. Consider the student’s performance with respect to the academic program’s expectations.
   a. Refer to the program’s guidelines for mid- and final evaluations
   b. Refer to program’s behavioral objectives
      i. In the syllabus
      ii. In correspondence to CCCE/CI
      iii. Consult with ACCE/DCE

   a. Refer to the academic program’s midterm and final evaluation expectations as guidelines.
   b. Refer to behavioral objectives in syllabus, letter to CCCE/CI from program, consult with ACCE/DCE.

   • CIs should have written guidelines from the academic program.
8. Communicate with the academic program and contact the ACCE/DCE.

Identification of the Exceptional Student (cont’d)

8. Communicate with the academic program and contact the ACCE/DCE.
   a. Use a formative evaluation instrument early.
   b. Provide a more detailed picture of the student’s performance.

   a. Consider using a formative evaluation tool early in the clinical experience to provide a more detailed picture of the student’s performance.

   • Especially when unsure about successful completion of the clinical experience.
   • Reevaluation may address all elements on the evaluation instrument, or only selected items (ie, those that are identified as problems or those that have changed).

Instructor’s Note: When is the appropriate time to talk with the ACCE/DCE? The ACCE/DCE should be alerted when there are concerns that may or may not necessarily warrant or expect action, and where student performance or behaviors are problematic. As you recall from Section V, part of an early warning system (EWS) allows for clear communication with respect to performance behaviors, learning objectives, and learning plans.
9. Use evaluation instruments to develop a portfolio of examples

Instructor's note: This “portfolio” of documentation should be presented not only as the ideal means of documenting a student's performance, but as the preferred and expected means of documentation for ALL students.

Identification of the Exceptional Student (cont’d)

9. Use evaluation instruments to develop a portfolio of examples.
   a. Formative Evaluation Instruments
      i. Weekly Planning Form
      ii. Anecdotal Record
      iii. Critical Incident Report
      iv. Journals
      v. Professional Behaviors Assessment (Kontney, May, Iglarsh; May, Morgan, Lemke et al)

   a. Formative Evaluation Instruments
      i. Weekly Planning Form (Section III, p 67)
      ii. Anecdotal Record
      iii. Critical Incident Report
      iv. Journals
      v. Professional Behaviors Assessment

next slide/page
b. Summative Performance Evaluation Instruments

Identification of the Exceptional Student (cont’d)

b. Summative Performance Evaluation Instruments
   i. APTA Clinical Performance Instruments (Roach, Frost, Francis et al; APTA)
   ii. Professional Behaviors Assessment
   iii. Program or consortium specific instrument
   iv. Other profession’s summative instruments

1. APTA Clinical Performance Instruments\textsuperscript{5,6}
2. Professional Behaviors Assessment\textsuperscript{3,4}
3. Program or consortium specific instruments
4. Other profession’s summative instruments

Instructor’s note: If there are participants in the program who are from professions other than physical therapy, please recognize their summative evaluation tools that would be included in the portfolio of examples.

Summary:

You should always be in the process of analyzing and documenting your student's performance, especially when the student does not meet or exceeds expectations. Although time consuming, this process produces a baseline that will help to determine as soon as possible what action, if any, to take.
By completing this process, you now have the means to identify elements of a student's performance or behavior that are above or below expectations.

You know the student's:
- level of learning
- performance in each domain

You have examples of the student's behavior.

As a CI, you seek for each student the maximum level of safe and effective practice for which that student is capable.

Therefore, using what we already know about clinical teaching skills, we will approach this next information to work with the exceptional student, using many of the same skills that are used for the typical student, but with some **special attention**...
1. Special Attention to the Learning Environment

Special Attention To The Learning Environment

a. Use observation, questioning, and listening skills to understand the student’s viewpoint.
   i. Student’s perception of expectations for the experience
   ii. Previous experiences
   iii. Personal goals and objectives
   iv. Goals may be negotiated with the student.

- Includes roles and responsibilities of both the student and the CI

ii. Previous experience

- Consider both type and number

iii. Personal goals and objectives for the clinical experience
iv. These goals may be negotiated with the student. In the case of the student who is performing beyond expectations, this may include exposure to areas of practice or skills that would be beyond “entry-level” performance.

- This approach models elements of adult learning that have been discussed previously.

next slide/page
b. Maintain unconditional positive regard

Special Attention To The Learning Environment (cont’d)

b. Maintain unconditional positive regard
   i. Keep an open mind for explanations/motivations
   ii. Focus on the behavior, not the person
   iii. Develop ways to work together

Remember: it is not necessary for you and the student to like each other!

You can use understanding and unconditional positive regard to maintain a learning environment that is conducive to engaging the student to work with you.

Examples of an unproductive clinical learning environment:
* If the student is intimidated, he/she will be less effective in his/her practice.
* If the goals are inconsistent, the student will react either by becoming passive or by setting out on his/her own and not following your mutually agreed upon plan.

Once the student has become engaged in the process, you need to foster that environment.

One of the ways to do that is to be very careful and deliberate about the types of communication skills that you use.

The discussion that follows is based on information taken from the business literature that addresses effective working relationships...

next slide/page
2. **Specialized Communication Skills**

The following strategies may prove effective when confronting the student who is demonstrating clinical behaviors deemed to be problematic.

**Specialized Communications Skills**  
(Patterson, Grenny, et al; Albardiaz; Welch)

a. Maintain an environment for open discussion
   i. Identify the problem to all parties
   ii. Be open to suggestions, alternatives, ideas, and compromise
   iii. Be succinct
   iv. Keep the environment non-threatening
   v. Use "cooling-off periods"
   vi. PRACTICE

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CREDENTIALED CLINICAL INSTRUCTOR PROGRAM

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a. Maintain an environment for open discussion
   i. Identify the problem to all parties

   - Do this in advance whenever possible.
   - Examples should be taken from documentation of the student’s performance to ensure that the identification of the problem remains clear and focused for all parties.

   a. Maintain a focus on the problem
   b. Use questions to gather and redirect discussion as needed
   ii. Be open to suggestions, alternatives, ideas, and compromise
   iii. Be succinct: know what you want to say and stick to the point
   iv. Use body, face, and voice to keep the environment non-threatening
   v. Use "cooling-off periods" as needed to keep all parties calm
   vi. PRACTICE

next slide/page
b. Manage defensiveness

Specialized Communications Skills (cont’d)

b. Manage defensiveness
   Prepare by...
   i. Being aware of sensitive areas
   ii. Separating the facts from your impressions
   iii. Considering your own role and contributions
   iv. Using a positive approach to work from the individual’s strengths
   v. Conveying clear messages and limits
   vi. Practicing and rehearsing

- Remember the defensiveness may be yours or theirs!

next slide/page
Specialized Communications Skills (cont’d)

b. Manage defensiveness

When meeting…

vii. Focus on the behavior, not the person
viii. Focus on professional requirements not being met
ix. Work to establish mutually acceptable goal(s) to all involved parties
x. Be prepared to have a third party present, when needed, especially in difficult discussion

When meeting…

7. Focus on the behavior, not the person
8. Focus on the professional requirements that are not being met
9. Work to establish a goal (or goals) that is (are) mutually acceptable to all parties involved

- Goals should be based on professional requirements as stated by facility or academic program.

10. Be prepared to have a third party present if needed, especially in difficult discussions

- This can be an ACCE/DCE, a CCCE, or other staff member.
c. Promote collegiality through disclosure and sharing

Specialized Communications Skills (cont’d)

c. Promote collegiality through disclosure and shared responsibility
   i. Focus on completion of the task
   ii. Complete the task by each person fulfilling responsibilities within his/her role
   iii. Use collegiality to define roles, not to place each person on the same level
   iv. Work together as colleagues, respecting each other’s roles to complete a task

3. Use collegiality to define roles, not to put each person on the same level

   - By "collegiality," we mean working together to generate decisions that have earned the mutual respect of each party.
   - This means that each party working within his/her role, generates mutually acceptable decisions.
   - This places both parties on firm ground, not necessarily equal ground; but each party knows what he/she has agreed to and what is expected of him/her.

Instructor's note: It is essential to emphasize the nature of collegiality as we are using it here. It does not mean that all parties are on an equal basis; rather it means that both student and CI equally are actively involved in doing their own part for developing and implementing program.

4. Work together as colleagues respecting each other’s roles to complete a task
5. Use disclosure to help each person understand each other person’s perception of roles and responsibilities

   - Disclosure that is not pertinent to the task at hand is not appropriate.
   - Some students may not have experience in communicating and behaving in a collegial manner. Role modeling collegiality while help the student learn specialized communication skills.

next slide/page
d. Use effective confrontation and negotiation skills

Specialized Communications Skills (cont’d)

d. Use disclosure to help each person understand perception of roles and responsibilities
   i. Use effective confrontation and negotiation skills
   ii. Problem presentation
   iii. Problem resolution
   iv. Interpersonal dimension
The Negotiation/Confrontation Assessment Form provides some specific behaviors the CI may find useful in developing and evaluating personal conflict management skills (and in assisting students in developing these skills as well). The form provides sample behaviors in 3 categories:

1. Problem Presentation,
2. Problem Resolution, and
3. Interpersonal Dimensions.

Ideally, both the CI and the student would demonstrate effective conflict management skills however this is often not the case.

- Form #1 lists effective behaviors for clinical instructors.
- Form #2 lists effective behaviors for students.
- Note that the 2 forms describe slightly different behaviors consistent with the roles of the CI and the student.

While confronting a student about problem behavior(s) is never easy, the CI may wish to convey to the student the expectations or “ground rules” contained in Form #2 prior to the meeting, or the CI should be purposeful in his or her attempts to facilitate the appropriate responses from the student (as outlined in Form #2).

For example, if the CI attempts to “state the problem clearly”, seldom will the student independently state “he/she has perceived the problem clearly.” It may fall to the CI to ask the student if he or she understands the problem and ask him or her to restate the problem from his/her perspective.
Form #1

**NEGOTIATION/CONFRONTATION ASSESSMENT FORM**

Directions: “CIs” should rate themselves and be rated by the “student” using this form.

<table>
<thead>
<tr>
<th>PROBLEM PRESENTATION</th>
<th>Self</th>
<th>Yes</th>
<th>No</th>
<th>Partner</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>States rationale for meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>States the problem clearly</td>
<td></td>
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<tr>
<td>Illustrates the problem with specific examples</td>
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<tr>
<td>States why the performance presents a problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks accuracy of background information</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requests other person’s point of view</td>
<td></td>
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</table>

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<tr>
<th>PROBLEM RESOLUTION</th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Presents suggested solutions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks feasibility of suggested solutions</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Considers alternative solutions</td>
<td></td>
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<td></td>
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<tr>
<td>Indicates limits of compromise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieves consensus on solution(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offers help to implement solution(s)</td>
<td></td>
<td></td>
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<tr>
<td>Shares appropriate degree of responsibility in managing outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL DIMENSIONS</th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Expresses feelings about the problem directly, using “I” messages</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Focuses on behavioral dimensions of the situation</td>
<td></td>
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<td></td>
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<tr>
<td>Balances compliments and constructive criticism</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Allows time for the other person to respond</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Uses appropriate attending skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintains appropriate body language</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows mutual respect and positive regard</td>
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</tr>
</tbody>
</table>

*Modified from a document courtesy of Susan Deusinger, PT, PhD, Washington University, St Louis, MO.*
Form #2

**NEGO-TIATION/CONFRONTATION ASSESSMENT FORM**

Directions: “Students” should rate themselves and be rated by the “Cl” using this form.

<table>
<thead>
<tr>
<th>PROBLEM PRESENTATION</th>
<th>Self</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>States perception of rationale for meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States perceived problem clearly</td>
<td></td>
<td></td>
</tr>
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</thead>
<tbody>
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<td>Presents suggested solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks feasibility of suggested solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considers alternative solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States specific behaviors that will lead to altered performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieves consensus on solution(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agrees to try to implement changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shares responsibility in managing outcomes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL DIMENSIONS</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Expresses feelings with “I” messages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focuses on professional performance elements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balances compliments and constructive criticism</td>
<td></td>
<td></td>
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<tr>
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*Modified from a document courtesy of Susan Deusinger, PT, PhD, Washington University, St Louis, MO.*
e. Always pay attention to written communication while planning learning experiences and while communicating with students

Specialized Communications Skills (cont’d)

e. Always pay attention to written communication while planning learning experiences and while communicating with students

i. Formative Evaluation Instruments: Weekly Planning Form, Critical Incident Report, Anecdotal Record, Professional Behaviors

ii. Student Program Planning Flow Chart (weekly/2 weeks/4 weeks) (Refer to Section III, p 73)

iii. Learning contracts

- This supports open, clear communication and effective collegial relations.
- You can use any of a variety of written forms.
- The purpose is to provide both broad and detailed plans of expectations and activities.
- This helps both parties communicate well, assess the situation accurately, and plan for progress appropriately.
- Can refer to domains for sequence and vocabulary.
Sample Learning Contract
Sample Learning Contract

The attached detailed clinical objectives reflect the results of a discussion with ______________________, CCCE/Cl at ______________________, in which we clarified expectations of my behavior and/or performance, in areas that were identified as problems ______________________ when? ______________________.

The purpose of defining specific performance statements is to clarify the expectations of my performance during the remainder of my clinical experience at ______________________.

I understand that I must incorporate these suggestions into my daily activities at ______________________. Failure to successfully meet these objectives by _________ date _________ will result in __________ (consequences: failure of the clinical experience, early termination of the experience, etc.)

I understand that emphasis on these objectives should in no way be construed to mean that the remainder of the goals and objectives for this experience are less important, or that successful completion of the remaining objectives is not required for successful completion of this experience.

______________________________  ______________________________
Student signature              Date

______________________________  ______________________________
CCCE/CI signature              Date

Summary:

In the first part of this program, we developed the basic skills for planning learning experiences that will help a student achieve the level of performance that is required for his/her clinical experiences. In addition to the skills for planning, we also discussed the need for examination, evaluation, diagnosis, prognosis, intervention, and outcomes of the patient.

In this section, we have applied the same format and the same skills, but with adaptations for the exceptional student.
C. Final Activity

Small-group activities that allow participants to apply what they have learned in the course occur at this point in the program.

Final Activity

Directions

1. View the formative evaluation/feedback video session between the CI and Fran (Activity 5, Section 2)
2. Form pairs: one person role plays the CI and the other person role plays the student Fran.
3. Review the Confidential Information provided and Negotiation/confrontation assessment forms.
4. Each person defines the problem(s) based on the video and their respective confidential information.
5. Role Play the negotiation/confrontation
6. Complete the “Negotiation/Confrontation Assessment Form” and discuss with partner

General Instructions

Step 1: View the formative evaluation/feedback session between the CI and Fran, the student, from Section II, Activity 5, p 48.
Step 2: Form pairs: one person will be the CI and the other will be the student Fran.
Step 3: Each person will review the following:
   - Confidential Information for the Student or the Clinical Instructor
   - Negotiation/Confrontation Assessment Forms
Step 4: Each person defines the problem(s) based on the video and their respective confidential information.
Step 5: Practice (role play) the weekly meeting in which the CI and student discuss the problems they identified and negotiate mutually acceptable behavioral objectives and learning experiences.
Step 6: Complete the “negotiation/confrontation assessment form”. The CI completes the column labeled “self” on the CI form and the student completes the column labeled “self” on the student form. Then exchange forms and complete the partner column on the respective forms.
Step 7: When all pairs have completed this task, reconvene to discuss the respective student problems, the resolutions that were worked out, and the process of confrontation and negotiation.
NOTE: While a form is included that outlines “effective” student behaviors in a negotiation/confrontation, participants may suggest that students seldom demonstrate these behaviors. This can be the case for some clinicians too. Role modeling negotiation/confrontation skills can be an effective way for students to learn. Role playing can be an effective teaching technique to help students, and CIs, improve their negotiation/confrontation skills.

This activity models the negotiation/confrontation role play activity in the Assessment Center, Station 4. As in the Assessment Center, participants will watch a video of a feedback session between a student (Fran from Section II, Activity 5, p 48) and the CI. With this activity, participants will recognize an exceptional student, define the student’s learning diagnosis (problem), practice specialized communication skills necessary for effective negotiation/confrontation, and develop mutually agreeable behavioral objectives and learning experiences.

Coach participants to use the confidential information to help them understand the behaviors observed on the video and to determine the outcomes the student and CI desire to negotiate. Instruct the participants to perform the negotiation with the skills they have; meaning they do not have to be the characters, they can be themselves. But, they must negotiate the following:
Student wanting as much experience in pediatrics CI wanting the student to display compassion to all patients, including those with chronic obstructive pulmonary disease (COPD) and manage patients of all ages.

You may want to have the participants reread the Case of Fran (Section II, Activity 5, p 48) before showing the video. You may want to have participants use the Student Program Planning Flow Chart or another formative evaluation instrument to help identify and document the student’s behavior, objective/goal, and learning experience. This could slow the activity down but it may help participants realize that using an instrument, such as the Student Program Planning Flow Chart, may help focus the discussion on the behavior and not the person.

This activity will take approximately 45 minutes to provide clear instructions (5 minutes), watch the video (~5 minutes), allow participants to read the confidential information (5 minutes), role play in pairs (15 minutes), and discuss the experience and solutions in a large group (15 minutes).
THE CASE OF FRAN
Final Role Play for Negotiation/Confrontation With the Exceptional Student (Role Play Video)

SCENE
An acute care setting. The CI approaches Fran while she is doing something (eg, documenting a patient note, gathering equipment for next patient), so it is a formative feedback session with time constraints. Fran is a little distracted with the activity she was doing when the CI started talking to her, and an interruption contributes to the student and CI not finishing the conversation in a satisfactory manner. The scene should capture catching Fran off-guard, which may contribute to her unchecked response.

CI: Hi Fran.

Fran: Hi.

CI: How did your examination of Mr Elliott go this morning?

Fran: It was Fine. I instructed him on a few exercises for his breathing for COPD and I discharged him.

CI: I couldn’t help but notice that your examination seemed a little rushed, especially when you were auscultating his lungs and assessing his breath sounds.

Fran: I’m just trying to manage my time this morning. After lunch I want to get upstairs to the pediatric unit and help with an examination up there.

CI: Will you see Mr Elliott again this afternoon before he is discharged?

Fran: No, he seems to be doing fine managing his COPD.

CI: But how will you know if he’s performing his breathing exercises correctly?

Fran: They’re pretty easy exercises, and he didn’t have any questions before I left the room.

CI: Proper breathing is very important for Mr Elliott’s condition, and so are education and encouragement to stop smoking. Did you include this in your instructions today?

Fran: I didn’t.

CI: Why not?

Fran: He has had COPD for several years, and he hasn’t quit smoking yet. I feel like it’s a waste of my time to try and convince him to change something he’s been doing for 30 years. I’m sure he’ll be back with another episode of dyspnea or shortness of breath.

CI: Fran, it seems to me that you do not like to work with Mr Elliott.

Fran: It’s not fun working with people who are coughing up phlegm and still smoking when they are on oxygen.

CI: But this is an acute care rotation; you know we have a lot of patients with breathing problems who can benefit from physical therapy. I think it would be a good idea for you to select and see more patients with COPD in your caseload.
Fran: I know I’ve already seen 3 or 4 of them and it’s my last few weeks. I would like to get more experience in pediatrics since that’s where I want to specialize after I graduate.

CI: I know, and I see that you are selecting as many pediatric patients as possible, but this is not a pediatrics experience. You are here to learn and gain skills in managing patients of different ages and conditions.

Fran: This is my final internship, and I’ve been meeting all my goals each week, and I would really like to spend more time with the pediatric unit. I need to build my resume so that I can work at a pediatric hospital after I graduate.

The conversation is interrupted by the CI getting paged/beeper goes off.

CI: Fran, This could be an emergency. I need to check on it right away. I think we should continue this discussion tomorrow during our weekly meeting.

Confidential Information for Fran, the student

Confidential information for Fran, the student:
As a former teacher in a day care setting, you taught a couple of students with cerebral palsy. You have always enjoyed working with children and feel that you can do more to help children as a physical therapist than as a teacher.

Communicating with others, asking relevant questions, and providing viable solutions have been some of your strengths identified by your professors and clinical instructors. You’ve also been commended for your self-directed learning behaviors.

As a student, you expressed your interest in working with pediatrics to your ACCE/DCE but you did not get placed in a pediatric experience. Now you are on your final experience in an acute care hospital. You have completed all your previous experiences without any difficulty and achieved entry-level performance on the PT CPI on all skills. Based on reflection of your strengths and weakness and your plan to become a pediatric certified specialist, you told your CI on the first day that you were interested in improving your examination skills and gaining as much experience as possible with pediatrics while on this clinical experience. Since you have progressed quickly, without any safety issues, your CI has allowed you to select your caseload for the past 2 weeks. There are 3 weeks remaining in the experience.

After viewing the feedback session between the CI and student, you will role play Fran, and your partner will role play the CI. What is important to you while negotiating is gaining experience evaluating and treating pediatric patients.
Confidential Information for the CI

Confidential information for CI:
Being a PT and CI in the acute care setting for many years, you feel that you have worked with students whose performance has ranged from below expectations to exceeding expectations. You have always had strategies to help “exceptional students” adjust to the stresses of working in the hospital. Your core values of excellence and compassion/caring drive you to provide individualized care to all your patients. This also drives you to try to be the best CI that you can be.

Your current student, Fran, is completing her final affiliation. She has completed all of her previous affiliations without difficulty and achieved entry-level performance on the CPI on all skills. On the first day, Fran identified her goals as improving her examination skills and gaining the ability to manage her time in an acute care setting, but also gaining as much experience as possible with pediatrics. Early on, Fran exhibited several adult learner characteristics that you feel are strengths, including being self-directed and problem-centered. But since you have been allowing Fran to select her own caseload for the past 2 weeks, you notice a discrepancy in her attitude toward treating patients with COPD. This has become a concern that you plan to address with Fran at your next weekly meeting. There are 3 weeks in the affiliation remaining.

After viewing the feedback session between the CI and student, you will role play the CI, and your partner will role play Fran. What is important to you while negotiating is that Fran gain experience managing patients of all ages and display compassion/caring for all her patients/clients, including patients with COPD.

next slide/page
Program Summary:  

At this point, you should be prepared to offer a quality experience to:

**Program Summary**  
*At this point, you should be prepared to:*

- Develop a planned educational experience.
- Establish objectives and learning experiences for the program.
- Maintain an environment that is conducive to effective clinical learning.

**Program Summary (cont’d)**

- Give feedback to the student during the process.
- Evaluate student clinical performance in the cognitive, psychomotor, and affective domains.
- Adapt each of these standard skills to manage a program for the exceptional student.
References


Section VII

Answer Keys and Additional Recommended Resources
Answer Keys  
(CCIP Participant Manual)  

Section II  

• Page 36, Activity 1 (Find Someone Who…)  

• Page 27, Activity 4  
  1. Affective  
  2. Cognitive  
  3. Cognitive  
  4. Psychomotor  
  5. Cognitive, affective  
  6. Cognitive  

• Page 41, Activity 3A  
  1. Knowledge  
  2. She is unable to select the interventions that are most appropriate to the patient.  
  3. At the minimum level of evaluation or higher to include analysis or synthesis.  
  4. She seems to have “knowledge” that the interventions she is choosing are appropriate. Has she considered all the alternatives?  

• Page 42, Activity 3B  
  1. Attitude  
  2. Curt does not value the opinions of others and the team process as it relates to the care and management of his patients.  
  3. “Receiving”  
  4.  
    a. Seek to determine whether Curt recognizes the impact of his communication skills on other team members and the team process.  
    b. Have Curt develop an outline of team members and the value that each team member plays in a patient’s recovery.  

• Page 45, Activity 4:  
  a. Following the lecture, know the steps in applying a below-knee prosthesis.  
    1. Audience and criterion are missing  
    2. No. Cannot measure “know.”  
    3. Following the lecture, the physical therapy student will <correctly> describe the steps in applying a below-knee prosthesis. <correctly = criterion>  
  b. Following a discussion with the CI, the student will study the preferred format for documenting initial examinations.  
    1. As stated, the criterion is missing. Nothing to indicate how well student must "study."  
    2. No. "Study the format” is process oriented rather than outcome oriented.  
    3. Following a discussion with the CI, the student will document an initial examination using the preferred format.
c. Given all the necessary supplies, the student will correctly demonstrate and explain the proper taping for a “goalkeeper's thumb” injury.
   1. Nothing is missing.
   2. No. Two outcomes are listed...demonstrate and explain.
   3. Make 2 objectives, 1 for each of the verbs. Given all the necessary supplies, the student will <correctly> demonstrate (or explain) the proper taping for a “goalkeeper's thumb” injury.

d. The instructor will show the student how to take blood pressure.
   1. As stated, the criterion is missing. Nothing indicates how well and under what circumstances the student will perform the skill of taking a blood pressure.
   2. No. Instructor-centered rather than student-centered.
   3. By the end of the week, the student will be able to accurately take a resting blood pressure on all patients.

- Page 46, Previous Activity 3A
  1. Lucy will correctly list all the interventions appropriate for...
  2. Lucy will explain the rationale for all interventions she has identified.
  3. Lucy will compare and contrast identified interventions vis-à-vis outcomes, cost effectiveness, and resources.

- Page 46, Previous Activity 3B
  1. Following a team meeting, Curt will recognize the impact of his communication skills on other team members.
  2. Curt will demonstrate value for team meetings by attending all meetings as scheduled.
  3. Following each team meeting, Curt will list 1 example or valuable insight gained from another team member regarding 1 of his patients.

- Page 48, Activity 5
  1. Self-directed learner; problem-centered learner
  2. Yes. Fran has not sought relevant concepts and is not ready to learn in this area. Fran does not appreciate the implications of respiratory function in a broad array of patient problems.
  3. Review with Fran the relationships between pediatric diagnoses and pulmonary physical therapy (eg, cystic fibrosis, asthma, pediatric burns). Discuss pulmonary physical therapy as an entry-level competency.

- Page 49, Activity 6 (Learning Styles Inventory)

- Page 52, Activity 7
  1. Notes are not completed on time. He does not use his free time well. He has not written learning objectives. Patients’ plans of care are not clearly defined and written. He does not participate in staff discussions on patient problem solving. A broader problem may be that Raj and Lorraine approach learning differently with different learning styles.
  2. Consider strategies that allow Raj to use his predominant learning style (ie, discuss with Raj when it is appropriate to be “experimental” in his clinical learning experiences). Consider strategies that push Raj to use a less dominant learning style (ie, developing a series of alternative plans of care in advance identifying why they are indicated). Clarify for Raj those responsibilities that are “non-negotiable” regardless of learning style (ie, notes written in a timely fashion).
Page 53, Activity 8

1. a) Yes, criterion implied with “distinguish”
   b) Yes
   c) and d) The student will distinguish between motor planning problems and weakness in a patient with hemiplegia.
   e) Cognitive

2. a) No; difficult to demonstrate acceptance
   b) Yes
   c) and d) By seeking out appropriate guidance from the CI, the student will identify areas of limited knowledge and experience.
   e) Affective

3. a) No; no criterion
   b) Yes
   c) and d) The student will prepare a treatment room for an established program for a child with hyperactivity within 5 minutes.
   e) Psychomotor

4. a) Yes
   b) Yes
   c) and d) The student will list appropriate tests and measures for the full examination of a patient complaining of knee pain.
   e) Cognitive

5. a) No; no criterion. Condition "given a patient with a torn meniscus" is implied.
   b) No; describes two outcomes
   c) and d) The student will accurately describe the necessary tests and measures for identification of a torn meniscus. OR Given a list of tests and measures used to diagnose a torn meniscus, the student will correctly explain the purpose of each test and measure.
   e) Both are cognitive

6. a) Yes
   b) Yes
   c) and d) The student will correctly reproduce a neurodevelopmental treatment program after observing the intervention two times with the same patient.
   e) Psychomotor

7. a) No; no criterion; condition is implied
   b) No; too general; too vague
   c) and d) The student will demonstrate professional behavior by consistently speaking with tact and diplomacy.
   e) Affective

8. a) Yes; condition is implied
   b) No; describes two outcomes
   c) and d) The student will demonstrate the ability to objectively identify manipulative behavior. OR Given a patient with manipulative behavior, the student will successfully maintain an appropriate helping relationship.
   e) The first objective is cognitive. The second objective is affective.
9. a) Yes; condition is implied  
b) Yes  
c) and d) The student will demonstrate the ability to set appropriate priorities by completing assigned responsibilities on time.  
e) Affective

10. a) No; no criterion  
b) Yes  
c) and d) Based on evidence, the student will defend his/her choice of intervention(s) for a patient with low back pain to a level acceptable to the clinical instructor.  
e) Cognitive

11. a) No; no criterion  
b) No; process oriented as opposed to outcome oriented  
c) and d) The student will collect <6> articles on the effects of hydrotherapy. Condition is implied.  
e) Cognitive

12. a) No; no condition; no criterion  
b) No; not measurable except by virtue of some other observable behavior  
c) and d) In the clinical setting, the student will demonstrate motivation by asking to observe the interventions of other therapists.  
e) Affective

13. a) Yes  
b) Yes  
c) and d) The student will design a plan of care for a child with cerebral palsy using an integrated program of therapeutic exercise techniques.  
e) Cognitive

14. a) No; no criterion  
b) No; two outcomes  
c) and d) The student will <accurately> assess his/her performance following a treatment session by <critically analyzing his/her performance for completeness, effectiveness, and efficiency>. In this case, we opted to use the second part as the criterion for the first rather than make 2 new objectives.  
e) Cognitive, affective

15. a) Yes; condition is implied  
b) Yes  
c) The student will document the results of an initial examination thoroughly, concisely, and within 1 hour.  
d) Cognitive

Section III

• Page 68, Activity 2  
(Answers might include the following, however this list is not exhaustive.)

Case 1: Donna

1. Background information:  
Based on academic and clinical experiences, is Donna able to: state the rationale
for medical diagnostic testing and use of MRI, relate to previous experience with physician therapist interaction, and explain the patient's medical background? What were her previous clinical education experiences? What evidence does Donna have to support her opinion? What has been Donna's previous interactions with physicians? Is this patient's physician receptive to requests from a Physical Therapist?

2. **Facility resources:**
   a. Interdisciplinary/team approach
   b. Opportunity to interact with physicians/other disciplines
   c. Have physicians receptive to Physical Therapists’ requests for testing
   d. Experience/skilled clinical educator

3. **Behavioral goal:**
   Donna will provide a persuasive, clear and concise consultation with the physician for the necessity of an MRI for this patient, by the end of this week. *(Donna may be persuasive and correct, but the MD will not agree)*

**Case 2: Juan**

1. **Background information:**
   Based on academic and clinical experiences, is Juan about to: demonstrate knowledge of safe patient handling techniques, perform body mechanics, use teaching skills, prepare (including completing required content) materials, provide appropriate pacing, and assess participants understanding of the information?

2. **Facility resources:**
   a. appropriate space
   b. Outline of course content
   c. CI who is willing to share expertise.

3. **Behavioral goal:**
   Juan will instruct the nurse’s aide body mechanics workshop, scheduled for 3 weeks from today, independently, addressing the required content and skills.

**Case 3: Suzanne**

1. **Background information:**
   Based on academic and clinical experiences is Suzanne able to: demonstrate knowledge of the roles and responsibilities of a PTA, of adult learner characteristics, and of effective personal interactive skills?

2. **Facility resources:**
   a. Opportunity to practice patient care
   b. Opportunity to interact with other students in physical therapy
   c. Atmosphere receptive to students
   d. An experienced/skilled CI
   e. Valuable resources related to direct supervision, best practice, state laws and regulations, and Medicare requirements for supervision of support personnel.

3. **Behavioral goal:**
   By the end of the week, Suzanne will appropriately direct and supervise Dianna’s work with a patient assigned by the CI.
Page 74, Activity 5

a. Roger is having difficulty in the psychomotor and affective domains. He is in the “acquisition” level of learning, still requiring active CI input. He needs to take full advantage of practice opportunities and feedback provided. He needs to demonstrate adult learning behaviors (self-directedness, a readiness to learn, and the use of his past experiences in learning) to improve his targeted behavior and successfully reach his goal. (Answer in Participant Manual)

Additional Information for Trainer

b. Roger is at the “acquisition” level of learning, still requiring active CI input (guidance and feedback) and still requiring practice. The CI’s responsibilities include involving the student as the CI plans the learning experience, providing guidance in the learning activity, feedback to the student, and the opportunity to practice skills being learned.

c. Roger should be taking full advantage of practice opportunities and feedback given. Roger should be demonstrating adult learning behaviors (self-directedness, a readiness to learn, and the use of his past experiences in learning).

d. Practice, demonstration-practice, and role play would all be appropriate, as they are learning methods that easily combine cognitive and psychomotor learning objectives. Formal research on Roger’s part to better understand abnormal movement patterns (and the complexity of this topic) may be useful and help build confidence.

e. (Example)
   i. Have Roger research clinical methods of managing abnormal movement patterns.
   ii. Role play several presentations of abnormal movement patterns (CI as the patient), then discuss their similarities and differences.
   iii. Use practice and demonstration-practice alternately as Roger and the CI explore movement differences in various patients.
**Student's Name:** Roger  
**Instructor(s):**  
**School:**  
**Date of Clinical Experience:** Add date of conference, which experience, what week of the experience

<table>
<thead>
<tr>
<th>Specific Targeted Behaviors</th>
<th>Long-term Goals</th>
<th>Objectives</th>
<th>Learning Experiences</th>
<th>Available Resources</th>
</tr>
</thead>
</table>
| Patient handling for patients with CVA and atypical movement patterns. | By mid-evaluation, Roger will be able to correctly control patients with CVAs and atypical movement patterns during intervention. | By the end of the week, Roger will be able to correctly adjust patient contact with 2 patients with CVA. | Roger will observe a PT working with a patient with atypical movement patterns, and then repeat the same handling techniques, with feedback from the PT. Roger will demonstrate handling techniques on the CI who will simulate a patient with atypical movement patterns. | Patient population  
Expertise of clinical staff  
Opportunity for student to practice patient care  
Staff willing to share expertise |
Section IV

Page 85, Activity 1

Anecdotal Record (format from Shea et al)

The CI simply records the facts of “what happened,” offering no judgments mixed with facts.

Student's Name: Jane Date: ________________

Evaluator/Observer: Robert

Setting: (Place, persons involved, atmosphere, etc)

Jane had made an appointment with Mrs J, who in the past week has refused physical therapy twice. When Jane arrived, the patient was on the telephone. Jane told the patient that she would return in a minute and asked the patient to end the conversation. When Jane returned, the patient was still on the phone and made no move to end the conversation.

Student Action or Behavior:

Jane interrupted Mrs J and firmly, but politely, asked her to end the conversation, since she had agreed to have her treatment at this time.

Evaluator Interpretation:

Jane demonstrated appropriate and assertive intervention to set limits on the patient's behavior. Assertiveness has been a challenge for her, and this is a good example of an appropriate application of the skill.

Jane Student Robert Clinical Instructor

Student's Signature Evaluator's Signature

Student's Comments:

It's difficult for me to feel like I'm being rude, but I can see the importance of setting limits on the patient's behavior.
Critical Incident Report (format from Shea et al)

*Directions: Record each entry clearly and concisely without reflecting any biases.*

<table>
<thead>
<tr>
<th>Date (time)</th>
<th>Antecedents</th>
<th>Behaviors</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/2 at 9:30 am</td>
<td>Bruce was assisting a 76-year-old patient with a total hip replacement during her first attempt at ambulation, non-weighting bearing, with a walker.</td>
<td>Bruce was text messaging on his cell phone while assisting the patient during ambulation. Bruce was not paying attention to the patient. Bruce did not note level of pain evidenced by the patient the patient’s incorrect gait pattern and distress.</td>
<td>If unsafe behavior such as this continues to occur, it will be written on his permanent evaluation.</td>
</tr>
<tr>
<td>10/15 at 2:00 pm</td>
<td>Bruce was assisting a patient in transferring from wheelchair to bed.</td>
<td>Bruce did not lock the wheelchair prior to assisting the patient to a standing position.</td>
<td>This behavior will be recorded on Bruce’s permanent evaluation. If behavior such as this continues, his mid-evaluation rating on “Safety” will be lowered and the ACCE/DCE will be contacted.</td>
</tr>
<tr>
<td>10/22 at 11:00 am</td>
<td>On the cardiopulmonary unit: Documentation following treatment session.</td>
<td>Documentation poor due to lack of thorough chart review and patient interview.</td>
<td>ACCE/DCE will be called to address repeated issues of safety, lack of concern for patient welfare, and interpersonal skills.</td>
</tr>
</tbody>
</table>

**Student’s Signature:** Bruce Student  
**Evaluator’s Signature:** Karen Clinical Instructor
Section V

Page 111, Activity 2 - Student Supervision, Billing and Documentation for Medicare Part a

1. Physical therapist students are not required to be in line-of-sight of the professional supervising therapist/assistant (Federal Register, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy.

The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:

- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.) (RAI Version 3.0 Manual, October 2011).

Actually the term billing is a misnomer. In the SNF setting if the PT or PTA student provides the service while in line-of-sight of the PT or PTA CI, then Medicare Part A permits the minutes can count toward the Minimal Data Set (MDS). (Refer to Medicare Student Supervision Chart on page TK).

All time that the student spends with patients should be documented. APTA recommends that the physical therapist co-sign the note of the physical therapist student and state the level of supervision that the PT determined was appropriate for the student and how/if the therapist was involved in the patient’s care. (Refer to Medicare Student Supervision Chart on All time that the student spends with patients should be documented. APTA recommends that the physical therapist co-sign the note of the physical therapist student and state the level of supervision that the PT determined was appropriate for the student and how/if the therapist was involved in the patient’s care. (Refer to Medicare Student Supervision Chart on pages 112-114). Please see Supervision Under Medicare chart for clarification of students working with Individual, Group, and Concurrent therapy.

Physical therapist assistant students are not required to be in line-of-sight of the professional supervising therapist/assistant (Federal Register, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. The minutes of student services count on the Minimum Data Set. Medicare no longer requires that the PT/PTA provide line-of-sight supervision of physical therapist assistant (PTA) student services. Rather, the supervising PT/PTA now has the authority to determine the appropriate level of supervision for the student, as appropriate within their state scope of practice. Additionally all state and professional practice guidelines for student supervision must be followed. Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy.
The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:

- The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.) (RAI Version 3.0 Manual, October 2011).

As with the PT student, under line-of-sight of the PT supervisor, the minutes of PTA student services count on the MDS.

APTA recommends that the physical therapist and assistant should co-sign the note of physical therapist assistant student and state the level of appropriate supervision used. Also, the documentation should reflect the requirements as indicated for individual therapy, concurrent therapy, and group therapy the same as for the physical therapist student. (Refer to Medicare Student Supervision Chart on page -TK). Please see Supervision Under Medicare chart for clarification of students working with Individual, Group, and Concurrent therapy.

Page 111, Activity 2 - Student Supervision, Billing and Documentation for Medicare Part B

Only the services of the physical therapist can be billed and paid under Medicare Part B. The services performed by a physical therapist student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. For Medicare Part B, the licensed physical therapist with a student cannot be managing two patients at the same time, such as in an open gym to meet the conditions provided below.

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician’s service, not for the student’s services).

APTA recommends that the licensed physical therapist complete documentation when supervising a physical therapist student. Documentation provided by students that is co-signed is a red flag for auditors with regard to whether or not
the Medicare Part B regulations were followed.

Only the services of the physical therapist can be billed and paid under Medicare Part B. The services performed by a physical therapist student are not reimbursed even if provided under "line of sight" supervision of the therapist; however, the presence of the student "in the room" does not make the service unbillable. For Medicare Part B, the licensed physical therapist with a student cannot be managing two patients at the same time, such as in an open gym to meet the conditions provided below.

Therapists may bill and be paid for the provision of services in the following scenarios:

- The qualified practitioner is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
- The qualified practitioner is present in the room guiding the student in service delivery when the therapy student and the therapy assistant student are participating in the provision of services, and the practitioner is not engaged in treating another patient or doing other tasks at the same time.
- The qualified practitioner is responsible for the services and as such, signs all documentation. (A student may, of course, also sign but it is not necessary since the Part B payment is for the clinician’s service, not for the student’s services).

Physical therapist assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy students, while providing services within their scope of work and performed under the direction and supervision of a licensed physical or occupational therapist to a Medicare beneficiary.

APTA recommends that the licensed physical therapist complete documentation when supervising a physical therapist student. Documentation provided by students that is co-signed is a red flag for auditors with regard to whether or not the Medicare Part B regulations were followed.

In addition, Medicare supervision regulations with respect to PTAs in a Comprehensive Outpatient Rehabilitation Facility (CORF) state that the services must be furnished by qualified personnel. If the personnel do not meet the qualifications in 485.705, then the qualified staff must be on the premises and must instruct these personnel in appropriate patient care service, techniques, and retain responsibility for their activities. A qualified professional representing each service made available at the facility must be either on the premises of the facility or must be available through direct telecommunications for consultation and assistance during the facility’s operating hours.

However, APTA has a position with regard to the PTA that states that “direct personal supervision requires that the physical therapist, or where allowable by law, the physical therapist assistant, is physically present and immediately available to direct and supervise tasks that are related to patient/client management. The direction and supervision is continuous throughout the time these tasks are performed. Telecommunications does not meet the requirement of direct personal supervision. Note that this position is less liberal than that of Medicare. In addition, care to be delivered must be within the state practice act and scope of the work of the PTA (Refer to Procedural Interventions Performed...
According to APTA policy, Ethical and Legal Considerations for Clinical Education (HOD P06-01-16-18), physical therapist and physical therapist assistant students are obligated to communicate information to their academic program regarding clinical education experiences that appear to be in conflict with these standards, policies, and positions. APTA has a policy, Financial Considerations in Practice (HOD P06-99-13-17) that opposes participation in underutilization or over utilization of services for personal or institutional gain, or participation in services that is in any way linked to the financial gain of the referral source.
Additional Recommended Reading


Introduction to the Assessment Center

Overview

The concept of the Assessment Center was initially developed and used to select military officer candidates during World War II and always included multiple testing formats with behavioral simulations. Through the investigative work of Susan Deusinger, PhD, PT and colleagues, this multimethod approach to competency-based evaluation was then applied to the assessment of physical therapist competence and clinical faculty development. This specific Assessment Center was created to measure the participant's ability to apply, in simulated situations, the critical knowledge and skill learned in the CI Education curriculum. We are grateful to Dr Deusinger who served as a consultant on this project in developing an Assessment Center model to be applied specifically to this Credentialed Clinical Instructor Program. In addition, the Guidelines for Clinical Instructors, originally approved by the House of Delegates of APTA in 1993 and last revised in 2004, were used in the development of the Assessment Center stations so that as many Guidelines as possible were evaluated through this process. Several of the Guidelines, specifically those related to the applicant's clinical competence, professional skills, ethical behavior, and time management abilities, were felt to be better assessed by the applicant's direct supervisor. These Guidelines have been included in a Participant Dossier, which must accompany each applicant's registration form. Taken together, the six stations of the Assessment Center, in conjunction with the Participant Dossier, provide a comprehensive assessment of each applicant's degree of compliance with the Guidelines for Clinical Instructors.

Organization of the Assessment Center

1. The Assessment Center is arranged in six (6) stations. Each station is designed to take no more than 30 minutes to complete. Participants may complete each station seated in a classroom, each with a writing surface, except for Station 4. Station 4 requires the participants to pair up for a role-play. This station will require room to spread out so that participants can hear each other and not disturb neighboring pairs. Consider using more than one room for groups of 20 participants or more. Each station will have one or more, color-coded answer sheets for participants to record their responses.

Station 1: Three different student scenarios are provided. Participants must develop goals and plan learning experiences.

Station 2: Weekly summaries of a student's performance are provided. The applicant must synthesize these observations of the student's performance and provide a midterm summary (summative evaluation).

Station 3: A short videotape of a student, patient, and CI interaction is presented to the group. Each applicant is given the opportunity to view the videotape once and to answer a variety of questions about what was observed, how he/she interpreted the information, and what a reasonable plan of action might be.
Station 4: Participants are paired to role-play the student/CI interaction that would follow the scenario just observed in the videotape. Confidential information about each of the roles is provided. Each participant is then asked to rate himself/herself and his/her partner on a Negotiation/Confrontation Assessment Form.

Station 5: A scenario is provided in which the student and the CI differ in opinion regarding the level of the student’s performance. This is an opportunity to assess communication and formative evaluation skills.

Station 6: Participants are asked to provide a student situation where the ACCE/DCE should be involved. Participants must determine when to notify the ACCE/DCE, how the ACCE/DCE is expected to help, and what information should be presented to the ACCE/DCE.

2. In preparation for the Assessment Center, each participant should be provided with a 2-pocket folder of materials to be used as he/she moves through each of the stations. The folder should include:

a) **Overview and general instructions** for the Assessment Center should be in the left pocket of the folder (sample included). *Use white paper.*

b) **Statement of Confidentiality** for all participants is required to sign this form before proceeding with the Assessment Center. Place in the right pocket of the folder and use white paper to make copies of this form. The forms should be collected and filed with the participants’ response sheets at the conclusion of the Assessment Center (sample included).

c) **Directions:** Each station has a set of directions. These directions should be packaged together, in order, on the left side of the folder. *Use color coding* (see below).

d) **Scenarios/Additional Information** specific to that station should be color-coded and provided in the left pocket of the folder after the directions.

e) **Response sheets:** Each station has 1 or more response sheets on which participants write all of their answers. These sheets should be packaged together, in order on the right side of the folder. Use the same color coding as the directions.

f) **Participant’s Score Report** form should be on white paper and placed in the right pocket of the folder, behind the response sheets (sample included).

g) **Course Evaluation** form should be placed behind the Participant Score Report on the right side of the folder. APTA will be email the evaluation to participants to complete electronically, however, printed versions are provided for reference.

**NOTE:** It is highly suggested that all materials specific to 1 station be copied in the same color. Color coding the stations in this way makes it much easier for participants to find the related material. White originals of the Assessment Center station materials may be found in the Trainer’s Manual. For better quality copies on color paper, use the white originals to copy onto color paper.
Summary of Folder Contents: All forms that get reused go on the left, all forms on which participants write go on the right.

Left side pocket (in order, front to back)
- Overview and general instructions
- Instructions and additional information sheets for Stations 1-6

Right side pocket (in order, front to back)
- Statement of Confidentiality
- Response sheets for Stations 1-6
- Participant Score Report form
- Course Evaluation form *(to be completed electronically)*

3. When the participants begin, they should put their name on each of the response sheets. **Instruct participants not to write on the folders or anything in the left pocket of their folder** (overview, instructions, scenarios, etc.) because trainers will be able to reuse these items each time they give the assessment center. Everything they write on is placed in the right pocket folder. **Remember right = write.** As participants complete each station, instruct them to replace their instruction sheets and response sheets in the folder, in order, 1-6.

4. Theoretically, stations should be completed in numerical order (#1 through #6) and station 4 must be completed immediately after station 3. Each station should be timed by the trainer/instructor. Participants who finish a station early should be encouraged to complete their course evaluation forms. The instructor may allow those who finish a station early to leave the room and return by the time for the beginning of the next station.

5. After all stations are completed, participants are given a packet of color-coded answer keys (one for each station) and self-score their responses. They then summarize their scores on the **Participant’s Score Report** (sample included) and turn it in, with the response sheets, to the instructor.

6. **Scoring:** Minimum points for each station are indicated on the Participant’s Score Report. Minimum scores are required for successful completion of each station. Each participant will need a packet of color-coded answer keys to complete his/her own scoring. The last page of the packet should be a copy of the Directions for Repackaging Assessment Center Materials.

If a participant fails to achieve the minimum score in a station, he/she should consult immediately with one of the program trainers for an interpretation of his/her response. Occasionally, the intent is correct, and the participant can receive credit, even though the wording may not be accurate.

Failure to successfully complete a station will preclude the individual from being credentialed at that time. The participant will be asked to return to the Assessment Center at a later date.
Participants who meet the minimum score requirement in each station will be credentialed as CIs according to the standards set forth by this program. Participants will receive APTA CI Credentialing (4-6 weeks) once paperwork has been received at APTA by the Credentialed Clinical Trainers.

7. After scoring, each participant must check out and turn in all materials related to the Assessment Center.

8. **Sample documents**
The following documents have been included for reference:
   a. Participant Dossier
   b. Overview and general instructions for participants
   c. Statement of Confidentiality
   d. Sample: Check Out Form
   e. Participant’s Score Report

**Considerations for Administering the Assessment Center**

1. It is useful to separate and repackage materials immediately after administering the Assessment Center. Ask the participants to do this when they finish scoring.

2. The only materials that should need to be reproduced for subsequent Assessment Centers are:
   - Response Sheets
   - Statement of Confidentiality
   - Participant’s Score Report
   - Course Evaluation Form (*to be completed electronically*)

3. Depending on available staff and the size of the group participating in the Assessment Center, it is recommended that at least 1 person be assigned to check persons out of the assessment center at the end. This person should collect the Participant Score Report, response sheets, and Statement of Confidentiality form from each participant. *The course evaluation will be sent electronically to participants by APTA.* See sample Check Out form at end of this section.

   It is useful to subdivide large groups into more manageable components of 20 to 30 persons and assign a trainer or attendant to each group so that they can run the Assessment Center as above, simultaneously. Multiple rooms will be needed for larger groups.

4. The trainer is responsible for summarizing the results of the assessment center (within the updated Manual Order Form) and sending them to ccip@apta.org following the end of the course.
FOR Program PARTICIPANTS
Directions for Repackaging the Assessment Center Materials

After you have finished self-scoring the Assessment Center but before you turn in your materials, please take a moment to repack these materials according to the following directions.

1. Take all of the “Response Sheets” on which you have written your answers and clip them together. You should turn in the following “Response Sheets”.
   - Station 1 = 3 pages
   - Station 2 = Midterm Summary Sheet
   - Station 3 = 1 page
   - Station 4 = Negotiation/Confrontation Assessment Form
   - Station 5 = 1 page
   - Station 6 = 1 page

   Put Your Individual Score Report on top of your response sheets. This packet will be collected by the trainer/instructor.

2. Take all of the “Directions” and additional information sheets that you originally found in the left pocket of the folder, and collate them, in order, with station 1 “Directions” on the top.

   Place the Directions/additional information sheets back in the left pocket of the folder and turn this in to the trainer/instructor.

3. Take all of the “Answer Keys”, and collate them, in order, with station 1 on top. (You should have 3 Answer Keys for station 1 whereas all other stations have only 1 Answer Key) and return them to the trainer/instructor.

4. Return any unused confrontation/negotiation forms to the instructor.

THANK YOU VERY MUCH FOR YOUR COOPERATION AND ASSISTANCE.
X = number of participants

Materials needed:

___X___ double pocket folders (1 for each participant)

Copying:

Clean, white copies of all the material necessary for the Assessment Center have been included. Copy the information as follows:

___X___ copies of the materials for each Assessment Center station. This is one per participant.

- All materials for each station have been clipped together.
- Copy each station’s materials in a different color, eg;
  - station 1=blue
  - station 2=green
- **NOTE:** Do not use dark colors
- Do not have the printer collate the material in each station, or you will spend extra time sorting the information

___X___ copies of Orientation/Overview, General Instructions (in white)
___X___ copies of Statement of Confidentiality (in white)
___X___ copies of Participant’s Score Report (in white)
___X___ copies of Program Evaluation form (in white) "completed electronically"
___X___ copies of Directions for Repackaging Assessment Materials (in white)
___X___ copies of Answer Keys for Stations 1-6 (colored coded to Stations above)

Collating/packaging:

1. **Assembly of Assessment Center folder (left side):**

   (From top to bottom)
   1 copy of Orientation/Overview, General Instructions
   1 copy of Directions and additional information sheets from each station (in order 1-6)

   The additional information sheets vary by station as follows:
   - Station 1=Scenarios (3 pages)
   - Station 2=Weekly Summaries (3 pages)
   - Station 3=Questions (1 page)
   - Station 4=David and his CI info (2 pages, double-sided)
   - Station 5=Scenario (1 page)
   - Station 6=Questions (1 page)
2. **Assembly of Assessment Center folder (right side):**

1 copy of **Statement of Confidentiality**  
1 copy of **Response Sheet(s)** from each station (in order 1-6)

The number of pages or type of Response Sheet for each station is as follows:
- Station 1=3  
- Station 2=Midterm Summary Sheet  
- Station 3=1  
- Station 4=2 Confrontation Assessment Forms  
- Station 5=1  
- Station 6=1

1 copy **Participant Score Report** form  
1 copy of **Program Evaluation** Form

3. **Scoring materials:** *These should be collated, but kept separately.* These will be distributed as a packet to each participant to score their responses.

Collation order:  
1 copy of the **Answer Key** from each station  
1 copy of **Directions for Repackaging Materials**

The number of answer key sheets varies by station as follows:  
- Station 1=3  
- Station 2=1  
- Station 3=1  
- Station 4=1  
- Station 5=1  
- Station 6=1

Pendaflex folders and plastic crates are very useful in keeping all of this material organized after it has been copied and packaged.

If you have any questions please call______________________________  
at______________________________
Statement of Confidentiality
APTA Credentialed Clinical Instructor Program

The Assessment Center was designed in order to provide a standard by which to measure the training of clinical instructors in physical therapist and physical therapist assistant clinical education.

The information and materials used in the Assessment Center were developed expressly for that purpose and will be used for future Assessment Centers.

By signing this form, you are agreeing to keep the contents, examples, scenarios, scoring, and all other materials used in the Assessment Center confidential, so that other clinical instructors may have the same opportunity, without undue advantage, to apply their knowledge and skills.

All participants must sign a Statement of Confidentiality before beginning the Assessment Center.

Participant’s Signature ____________________________ Date ____________________________
## Participant's Score Report

### The Assessment Center: APTA Credentialed Clinical Instructor Program

**Participant Name:** _____________________________________________  **Date:** ______________________

**Location:** ____________________________________________  **Sponsor:** ______________________

**Directions:**
1. Enter your score for each question.
2. Total your score for each station in the shaded column.
3. Place a check mark (✓) in the right hand column if you met the criteria for successful completion of that station.
4. Total the shaded column for your Assessment Center score.

**Required point totals for successful completion of the item/station are in ( )**  

<table>
<thead>
<tr>
<th>Station 1</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenario 2  1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR 2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenario 3  1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AND 2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Score Station 1:**  

<table>
<thead>
<tr>
<th>Station 2</th>
<th></th>
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**Total Score Station 2:**  

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**Total Score Station 3:**  

Total score must be at least 4, with at least 1 point in each area.

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**Total Score Station 4:**  

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**Total Score Station 5:**  

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**Total Score Station 6:**  

Total score must be at least 3, with at least 1 point in each area.

**Assessment Center Score (add column):**  

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**Score:**  

**“✓” or no “✓”**
## APTA Credentialed Clinical Instructor Program

### Assessment Center

#### Check Out Form

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<th>Participant Name</th>
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The Assessment Center

- The Assessment Center is arranged in 6 stations.
- Each station is designed to assess, in simulation, the knowledge, and/or skill that you have gained through CI training and/or experience, that is applicable and desired in the supervision and management of students in the clinical setting.
- All stations are defined to take no more than 30 minutes to complete. A relatively strict schedule must be adhered to.

Summary of Stations

Station 1: You are provided with 3 different student situations. This station requires that you develop goals and plan learning experiences.

Station 2: Weekly summaries of a student’s performance are provided. You must synthesize these observations of the student’s performance for a midterm summary (summative evaluation).

Station 3: A videotape of a student, patient, and CI interaction is played. You are given the opportunity to view the videotape once, and to answer a variety of questions about what you saw, how you interpreted the information, and what a reasonable plan of action might be.

Station 4: You are paired with another participant to role play the student/CI interaction that would follow the situation you just observed in the videotape. Confidential information about each of the roles is provided. You are asked to rate yourself and your partner on a Negotiation/Confrontation Assessment Form.

Station 5: The scenario describes conflicting opinions about the student’s performance. This is an opportunity to assess communication and formative evaluation skills.

Station 6: You are asked to consider your relationship with the academic institution, in a challenging student situation.

NOTE: Station 3 is a timed station, in that a second group cannot begin until the time for the first group has expired. Station 4 must be competed immediately after station 3. Stay with your assigned group for each of these stations and follow schedule provided.

Process

- Each station requires a set of directions. These are color coded, clearly labeled, and can be found in the left side of your packet.

- Each station also requires 1 or more response sheets on which you will write all of your answers. The response sheets are color coded, clearly labeled, and can be found in the right side of your packet.
Directions:

1. Check in the left pocket of your folder and obtain the sheets with the scenarios related to Station 1. **Do not write on the scenario sheets.**

2. The *response sheets* for station 1 are clearly marked and can be found in the right side of your folder. There is a separate response sheet (ie, Response Sheet 1, Response Sheet 2, and Response Sheet 3) for each of the different scenarios provided.

3. Read each of the three scenarios carefully.

4. Using what you know about developing planned learning experiences; complete the response sheet for each scenario.

   You will have 30 minutes to complete all of your answers.

5. When you are finished, return these instructions and the scenario sheets to your left folder pocket and the response sheets to your right folder pocket and retain for scoring during the debriefing session.

   If you finish early, you may use the time left to complete your course evaluation form, found in the right pocket of your folder.

Follow the trainer’s instructions on how to proceed to the next station.
Scenario 1:

You are the CI for a student who is scheduled for his/her first-clinical experience and will arrive at your clinical facility in 3 days. As is customary at your facility, you send out a welcome/orientation packet to students approximately 1 month prior to the planned clinical experience. In that packet, you ask students to send you a list of their specific learning needs/interests that they hope to achieve at your facility. Today, you have received the following letter from the new student assigned to your facility.

Consider the resources that you have available to you at the clinical experience. What areas would you and the student discuss that would be important to address? Remember to arrive at more specific mutually agreed upon goals for this experience.

Dear (your name),

I received your information packet 3 weeks ago describing the policies, procedures, and learning experiences available for me at Sunny Hollow Physical Therapy. I am very excited to begin my clinical experience and am sure that I will learn a lot from you. I have my school materials all packed so that I will have the resources I will need to review and study at night.

In your packet, you asked me to specify my long term goals and learning needs that could be addressed at your facility. After reviewing your packet of information about Sunny Hollow Physical Therapy, I have come up with the following list:

Long Term Goals

1. I need to learn everything!
2. I hope to have lots of different patients.
3. I think I need some work on modalities.
4. I would like to write better patient notes.
5. I want to learn something different from every patient.

I hope my goals are helpful. I look forward to getting to Sunny Hollow Physical Therapy soon.

Sincerely,

(your student's name)

Note: Your interpretation of this scenario is that the goals the student has identified are not specific enough.

Based on the above information, complete the response sheet for Scenario 1.
Response Sheet/Scenario 1:

1. What process steps would you take to assist the student in making these goals realistic for his/her level and for your setting? (For example: Seek to understand more specifically the student’s perceived needs in modalities and documentation.)

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Answer Key/Scoring Scenario 1: Do not write on this page. Indicate all scores on the Individual Score Report.

What process steps would you take to assist the student in making these goals realistic for his/her level and for your setting?

- Identify measurable behavioral objectives that a specific learning experience could be measured against.
- Explain that you have expectations of the student’s ultimate performance. Make those expectations clear.
- Compare your expectations with those of the student in a particular learning experience.
- Identify the learning expectations that the school has for this particular level and type of clinical experience, including previous didactic preparation.
- Identify the student’s past experience with and performance in this particular skill, behavior, or area of knowledge.
- Identify the opportunities in your facility/environment that would provide this learning experience.

For each correct answer, score 1 pt.

You must achieve at least 2 points to have successfully completed this portion of station 1.
Scenario 2:

A student has been working with you for the past two (2) weeks. This is the second full-time clinical experience for the student. The setting is a hospital outpatient facility that has available patients with a wide variety of conditions, but primarily patients with musculoskeletal problems (e.g., low back pain, tendonitis, bursitis, etc). At the second weekly conference, you and the student agree on three specific areas of performance to be improved over the next week.

These are:

1. Setting measurable short- and long-term goals within the plan of care.
2. Instructing a patient in a therapeutic exercise program.
3. Performing manual therapy/mobilization techniques at the shoulder.

During these first two (2) weeks, your discussion and observations with the student have led you to conclude that this student is most comfortable with a learning style of experimentation; that is learning by doing, reflecting on the experiences, making changes, and doing it again.

Using this information, complete the response sheet for scenario 2.
Response Sheet/Scenario 2:

1. For one of the student’s three performance areas to be improved, describe a learning experience that allows the student to use his/her preferred style of learning (experimentation).

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2. Using a different performance area, describe a learning experience that challenges the student to broaden his/her repertoire by using a less preferred style of learning (eg, experiencing, conceptualizing, reflective observation).

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Answer Key/Scoring Scenario 2: Do not write on this page. Indicate all scores on the Individual Score Report.

1. For one of the student’s three performance areas to be improved, describe a learning experience that allows the student to use his/her preferred style of learning (experimentation).

   If your learning experience includes active participation by the student, you have incorporated his/her preferred learning style.  
   
   score 1 pt.

2. Using a different student performance area, describe a learning experience that challenges the student to broaden his/her repertoire by using a less preferred style of learning (eg, experiencing, conceptualizing, and reflective observation).

   If you developed a learning experience that requires the student to draw from past experiences to apply those lessons in this situation, you have successfully incorporated experiencing into this activity.  
   
   score 1 pt.

   If you developed a learning experience that requires the student to consider in advance a variety of options and plan ahead for appropriate intervention, you have successfully incorporated reflective observation into this activity.  
   
   score 1 pt.

   If you have developed a learning experience that requires the student to develop concepts, themes, or transfer of knowledge and skills from past experiences you have successfully incorporated conceptualizing into this activity.  
   
   score 1 pt.

You must achieve at least 1 point to have successfully completed this portion of station 1.
Scenario 3:

You have been working with a student on his/her final-clinical experience for the last four (4) weeks. The student has made rapid and steady progress in his/her learning. The clinical experience is an inpatient rehabilitation hospital setting.

As you approach the student's midterm evaluation for this clinical experience, it is clear that the student has satisfied all the minimal/essential requirements of the clinical experience as outlined by the academic institution. Given the remaining four (4) weeks, you and the student agree that you need to plan some learning experiences that will take the student beyond the minimal/essential performance requirements of the clinical experience.

The student expresses interest in having some experiences on one of the specialty rotations within the rehabilitation department (e.g., Traumatic Brain Injury team, Spinal Cord Injury team, Amputee team). In particular, the student would like to develop skills in some of the advanced intervention techniques used with these patient populations. You agree that learning experiences in one of these areas would be appropriate.

Together, you have agreed upon the following student-centered long-term behavioral objective that challenges the student’s ability beyond the minimum level.

*The student will independently teach the patient to perform high-level mobility skills.*

In this context, plan a learning experience for this student using the response sheet for scenario 3.
Response Sheet/Scenario 3:

1. Identify two short-term behavioral objectives for this student that would lead to successful accomplishment of your long-term goal.

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2. For each short-term behavioral objective, list two questions you would ask this student to assess his/her readiness (knowledge and skill) in order to continue with this learning experience.

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Answer Key/Scoring Scenario 3: Do not write on this page. Indicate all scores on the Individual Score Report.

1. Identify two short-term behavioral objectives that would lead to successful accomplishment of your long-term goal.
   a. If your short-term goals include all four components (audience, behavior, condition, and degree), **score 1 pt.** for each correctly written goal.
   b. If your goal statements clearly relate to your long-term goal, **score 1 pt.** for each related goal.

2. For each short-term behavioral objective, list two questions you would ask this student to assess his/her readiness (knowledge and skill) in order to continue with this learning experience.
   Each question must relate to the student’s
   a. knowledge
   b. skill
   and/or
   and to
   c. the specific short-term behavioral objective

Score 1 pt for each question that meets the above criteria.

You must achieve at least 2 points with at least 1 point in #1 and 1 point in #2, to have successfully completed this portion of station 1.
Directions:

1. Check in the left pocket of your folder and obtain the sheets with the information related to Station 2. Do not write on the information sheets.

2. The information sheets are three Weekly Planning Forms provided for the same student for a period of three (3) weeks.

3. The response sheet entitled “Midterm Summary” is clearly marked and can be found in the right side of your folder.

4. Read the three Weekly Planning Forms carefully.

5. After reviewing the Weekly Planning Forms, use what you know about the student from the Forms to write a midterm summary for this student. Use the response sheet entitled “Midterm Summary” to complete your response.

You will have 30 minutes to complete your response.

6. When you are finished, return these instructions and the information sheets to your left folder pocket and the response sheet to your right folder pocket and retain for scoring during the debriefing session.

If you finish early, you may use the time left to complete your course evaluation form, found in the right pocket of your folder.

Follow the trainer’s instructions on how to proceed to the next station.
Student: Missy                        Clinical Instructor: Cynthia
Date: July 7                        Week of Clinical Experience: End of Week 1

Rotation (Service): OP Orthopedic

STUDENT’S REVIEW OF THE WEEK:

Considerations
When completing this form consider the 5 performance dimensions: quality of care, supervision/guidance required, consistency of performance, complexity of tasks/environment, and efficiency of performance.

- Yesterday, I observed two new examinations; kind of boring just standing there, but then today she let me assist with one other examination.

- I couldn’t remember any of my bony landmarks for the upper extremity.

- Did an ultrasound, but I need a review of the machine. I think my technique was OK.

CI’S REVIEW OF THE WEEK:

Considerations
When completing this form consider the 5 performance dimensions: quality of care, supervision/guidance required, consistency of performance, complexity of tasks/environment, and efficiency of performance.

- Missy observed two new examinations.

- Assisted with examination of the shoulder; did range of motion and manual muscle test: needs to review bony landmarks and practice manual skills.

- Background knowledge seems adequate in response to my questions—a bit slow to process information though.

- Needs to ask more questions—I’m not sure whether she’s following along or not.

- Documented notes for two patient initial examinations based on facility documentation policies — does not have a good understanding of this concept. Needs to use medical terminology more consistently.

Goals for the Week of: July 10

1. Complete uncomplicated examination of a patient with upper extremity condition (including range of motion, manual muscle test, and special tests) with guidance.
2. Assist in lower extremity patient examinations as available.
3. Develop plans of care for patient examinations where I observed and participated in last week.
Assessment Center
Station 2

Weekly Summary Form #2

Student: Missy
Clinical Instructor: Cynthia

Date: July 14
Week of Clinical Experience: End of Week 2
Rotation (Service): OP Orthopedic

STUDENT’S REVIEW OF THE WEEK:

Considerations
When completing this form consider the 5 performance dimensions: quality of care, supervision/guidance, consistency, complexity, and efficiency.

- Did an upper extremity examination independently with some assistance from Cynthia.
- Can’t seem to get the hang of documenting notes using the facility’s system, especially for initial examinations. Progress notes are much easier for me. I think Cynthia agrees.
- Feeling better with administering intervention. Once I know what I want to do, it’s easy. But I spend a lot of time trying to come up with activities.

CI’S REVIEW OF THE WEEK:

Considerations
When completing this form consider the 5 performance dimensions: quality of care, supervision/guidance, consistency, complexity, and efficiency.

- Asking better questions now when given verbal cues. Still somewhat hesitant, but responds to encouragement that it is OK to ask questions.
- Completed new upper extremity examination—special tests are correct, but Missy consistently repeats them to confirm her findings. Need to develop confidence to perform test only once.
- Assisted with lower extremity examinations—goniometry and manual muscle test better but still need verbal cues for accurate hand placement and reading of goniometer. Missy knew of these examinations in advance; needs to take more responsibility for preparation. Needs guidance to interpret findings and develop plan of care, but this is only her second week.
- All examinations need better preparation in terms of organization. Suggest that Missy write out plan or follow departmental format. Still requires considerable verbal assistance to avoid having patient change positions or repeat tests during examinations.
- Doing well with implementing established plan of care; needs lots of questioning from me to draw out ideas for developing new plan of care and interventions. Needs to take initiative to begin to plan established interventions on her own. Academic background is sufficient to do this effectively and with only guidance from me.
- Progress notes are better—still having difficulty with documenting initial examinations; specific measurements and some basic information are frequently missing.
- Documentation format still troublesome—she remains unsure of where to write information about interventions versus re-examination information. Also requires assistance to know how much detail to write in progress notes. Missy got a bit defensive when I asked her to rewrite a note a second time.
- Written and verbal communication—needs to work on appropriate use of medical terminology with patients and staff. Needs to show more confidence and a more professional presence with her patients.

Goals for the Week of: July 17

1. Continue with exposure to new patient examinations.
2. Review initial patient examinations of other staff for format guidance.
3. Complete a re-examination of a patient, with guidance.
4. Use appropriate terminology in written communication 80% of the time.
Weekly Summary Form #3

Student: Missy  Clinical Instructor: Cynthia

Date: July 21  Week of Clinical Experience: End of Week 3
Rotation (Service): OP Orthopedic

STUDENT’S REVIEW OF THE WEEK:

Considerations
When completing this form consider the 5 performance dimensions: quality of care, supervision/guidance required, consistency of performance, complexity of tasks/environment, and efficiency of performance.

- Did a shoulder examination. This was more complicated, but I only needed a little help from Cynthia.
- Did more lower extremity examinations—got flustered with patient with multiple fractures and lots of pain.
- Feeling comfortable with interpretation of examination findings. I think I see where plan of care and interventions fit.
- I’ve been writing progress notes in the chart...I must be doing better. Still need to rewrite initial examinations, but I feel like they’re much better, too.
- Getting comfortable giving instructions to patients—still struggling a little with medical terms—I’m always afraid I’ll pronounce something wrong.

CI’S REVIEW OF THE WEEK:

Considerations
When completing this form consider the 5 performance dimensions: quality of care, supervision/guidance required, consistency of performance, complexity of tasks/environment, and efficiency of performance.

- Completed new upper extremity examination on a patient with impaired joint mobility and muscle performance associated with capsular restriction. Examination is still slow, but now follows her own plan of care, so some improvements in efficiency are noted. Also basic tests are now accurate—still needs occasional verbal cues for special tests.
- Assisted in two more lower extremity examinations; prepared for one but not for the other. Became flustered with one examination which was more complex—needed verbal cues to return to her basic plan and gather as much information as she was able.
- Needs reminders to complete most important examination techniques first—set appropriate priorities when planning for examinations. Also needs to take more initiative in analysis of examination findings, although improvements noted here with some ideas developed on her own.
- Interventions improving, now independent with familiar patients; also showing more initiative in offering own ideas for interventions.
- Progress notes need only small adjustment for including all essential information. Initial examinations improved, but still needs to be more thorough in including all essential information for examination baseline—i.e., special test results, posture, general medical history.
- Communicates effectively with patients—making good attempts to use terminology appropriately. Needs to show more confidence with patients, also with staff in communicating about patients.

Goals for the Week of: July 24
1. Complete new non-complicated patient upper extremity examination within 2 hour, independently.
2. Complete new examination of a patient with lower extremity condition with guidance/minimal assistance.
3. Develop plans of care for #1 and #2 with minimal input.
4. Document initial examinations to the satisfaction of CI—no rewrite necessary.
5. Use appropriate terminology 100% of the time.
Assessment Center  
Station 2  

Response Sheet:  

Midterm Summary  

Areas of Strength:  

|  

Areas to Strengthen:  

|  

In Order of Importance, List Ideas/Plans for Improving Areas to Strengthen:  
(to be implemented by student and/or CI)  

|
Answer Key/Score Sheet:
Midterm Summary

Areas of Strength:
- Has shown steady improvement over the first 3 weeks, demonstrating ability to learn.
- Carrying out plans of care well.
- Good use of modalities.
- Asking better questions
- Demonstrating pre-consideration of indications and contraindications.
- No issues with safety; asks if unsure.

Score 1 pt for each match with above, OR
Score 1 pt for any item that demonstrates educational growth OR demonstrates the presence of safe and effective practice.

Areas to Strengthen:
- Confidence in measurement techniques.
- Setting priorities for patient examinations using good techniques (what’s most important to do and what will give me the most information).
- Documentation, ability to use the facility’s format appropriately.
- Consistency in use of appropriate terminology—terminology appropriate to audience.
- Development of plans of care; creativity in plans of care planning and interventions.

Score 1 pt for each match with above, OR
Score 1 pt for any item that indicates significant educational growth is still required to meet minimum requirements OR indicates that safe and effective practice is lacking.

Ideas/Plans for Improving Areas to Strengthen (to be implemented by student and/or CI):
- CI will provide “paper patients” (previously treated and now discharged) initial examinations so Missy can practice developing plans of care. Should include rationale for interventions chosen.
- CI will provide practice diagnoses: Missy will identify appropriate technique in conducting tests and measures within the examination, in order of implementation, and with rationale.
- Student will demonstrate preparation for upcoming examinations by initiating discussion with CI, prior to examination session, indicating plans for session, sequence within the examination, and rationale.
- CI will provide as many opportunities as possible for Missy to complete upper extremity and lower extremity patient examinations, increasing patient complexity as appropriate.
- Missy will practice documenting in the facility’s format, with specific attention to using medical terminology.
- Missy will practice basic examination techniques on friends, relatives, etc using comfort and confidence in manual skills involved and positioning required.

Score 1 pt for each match with above, OR
Score 1 pt for any item that directly relates to previously identified Areas to strengthen.

Score 1 pt if your prioritization of plans reflects the step-wise, hierarchical nature of learning.

You must score at least 3 points, with at least 1 point in each section, to have successfully completed station 2.
Directions:

1. Check in with the attendant and obtain a copy of the questions related to the videotape you are about to see. Do not write on the question sheet.

2. Select a seat.

3. The response sheet for Station 3 is clearly labeled and can be found in the right side of your packet.

4. You will have one opportunity to view the videotape. It will be operated by the attendant in the room and will take approximately 5 minutes.

General information about the videotape:

- “David” is a PT student on his second of three clinical experiences. He did his first clinical experience in an outpatient orthopedics setting.

- The CI has worked with many students prior to David and has been practicing in this setting for 5 years.

- The CI and David are working in a small community hospital, on the general medicine rotation.

5. You may begin answering the questions as soon as the videotape is over.

6. Retain your questions sheet and response sheet for scoring during the debriefing session.

You must now proceed to Station 4.
Questions:
Please answer all questions on the response sheet provided. Do not write on this sheet.

1. List two concerns you would have about this student based on the discussion outside of Mr. McDermott’s room? For example: “Is this student aware of acute care medical issues?”

2. After patient care was completed and you had left the room, what question would you ask David for him to assess his performance? (The question relates to student clinical education and not clinical practice, ie NOT did you wash your hands)

3. What information would you seek to gather in your discussion with David?

4. Now that you have collected the above information, what general steps would you take to address these issues?
Response Sheet:

1. 
2. 
3. 
4. 
1. List two concerns you would have about this student based on the discussion outside of Mr. McDermott’s room?
   - ability to consider all of the patient’s needs
   - safety awareness
   - assertiveness
   - knowledge/experience with this diagnosis
   - student is aware of OSHA regulations for standard precautions
   - student is aware of the need to obtain informed consent from the patient prior to providing treatment

   For each correct answer, score 1 pt.

2. What is the first question you would ask David after the treatment was completed and you had left the room?
   - If you could do that over again, what would you do differently?
   - How would you assess your performance with Mr. McDermott?
   - If you were me, what feedback would you give you?
   - How would you explain your problems with Mr. McDermott?

   or any question that had to do with:
   - student’s assessment of his performance
   - student’s knowledge of the diagnosis
   - student’s assessment of patient’s tolerance to treatment
   - student’s assessment of the effectiveness of treatment

   If your response matched any of the responses listed above, score 1 pt.

3. What information would you seek to gather in your discussion with David?
   - At what point did he become unable to continue the treatment and why?
   - Are there knowledge deficits (eg, vital signs, knowledge of diagnosis, interpretation of vital signs or of changes in vital signs)?
   - Are there deficits in skill (eg, execution of vital signs)?
   - Is the student lacking in previous experience with this diagnosis? with patients that are acutely ill?
   - What is the student’s assessment of his performance and/or strategies to improve performance?
   - What, if anything, would make him able to successfully complete the treatment the next time?

   For each correct answer, score 1 pt.

4. Now that you have collected the above information, what subsequent steps would you take to address these issues?
   - delineate responsibilities for the learning experience between yourself and the student
   - identify the source and the resources to “fix” each problem
   - compose behavioral objectives to identify a “successful” outcome for each problem
   - outline actions to be taken to resolve each problem
   - define a time line for each action and resolution

   For each correct answer, score 1 pt.

You must score at least 4 points, with at least 1 point in each section, to have successfully completed station 3.
Directions:

1. Check the left pocket of your folder and obtain a copy of the General Instructions/Confidential Information for your upcoming role in the confrontation role-play. You will be either David (student) or the CI. Choose a partner and choose your role. Read only the sheet with instructions for your role. Return the other sheet to your left pocket folder. Do not write on the General Instructions/Confidential Information sheets.

2. The Negotiation/Confrontation Assessment Forms are the response sheets for Station 4. They are clearly labeled and can be found in the right side of your folder. There are two Negotiation/Confrontation Assessment Forms: One is labeled “CI Form” and the other is labeled “Student Form”. Use only the form that matches your role.

3. Each pair should sit across from one another. You should work within the following time frames. Your goal is to negotiate for a positive outcome.

   - Review of confidential information  2 minutes
   - Role play of confrontation   5 minutes
   - Score confrontation assessment forms  8 minutes

   - On your copy of the Negotiation/Confrontation Assessment Form, score yourself first, in the column marked “Self” by placing a check under the “yes” column—if you demonstrated the behavior listed (or a variation of the behavior), or under the “no” column if you did not demonstrate the behavior (or a variation) listed.

   - Switch forms with your partner.

   - On your partner’s form, under the column labeled “Partner” rate your partner by checking the “yes” column to indicate behaviors (or variations of the behaviors) displayed or “no” to indicate the behaviors were not displayed.

   - Switch forms again, returning each form to its originator for discussion and scoring.

   Discuss confrontation and scoring  15 minutes

4. When you are finished, return these instructions and the confidential information sheet to your left folder pocket and the response sheet to your right folder pocket and retain for scoring during the debriefing session.

Follow the trainer’s instructions on how to proceed to the next station.
Clinical Instructor (CI)

General Instructions:

At station 1, David and his CI worked out a plan to help David work more effectively with Mr. McDermott. However, at the next treatment session, David’s performance is essentially the same as you observed in the videotape, and the CI determines that it is time to have a focused discussion of his performance with David.

In this session, you and your partner will simulate this confrontation. You have each received some detailed information about your character, as well as a Negotiation/Confrontation Assessment Form. Your task at this station is to represent your character in this confrontation. Each character has a strong desire to make the other person understand his/her issues in this situation and to come to some reasonable plan to resolve the problems with David’s performance.

Once you have read your Confidential Instructions, plan how you would like to approach this discussion, with the goal of making the other person understand how you feel. You also need to develop a mutually acceptable plan for resolving David’s problems.

At the conclusion of your discussion, you will have time to score the effectiveness of your partner’s performance in this task, as well as your own. You will then have time to discuss your roles, your performance, and your scoring.

Confidential Information for the Clinical Instructor (CI):

CI: You have been a CI for 7 years. Your focused area of clinical practice is acute care, even though it has only been in the past few years that you feel that your colleagues have recognized this as an area of specialty. You feel very strongly that safe and effective management of acutely ill patients is essential to the practice of physical therapy, as nearly any other kind of medical care necessarily follows a stay in the acute care setting.

Because this is your clinical focus, you see it as your mission to guide students through acute care clinical experiences. Your emphasis in teaching is on understanding the essential issues in acute care management. You are generally very patient with your students, but you become a bit defensive if you even suspect that a student working with you is just “putting in time” and has no real interest in acute care management. You expect every student to be as dedicated to learning as you are to teaching, and although you are patient, you rarely, if ever, compromise your standards for dedicated learning. You NEVER compromise your standards for the patient’s safety.
David, PT Student

General Instructions:

At station 1, David and his CI worked out a plan to help David work more effectively with Mr. McDermott. However, at the next treatment session, David's performance is essentially the same as you observed in the videotape, and the CI determines that it is time to have a focused discussion of his performance with David.

In this session, you and your partner will simulate this confrontation. You have each received some detailed information about your character, as well as a Negotiation/Confrontation Assessment Form. Your task at this station is to represent your character in this confrontation. Each character has a strong desire to make the other person understand his/her issues in this situation and to come to some reasonable plan to resolve the problems with David’s performance.

Once you have read your Confidential Instructions, plan how you would like to approach this discussion, with the goal of making the other person understand how you feel. You also need to develop a mutually acceptable plan for resolving David’s problems.

At the conclusion of your discussion, you will have time to score the effectiveness of your partner’s performance in this task, as well as your own. You will then have time to discuss your roles, your performance, and your scoring.

Confidential Information for David, PT Student:

You have wanted to be a PT ever since you saw your grandmother receive physical therapy.

You have done lots of volunteer work and like working with an adult and elderly population. But most of your experience has been in escorting patients to and from their rooms, sitting with them while they do their exercises, talking to them while they are in the whirlpool, and managing the laundry and mail. You have rarely been up on the patient care floors (except to return a patient to his/her room), and when you have, there has always been a nurse or PT present.

On this clinical experience, you are puzzled with how to put together the things that you know; you know what you were taught in school and learned in the laboratory sessions; and you know what you have seen in your volunteer experience. When you are with a patient, you tend to do what you are familiar with and forget what you learned in school, because the clinical setting is so different from being in the laboratory. You just cannot understand how anyone remembers all of the important things that your CI expects you to do when you are with a patient.

NOTE: Assume that you had a class in your academic program about negotiating and communicating with CIs (similar to the information presented in this program). As you role play this situation, act in the manner of an appropriately assertive student attempting to demonstrate effective negotiation/confrontation skills.
Assessment Center
Station 4
NEGOTIATION/CONFRONTATION ASSESSMENT FORM
CI FORM

Directions: “CIs” should rate themselves under the column labeled “Self” and also be rated by the “student” under the column labeled “Partner”.

<table>
<thead>
<tr>
<th></th>
<th>Self</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

**PROBLEM PRESENTATION**
- States rationale for meeting
- States the problem clearly
- Illustrates the problem with specific examples
- States why the performance presents a problem
- Checks accuracy of background information
- Requests other person’s point of view

**PROBLEM RESOLUTION**
- Presents suggested solutions
- Checks feasibility of suggested solutions
- Considers alternative solutions
- Indicates limits of compromise
- Achieves consensus on solution(s)
- Offers help to implement changes
- Shares appropriate degree of responsibility in managing outcomes

**INTERPERSONAL DIMENSIONS**
- Expresses feelings about the problem directly, using “I” messages
- Focuses on behavioral dimensions of the situation
- Balances compliments and constructive criticism
- Allows time for the other person to respond
- Uses appropriate attending skills
- Maintains appropriate body language
- Shows mutual respect and positive regard

Count the number of “yes” responses you gave yourself and enter here ________
Count the number of “yes” responses your partner gave you and enter here ________

Total “yes” responses ________

Modified from a document courtesy of Susan Deusinger, PT, PhD, Washington University, St Louis, Mo.
Assessment Center
Station 4
NEGOTIATION/CONFRONTATION ASSESSMENT FORM
STUDENT FORM

Directions: “Students” should rate themselves under the column labeled “Self” and also be rated by the “CI” under the column labeled “Partner”.

<table>
<thead>
<tr>
<th>PROBLEM PRESENTATION</th>
<th>Self</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>States perception of rationale for meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States perceived problem clearly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illustrates the problem with specific examples</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States why the performance presents a problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks accuracy of background information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requests other person’s point of view</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROBLEM RESOLUTION</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Presents suggested solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks feasibility of suggested solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considers alternative solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>States specific behaviors that will lead to altered performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieves consensus on solution(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agrees to try to implement changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shares responsibility in managing outcomes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERPERSONAL DIMENSIONS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expresses feelings with “I” messages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focuses on professional performance elements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balances compliments and constructive criticism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allows time for the other person to respond</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses appropriate attending skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintains appropriate body language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows mutual respect and positive regard</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Count the number of “yes” responses you gave yourself and enter here    ______
Count the number of “yes” responses your partner gave you and enter here  ______
Total “yes” responses                                                        ______

Modified from a document courtesy of Susan Deusinger, PT, PhD, Washington University, St Louis, Mo.
Answer Key/Scoring:

Do not write on this form. Indicate your score on the Individual Score Report.

At the end of the confrontation in station 4, you were asked to add the number of “yes” responses you awarded yourself and the number of “yes” responses your partner awarded you and arrive at a total.

If your total number of “yes” responses was >32  score 5 pts
If your total number of “yes” responses was 26-32  score 3 pts
If your total number of “yes” responses was <26  score 0
Directions:

1. Check in the left pocket of your folder and obtain the sheet with the scenario related to Station 5. Do not write on the scenario sheet.

2. Read the scenario carefully.

3. The response sheet for station 5 is clearly marked and can be found in the right side of your folder.

4. Complete the response sheet using what you know about formative and summative evaluation and communication skills.

You will have 30 minutes to complete your answers.

5. When you are finished, return these instructions and the scenario sheet to your left folder pocket and the response sheet to your right folder pocket and retain for scoring during the debriefing session.

If you finish early, you may use the time left to complete your course evaluation form, found in the right pocket of your folder.

Follow the trainer’s instructions on how to proceed to the next station.
**Scenario:**

You have been supervising a student for the past 4 weeks in an outpatient private practice setting. This is the second full-time clinical experience for this student. Your schedule has been very hectic, and weekly meetings to review progress/set goals have sometimes been missed.

You and the student sit down to review midterm performance assessments as written by the student (self-assessment) and yourself (CI’s assessment). As you review the student’s self-assessment (and the student reviews your assessment), it becomes clear that there are some major discrepancies in the performance scores of these two evaluations. Specifically:

<table>
<thead>
<tr>
<th>Performance</th>
<th>CI Assessment</th>
<th>Student Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Examination/Data Collection Skills</td>
<td>Requires supervision and frequent cues to be thorough</td>
<td>Performing independently</td>
</tr>
<tr>
<td>Plan of Care/Provision of directed and selected interventions</td>
<td>Plans are basic and limited, often requiring elaboration by CI</td>
<td>I need a little help for some patients, but usually I’m just fine with this.</td>
</tr>
<tr>
<td>Documentation</td>
<td>Notes are clear but too wordy; frequently late; occasionally important omissions</td>
<td>My notes are consistently well ordered. CI is occasionally too picky.</td>
</tr>
<tr>
<td>Patient Education</td>
<td>Need to avoid use of medical jargon; needs to adjust communication to level of patient</td>
<td>I have good rapport with my patients.</td>
</tr>
</tbody>
</table>

Based on these discrepancies, you begin a discussion with the student about how and why these different perspectives on the student’s performance have occurred and why they have not been more apparent to either of you before now.

The response sheet for this scenario addresses issues that may be a part of your discussion with this student.
Assessment Center
Station 5

Response Sheet:

1. List three (3) factors that may have contributed to the discrepancy between the CI and the student in the assessment of the student’s performance.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. For each factor listed in #1 above, identify and describe one specific plan designed to address the issue.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Answer Key/Scoring:

1. List three (3) factors that may have contributed to the discrepancy between the CI and the student in the assessment of the student’s performance.
   a. CI not observing sufficient amount of student’s activities.
   b. Expectations/level of performance are not clear between student and CI.
   c. Student does not have good self-assessment skills.
   d. CI depends on other sources of performance evaluation data that are not accurate.

   **Score 1 pt for each match with above, OR**
   **Score 1 pt for any factor listed that describes lack of, poor quality of, or insufficient communication between CI and student.**

2. For each factor listed in #1 above, identify and describe one specific plan designed to address the issue.
   a. The student and CI should each take time to provide examples, specifics, and rationale for their assessment of the student’s performance.
   b. Student performance expectations should be reviewed and clarified (involving the academic institution, if necessary).
   c. A reevaluation of student’s performance should be completed and agreement reached, if possible.
   d. Regular formative feedback sessions, including an assessment of student performance by the student and the CI, should occur regularly thereafter to avoid future discrepancies.

   **Score 1 pt for each match with above, OR**
   **Score 1 pt for each plan that specifically addresses a factor in #1.**

   **Score 1 pt as a bonus if you have included "building in regular formative feedback sessions" ("d" above) in your plans.**

You must score a total of 2 points, with at least 1 point in each section, to have successfully completed station 5.
Directions:

1. Check in with the staff member and obtain a copy of the questions to be used in this activity. **Do not write on the question sheet.**

2. The *response sheet* for station 6 is clearly marked and can be found in the right side of your folder.

3. You will have 30 minutes to complete this station.

4. When you are finished, return these instructions and the question sheet to your left folder pocket and the response sheet to your right folder pocket and retain for scoring during the debriefing session.

   If you finish early, you may use the time left to complete your course evaluation form, found in the right pocket of your folder.

Follow the trainer’s instructions on how to proceed to the next station.
It is necessary for any effective CI to recognize the need to contact the academic institution regarding a student’s clinical performance.

**Questions:**

1a. Provide an example of a student situation in which you would consider it appropriate to involve the ACCE/DCE. Your example should describe specific student behavior or level of performance.

1b. Indicate the point at which the behavior or performance (described in 1a.) warrants the involvement of the ACCE/DCE.

2. Briefly describe your expectations of ACCE/DCE notification or involvement. How are you expecting the ACCE/DCE to help?

3. List and/or describe briefly the information you would present to the ACCE/DCE.

4. What are the legal reasons and/or implications to consider when providing this information to the ACCE/DCE and academic program?
1a. Provide an example of a student situation.

________________________________________________________________
________________________________________________________________
________________________________________________________________

1b. At what point you would contact the ACCE/DCE based on the example described in 1a.

________________________________________________________________
________________________________________________________________
________________________________________________________________

2. Briefly describe your expectations of ACCE/DCE notification or involvement. How are you expecting the ACCE/DCE to help?

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

3. List and/or describe briefly the information you would present to the ACCE/DCE.

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

4. What are the legal reasons and/or implications when providing this information to the ACCE/DCE and academic program?

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
Answer Key/Scoring: Do not write on this form. Indicate your scores on the Individual Score Report.

1. Provide an example of a student situation in which you would consider it appropriate to involve the ACCE/DCE.

   If your response includes
   a) a specific example of student behavior or level of performance and
   b) the point at which you would involve the ACCE/DCE

   Score 1 pt.

2. Briefly describe your expectations of ACCE/DCE notification or involvement. How are you expecting the ACCE/DCE to help?

   • awareness of situation only
   • to provide advice or assistance
   • to agree to student removal from the clinical setting
   • to provide mediation or for help with problem solving
   • to provide another perspective
   • to advocate for the student
   • to intervene for purposes of communication

   For each answer that fits into an above category, score 1 pt. each.

3. List and/or describe briefly the information you would present to the ACCE.

   • documentation of problem
   • midterm evaluation results
   • anecdotal records
   • critical incident reports
   • multiple examples
   • documentation of remediation attempts/outcomes
   • examples of/documentation of communication to student
   • student’s responses

   For each correct response, score 1 pt. each.

4. What are the legal reasons and/or implications to consider when providing this information to the ACCE/DCE and academic program?

   • documentation trail
   • minimize litigation
   • early warning system
   • due process
   • academic dismissal

   For each correct response, score 1 pt. each.

Total score must be at least 4 points, with at least 1 point in each area, to have successfully completed station 6.
# Credentialed Clinical Instructor Program (CCIP)

## Participant Program Evaluation

<table>
<thead>
<tr>
<th>Trainer(s):</th>
<th>Course Dates:</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Sponsor:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**I am a (please check):**  
- PT [ ]  
- PTA [ ]  
- Non-PT Provider: [ ] (specify)

**Rate the effectiveness of the program areas by checking the box that best represents your response.**

<table>
<thead>
<tr>
<th>Program Area</th>
<th>Poor</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. The Clinician as Clinical Educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenter:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II. Readiness to Learn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenter:</td>
<td></td>
<td></td>
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<tr>
<td>III. Facilitating Learning in the Clinical Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenter:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV. Performance Assessment – The Clinical Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenter:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V. Legal, Regulatory, and ADA Issues in Clinical Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenter:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI. Managing the Exceptional Student and the Student with Problems in Clinical Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenter:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VII. Program viewed as a whole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How well did the sessions build effectively on each other and logically relate to one another?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VIII. Assessment Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How well did the assessment center thoroughly address the information presented in the program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IX. Course Materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How well did the course materials meet your needs?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Feedback for the Credentialed Trainer(s):**

**Comments on the Activities:**

**What do you feel could have improved this training program?** (Feel free to continue on back side of page)
OUTCOME CRITERIA

There are specific outcome criteria against which experienced physical therapy clinical instructors must assess themselves to determine their readiness to complete the Assessment Center without taking the Credentialed Clinical Instructor Program didactic component. The experienced CI must possess all of the criteria listed below to ensure the likelihood of successfully completing the 6 stations of the Assessment Center. Persons who are to become credentialed through this alternative mechanism must still complete and submit in advance of completing the Assessment Center, a Participant Dossier, and must notify the Trainer and/or sponsoring organization of the course of his/her intent is to complete only the Assessment Center to receive APTA CI Credentialing. In addition, the applicant is still required to pay fees associated with credentialing (APTA physical therapy nonmember = $180, member discount = $90) to include a copy of the APTA Physical Therapy Credentialed Clinical Instructor Program Manual (same as the one used for the course) to use for study purposes, the Assessment Center fee, and costs associated with printing and mailing the credential.

The experienced physical therapy clinical instructor must possess all of the following:

- Understanding of and experience with the management of the student with exceptional performance and student with performance problems.
- Knowledge of the partnership and role and relationship of the “players” in clinical education.
- Knowledge of the Guidelines and Self-Assessment for Clinical Instructors and Professionalism in Physical Therapy: Core Values.
- Ability to communicate effectively in a variety of situations including those involving conflict and negotiation.
- Ability to define student readiness and plan and conduct relevant learning experiences.
- Ability to conduct and document formative and summative evaluations and provide information about student performance.
- Ability to apply the principles of teaching and learning in the instructional process.
- Ability to adjust supervisory approach based on the student’s need.
- Application of knowledge of legal, regulatory, and ADA issues related to clinical education.
- Ability to manage students with exceptional performance and performance with difficulties through a learning diagnosis and the use of documentation.

If the experienced physical therapy clinical instructor does not successfully complete the Assessment Center, then he/she will be encouraged by the course trainer to complete the entire Credentialed CI Program Course in preparation for successfully completing the Assessment Center and receiving APTA CI Credentialing.

Instructor’s note: Credentialed trainers should determine in advance of offering the CI Education and Credentialing Program the number of individuals that can be accommodated in both the Program and the Assessment Center. Based on that number, the trainer(s) can further assess whether or not they are able to accommodate additional experienced CIs who would complete only the Assessment Center. If there are many persons interested in completing the Assessment Center as an experienced CI, consideration might be given to offering only the Assessment Center for those individuals without offering the CI Education Program at that time.
The anticipated number of participants will have a bearing on the space requirements that you will need to conduct the Credentialed CI Program and Assessment Center effectively.

Space constraints of the location may dictate how many participants you can accept. Also worthy of consideration is that additional rooms will add expense to the host/sponsoring organization. They may have space available, but not be able to afford the extra cost.

However, once either or both of these variables have been determined, you can begin planning your resource needs.

Strive for an even number of participants for ease in administering the role-play in Station 4 of the Assessment Center. Should you have an uneven number, you may opt to ask one participant to role play a second time or you will need to find someone else who is willing to help you out.

You may choose to have one group or multiple groups.

We recommend keeping group size to approximately 30 persons, for ease in viewing the video clip in Station 3. The following guidelines have been used successfully.

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Number of Groups</th>
<th>Room/Space Requirements</th>
<th>Nice, but not Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 30</td>
<td>1</td>
<td>1 meeting room - with enough space for and move around without disturbing a neighbor</td>
<td>additional large room for scoring - allows participants to talk without disturbing individuals still completing Assessment Center Stations</td>
</tr>
</tbody>
</table>
| 30-60                  | 2-3              | 1 large meeting room (as above)  
2 breakout rooms, (same as above) - each one large enough to accommodate the largest group--used for Stations 3 and 4 | same as above |
| 60-90                  | 2-3 (4 groups are possible but it would lengthen the time taken to complete the Assessment Center) | same as above | same as above |
Personnel Needs For Managing The Assessment Center

- The amount of assistance you will need to administer the Assessment Center will vary depending on the number of participants and groups.

- It is not required, or even necessary, that your assistants (station managers) be physical therapists or physical therapist assistants or other professionals. A group of reliable students, administrative assistants, and support staff can do a very nice job running each Station.

- The guidelines below have been useful.

**Minimum requirements: 1a and 1b can assist at more than one Station**

<table>
<thead>
<tr>
<th></th>
<th>1 Group All Stations Completed in 1 Day</th>
<th>1 Group Stations Completed Over 2 Days</th>
<th>2-3 Groups All Stations Completed in 1 Day</th>
<th>2-3 Groups Stations Completed Over 2 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Station 1</td>
<td>1a</td>
<td>1a</td>
<td>1a</td>
<td>1a</td>
</tr>
<tr>
<td>Station 2</td>
<td>1b</td>
<td>1b</td>
<td>1b</td>
<td>1b</td>
</tr>
<tr>
<td>Station 3</td>
<td>1a</td>
<td>1a</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Station 4</td>
<td>1b</td>
<td>1 (day one)</td>
<td>1</td>
<td>1 (day one)</td>
</tr>
<tr>
<td>Station 5</td>
<td>1</td>
<td>1 (day one)</td>
<td>1</td>
<td>1 (day one)</td>
</tr>
<tr>
<td>Station 6</td>
<td>1</td>
<td>1b</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Scoring</td>
<td>1 plus program instructors</td>
<td>1 plus program instructors</td>
<td>1a and 1b plus program instructors</td>
<td>1a and 1b plus program instructors</td>
</tr>
<tr>
<td></td>
<td>TOTAL 5 plus program instructors</td>
<td>TOTAL 2 for day 1; 3 plus program instructors for day 2</td>
<td>TOTAL 5 plus program instructors</td>
<td>TOTAL 2 for day 1; 4 plus program instructors for day 2</td>
</tr>
</tbody>
</table>

If you have the luxury of more assistants than what has been identified above, it is preferable to have at least 2 persons per station. In this way, the “check-in” process per stations is not as time consuming. With multiple groups, try to ensure that there is more than one person at the scoring table. See responsibilities per Station for details.
Orientation to Assessment Center Stations for Station Managers

Prior to beginning any of the Assessment Center Stations, it is highly recommended that you orient your Station Managers to the process in general, and then to their specific Station responsibilities.

General Instructions:

1. Each Station Manager has been provided with a list of participants, divided into groups, and an Assessment Center (schedule). Thus, they will know which group to expect and when.

2. Review Assessment Center Schedule with Station Managers.

3. All Station Managers will check participants in when they arrive. It is not necessary to check them out as they leave.

4. As participants check in, provide them with the additional information they will need to complete the Station. It is not necessary for them to return this information to you as they leave. They may need it for scoring purposes at the end of the Assessment Center.

5. Station Managers should refer all content and process questions related to the Station to one of the Trainers. Unless they are absolutely certain of the answer, they should not attempt to answer the question themselves.

6. Managers of Stations 3 and 4 should not allow persons to begin the Station earlier than their scheduled time.

At this point, it is very useful to review each of the Stations specifically.

Station 3

Program Instructor:

- If applicable, go to the room where the video will be shown.
- Review the operation of the computer and LCD with the Station Manager.
- Cue the video until the introductory music begins, then stop the video.
- Review the following Station Manager responsibilities for Station 3.

Station Manager:

- Check all participants in and provide them with the questions they will need to answer.
- Wait until all participants are seated.
- Explain to participants that they will view a video of approximately 5 minutes in length. They will view it only once.
- Give participants a few minutes to review the questions they were just given.
- Run the video (USB).
- Stop the video at the closing music.
- Allow participants in the time remaining to answer the questions provided.
- End the session at the appointed time.
- Instruct the group to proceed directly to Station 4.

Station 4

Program Instructor:

- If applicable, go to the room where the role-play will take place.
- Remind the Station Manager that this Station is a Negotiation/Confrontation based on the video that participants have just viewed.
- It is critical that for each pair of participants, 1 person plays Cathy and the other person plays Linda.
• Cathy and Linda should sit directly opposite each other, across from each other at a table.

**Station Manager:**

- Check all participants in and pair them off as they arrive.
- One pair will receive the confidential information for Linda. The other pair will receive the confidential information for Cathy.
- Have each pair take seats across the table from each other and begin reading their confidential information.
- When all are seated, explain that this Station is a continuation of what they have just observed in the video in Station 3.
- Each has received confidential information related to their role.
- They should read the confidential information, follow the directions provided for Station 4, and role-play the confrontation as if they were that person.
- Following the role-play, they should follow the instructions closely and complete the negotiation/confrontation assessment form provided in the right pocket of their folder.
- Before leaving, they should score the confrontation form as instructed.
- Terminate the session at the appointed time.

**Stations 1, 2, 5, 6**

**Program Instructor:**

- Show Station Managers where their Stations will be located.
- In general, each of these Stations requires only checking participants in and distributing the additional information that is required for that station.

**Station Managers:**

- Check participants in.
- Provide additional information that is required for that Station.

<table>
<thead>
<tr>
<th>Station</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Station 1</td>
<td>3 pages of scenarios</td>
</tr>
<tr>
<td>Station 2</td>
<td>3 weekly summaries</td>
</tr>
<tr>
<td>Station 5</td>
<td>1 scenario</td>
</tr>
<tr>
<td>Station 6</td>
<td>1 page of questions</td>
</tr>
</tbody>
</table>

**Scoring Table (It is recommended that at least 2 persons be at this table)**

**Program Instructor:**

- Show Station Managers where the Scoring Table will be located.
- Station Managers should direct all questions regarding interpretation of scoring to the program instructors.

**Station Manager 1:**

- Confirm with each participant that he/she has completed all six Stations of the Assessment Center.
- If all Stations have been completed, provide the participant with a packet of **Answer Keys**, a **Participant Score Report**, and **Directions for Repackaging Materials** when they have completed scoring.
- Instruct the participant to write on only the **Participant Score Report**.
- Direct the participant to a room where they may self-score the Assessment Center.

**Station Manager 2:**

- As participants complete the scoring process, check to see that they have achieved the required score (21).
- Participants’ Response Sheets (all the pages they have written on) with the **Participant Score Sheet** on top should be clipped together and placed in a pile.
- **Answer Keys**, collated, in order, should be placed in a separate pile.
- All Directions sheets should be collated in order, and placed back in the left pocket of the folder, and collected.
Train-the-Trainer

- All additional information that was provided as they entered each Assessment Center Station should be collated in order, or separated into individual piles on a separate table.
- Participants who successfully achieve the required score will subsequently receive their clinical instructor credential and CEUs for completing the program from APTA following the submission of this information by the Trainer to APTA.
Instructions for Copying, Collating, and Packaging Assessment Center Materials

1. Assessment Center materials have been provided to you for each station.

2. For each station you should find directions, response sheet(s), answer key(s), and additional information that are provided to participants as they enter each station.

   Number of pages of each of these items vary by Station and are summarized in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Directions</th>
<th>Response Sheets</th>
<th>Answer Keys</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Station 1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>Scenarios (3 pages)</td>
</tr>
<tr>
<td>Station 2</td>
<td>1</td>
<td>Midterm Summary Sheet</td>
<td>1</td>
<td>Weekly Summaries (3 pages)</td>
</tr>
<tr>
<td>Station 3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Questions (1 page)</td>
</tr>
<tr>
<td>Station 4</td>
<td>1</td>
<td>Negotiation/Confrontation Assessment Form</td>
<td>1</td>
<td>Confidential Information on Linda Murphy or Cathy McDowell</td>
</tr>
<tr>
<td>Station 5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Scenario (1 page)</td>
</tr>
<tr>
<td>Station 6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Questions (1 page)</td>
</tr>
</tbody>
</table>

3. Additional documents required for the Assessment Center include:
   - Confidentiality Form
   - Orientation/Overview and General Instructions
   - Individual Scoring Sheets
   - Program Evaluation Forms
   - Assessment Center Schedule (depending upon schedule)
   - Directions for Repackaging Assessment Center Materials

4. The instructions on the next page(s) can be used if you are doing the copying or they can be sent with clean copies of the Assessment Center materials for your sponsoring organization to prepare.
## Sample Program Schedules

<table>
<thead>
<tr>
<th>Program</th>
<th>Total Time Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section I</td>
<td>1.5 hours</td>
</tr>
<tr>
<td>Section II</td>
<td>2.5 hours</td>
</tr>
<tr>
<td>Section III</td>
<td>2 hours</td>
</tr>
<tr>
<td>Section IV</td>
<td>2 hours</td>
</tr>
<tr>
<td>Section V</td>
<td>2 hours</td>
</tr>
<tr>
<td>Section VI</td>
<td>2 hours</td>
</tr>
<tr>
<td>Assessment Center</td>
<td>3 hours</td>
</tr>
</tbody>
</table>

These are absolute minimum time frames. If extra time is available, Section VI should be allocated the time first because of the small group work and discussion.

### Two-Day Program/Assessment Center

<table>
<thead>
<tr>
<th>Program Day 1</th>
<th>Program Day 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Section IV</td>
</tr>
<tr>
<td>8:30</td>
<td>Section I</td>
</tr>
<tr>
<td>10:00</td>
<td>Break</td>
</tr>
<tr>
<td>10:15</td>
<td>Break</td>
</tr>
<tr>
<td>12:15</td>
<td>Lunch</td>
</tr>
<tr>
<td>12:30</td>
<td>Lunch</td>
</tr>
<tr>
<td>12:45</td>
<td>Section VI</td>
</tr>
<tr>
<td>1:30</td>
<td>Section III</td>
</tr>
<tr>
<td>2:45</td>
<td>Assessment Center</td>
</tr>
<tr>
<td></td>
<td>Station 3</td>
</tr>
<tr>
<td>3:15</td>
<td>Station 4</td>
</tr>
<tr>
<td>3:30</td>
<td>Break</td>
</tr>
<tr>
<td>3:45</td>
<td>Orientation to AC</td>
</tr>
<tr>
<td>4:00</td>
<td>AC Station 1</td>
</tr>
<tr>
<td>4:15</td>
<td>AC Station 2</td>
</tr>
<tr>
<td>4:30</td>
<td>Debriefing Scoring and Evaluation</td>
</tr>
<tr>
<td>4:45</td>
<td></td>
</tr>
<tr>
<td>5:00</td>
<td>Adjourn</td>
</tr>
<tr>
<td></td>
<td>Adjourn</td>
</tr>
</tbody>
</table>
Two-Day Program/Assessment Center on Second Day

The model of having all of the Assessment Center scheduled for 3 hours at the end of the second day or even split in the morning and afternoon of the second day is not recommended for the following reasons:

- Participants find it difficult to sit through 1 or 2 full days of presentation (even though it is interactive) as in Day 1.
- Completing all 6 Stations of the Assessment Center in one block of time, plus scoring the results, has been overwhelming to many of the participants.
- Having an opportunity to complete 2 of the Assessment Center Stations on the first day reduces the overall anxiety and stress for some, associated with completing a competency-based component in a continuing education program.

The model does, however, allow participants to review and integrate information from Day 1 before they are required to complete any Assessment Center Stations and is time efficient and accessible for experienced CIs completing only the Assessment Center.

The following schedule is a sample 3-day format that has been offered as part of a larger conference with other iterations of this configuration possible. Participants have an opportunity to integrate information overnight, before being asked to complete related Assessment Center Stations. Also, additional time is available using a 3-day format and has been added to a number of the sessions.

Three-day Program/Assessment Center Sample Format

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Assessment Ctr</td>
<td>Assessment Ctr</td>
<td>Orientation</td>
</tr>
<tr>
<td>8:30</td>
<td>Station 1</td>
<td>Station 2</td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>Station 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>Section I</td>
<td>Section IV</td>
<td></td>
</tr>
<tr>
<td>10:15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td></td>
<td>Scoring Begins</td>
<td></td>
</tr>
<tr>
<td>11:15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>Lunch</td>
<td></td>
<td>Adjourn</td>
</tr>
<tr>
<td>12:00</td>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td>Section II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00</td>
<td></td>
<td></td>
<td>Section V</td>
</tr>
<tr>
<td>1:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:00</td>
<td>Break</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>3:15</td>
<td>Section III</td>
<td>Section VI</td>
<td></td>
</tr>
<tr>
<td>4:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:15</td>
<td>Adjourn</td>
<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>
# Assessment Center Schedule 1
(All Stations completed in one day)

<table>
<thead>
<tr>
<th>Time</th>
<th>Station 1</th>
<th>Station 2</th>
<th>Station 3</th>
<th>Station 4</th>
<th>Station 5</th>
<th>Station 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
<td>Group 1</td>
<td></td>
<td></td>
<td></td>
<td>Group 3</td>
<td>Group 2</td>
</tr>
<tr>
<td>1:30</td>
<td>Group 2</td>
<td>Group 1</td>
<td></td>
<td></td>
<td></td>
<td>Group 3</td>
</tr>
<tr>
<td>2:00</td>
<td>Group 3</td>
<td>Group 2</td>
<td>Group 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:30</td>
<td>Group 3</td>
<td></td>
<td></td>
<td>Group 2</td>
<td>Group 1</td>
<td></td>
</tr>
<tr>
<td>3:00</td>
<td></td>
<td></td>
<td></td>
<td>Group 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Group 3</td>
<td></td>
</tr>
<tr>
<td>4:00-4:30</td>
<td>Scoring Begins (allow 1 hour)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Adjourn*

*Allow 2 hour per Assessment Center Station. The sample schedules begin at 1:00 pm for purposes of explanation only. They could begin at any time.*

6 Stations @ 30 minutes each = 3 hours
Scoring = 1 hour
Total time = 4 hours

If you have only one group, follow the schedule for Group 1.
Train the Trainer

Assessment Center Schedule 2
(Stations 3 and 4 done as a large group one day)
(Stations 1, 2, 5 and 6 done on subsequent day)

<table>
<thead>
<tr>
<th>Time</th>
<th>Station 1</th>
<th>Station 2</th>
<th>Station 3</th>
<th>Station 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
<td>Group 1</td>
<td></td>
<td>Group 3</td>
<td>Group 2</td>
</tr>
<tr>
<td>1:30</td>
<td>Group 2</td>
<td><strong>Group 1</strong></td>
<td></td>
<td>Group 3</td>
</tr>
<tr>
<td>2:00</td>
<td>Group 3</td>
<td>Group 2</td>
<td><strong>Group 1</strong></td>
<td></td>
</tr>
<tr>
<td>2:30</td>
<td>Group 3</td>
<td>Group 2</td>
<td>Group 1</td>
<td><strong>Group 1</strong></td>
</tr>
<tr>
<td>3:00-</td>
<td></td>
<td></td>
<td><strong>Scoring Begins (allow 1 hour)</strong></td>
<td></td>
</tr>
<tr>
<td>3:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:00</td>
<td><strong>Adjourn</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This schedule is also based on 30 minutes per Assessment Center Station.

If you have only one group, follow the schedule for Group 1.

4 Stations @ 30 minutes each = 2 hours
Scoring = 1 hour
Total time = 3 hours
Delivering the Credentialed CI Program in a Weekly Format

Logistics for presentation of a workshop in weekly sessions

1. Planning
   - Plan for 4 weeks
   - Plan for 4 hours per night
   - Plan for extra week if necessary due to cancellation
   - Be aware of holidays: local and religious

2. Brochure
   - Explicitly state in several places in the registration marketing materials that the participant must agree to attend each session in its entirety or risk not completing the program to earn CEUs or the CI Credential certificate.
   - Include the participant agreement contract in the brochure which states that the participant understands and agrees to this condition.

3. Timing
   - One of the greatest advantages of this format is that it allows more time for each section than in the 2-day format.
   - The Trainer may need to “energize” the group at the beginning of each session since they are coming from work and in the case where the program is not being convened with staff in one facility, may not have seen each other for a week.
   - Design and schedule breaks which are sensitive to the needs of those participants who have come directly from work.
   - Integrate Assessment Center activities into the evening schedule - some groups prefer them at the beginning of the session whereas others prefer them at the end of the session.
   - Leave time for each participant to score his/her Assessment Center at the end of the last week.

4. Logistics
   - Another advantage of this format is that it gives the Trainer time to prepare materials to be handed out before each session.
   - Trainer(s) may want to include a weekly attendance sheet for each participant which is initialed at the conclusion of each session. This provides documentation that the participant has attended each session in its entirety.

5. General Advantages of this Format
   - Provides more time for each section.
   - Groups develop a rapport over time.
   - There is time and opportunity available to discuss actual cases over the duration of the program.
   - Participants develop more opportunities for networking.
   - Provides for a manageable schedule for a single Trainer and a new Trainer allows for team-teaching, perhaps with an experienced Trainer mentoring a newer Trainer.
COST ANALYSIS

I. Duplication of Materials
   A. Promotional Materials
      • program announcement/flyer
         printing (must include 1-page Participant Dossier unless
         provided electronically – See Introduction to Assessment Center)
         folding
         envelopes
         mailing labels
         postage
         EX: 4 page flyer to 2000 persons = $440
               postage x 2000 = $740
   B. Participant CI Manual paid to APTA at rate of:
      $90/APTA member
      $180/physical therapy nonmember, regular price
      $230/nonphysical therapy provider
   C. Assessment Center (initial cost) Based on 25 participants
      • two pocket folders (packages of 10)
      • Station 1 = 10 pages @ .06/page 15.00
      • Station 2 = 6 pages @ .06/page 9.00
      • Station 3 = 4 pages 6.00
      • Station 4 = 6 pages 9.00
      • Station 5 = 4 pages 6.00
      • Station 6 = 4 pages 6.00
      • Individual Score Report 1 page @ .06/page 1.50
      • Confidentiality Form 1 page 1.50
      • Assessment Ctr Instructions 2 sides @ .055/side 2.75
      • Instructions for Repackaging 3 sides @ .055/side 4.13
      • Program Evaluation Form 3 sides 4.13
         total $65.01
   Assessment Center (repeat program for 25 persons)
      • Station 1 = 3 pages @ .06/page 4.50
      • Station 2 = 1 page 1.50
      • Station 3 = 1 page 1.50
      • Station 4 = 1 page 1.50
      • Station 5 = 1 page 1.50
      • Station 6 = 1 page 1.50
      • Individual Score Report 1 page 1.50
      • Confidentiality Form 1 page 1.50
      • Program Evaluation Form 3 sides @ .055/side 4.13
         total $19.13
Section VI

Case 1: 25 ccs of Confrontation Form (2 sides @ .055/side)  

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>total</td>
</tr>
<tr>
<td>25 ccs of Confrontation Form</td>
<td>$2.75</td>
</tr>
<tr>
<td>(2 sides @ .055/side)</td>
<td></td>
</tr>
</tbody>
</table>

II. Host Site

Based on 2-day program for 25 participants
Room needs Day 1: meeting room
Lunchroom

Room needs Day 2: meeting room
lunch room (can also use for scoring Assessment Center)
1 breakout room

A. Hotel (Advantages: convenience of location; accommodates overnight participants; one location; free parking; on-site coordinator. Disadvantages: meeting room fees; cost of overnight stay; A-V rental fees)

1. Meeting Rooms:
   - average rate of $800/room (can always get room free if providing lunch)
   - set lunchroom in rounds. Can use for scoring and debriefing and will not have to re-set the room.

2. Breakout rooms (if needed)
   - $50 - $75/day

3. Food costs-includes continental breakfast 2 days
   - AM replenishing 2 days
   - PM replenishing 2 days
   - Total cost breaks ~$10/pp day
   - lunch ~$12-15/pp
   - Try to keep food cost per person per day to less than $25.00/day

4. Hotel room (conference rate)
   - aim for $100-$125/night

5. A-V Needs
   - LCD = $650
   - Screen = $85/day
   - Podium = usually free w/fixed microphone
   - Lavaliere microphone = $50/day for cordless (if required)
   - Extension cord/power strip = $15/day
   - Flip chart = $25/day
B. *University or College
   - **Advantages:** little or no cost for A-V; usually no room fee BUT lecture halls may not be well suited
   - **Disadvantages:** scheduling at other than vacation times can be problematic; food costs; parking; lack of on-site coordinator

C. *Hospitals
   - **Advantages:** A-V usually available if a teaching hospital; may be no room fee or may have to negotiate the room fee
   - **Disadvantages:** scheduling space may be difficult; food costs; Hospital parking may have associated fee and/or be limited; lack of on-site coordinator

*III. Alternative Delivery Model (4 sessions held over 4 weeks, in the evenings 5-9 PM)*
   - Hospitals and Universities are well suited to this model
   - Not as limited by the University calendar
   - Limit size of group to 20-30
   - Requires only 1 room
   - Food costs minimal - provide cookies, bagels etc or participants can bring food
   - No overnight hotel costs
   - A-V usually available
   - Parking more accessible

**Sample Schedule:**

**Week 1:**
   - Introduction
   - Section I and 2

**Week 2:**
   - Section 3
   - **Assessment Center Stations 1 & 2**

**Week 3:**
   - Section 4 and 5

**Week 4:**
   - Section 6
   - **Assessment Center Stations 3, 4, 5, and 6**
   - Scoring and Program Evaluation
SAMPLE PROGRAM ANNOUNCEMENT

Saturday and Sunday
March 27-28, 2013
8:00 am - 5:00 pm

at the
-----------------location----------------
-----------------address----------------
--------------------------------------------

For reservations call _______________or fax_________________

This program is recognized by the American Physical Therapy Association (APTA) as a Credentialed Clinical Instructor (CI) Program and is being sponsored by _________________. It takes 15 hours to complete the entire program that includes the didactic CI Education component and the Assessment Center for the Credentialing component.

The program addresses issues of planning and preparing for physical therapy and other health profession’s students during their clinical education experiences; developing learning experiences and supporting ongoing learning through questioning and effective feedback. A discussion of legal and regulatory issues associated with clinical educators is addressed, including issues presented by ADA legislation. The program closes with developing skills in identifying and managing students with exceptional performance as well as students presenting with problems.

The “Assessment Center” available only to physical therapists and physical therapist assistants, provides the participant with the opportunity to apply information from the program in simulated situations. Successful completion of each station in the Assessment Center results in the awarding of APTA Clinical Instructor Credentialing. The 6 stations of the Assessment Center have been integrated into the program schedule. **Therefore, it is essential for each participant to attend all sessions of the Program and Assessment Center in its entirety.** (May vary based on the configuration used).

The Program and Assessment Center will be useful for both new and experienced physical therapist and physical therapist assistant educators involved with clinical education. In addition, the Program is helpful for and available to clinical educators from nonphysical therapy providers based on a solid theoretical foundation. While the information presented covers the basic skills for clinical instructors, the interactive tasks and large and small group discussions will be of benefit even to experienced educators.

**Note:** All participants must attend each session in its entirety and complete the Assessment Center to be eligible for credentialing. No partial CEUs will be awarded to participants who attend only a portion of the program.
Refund Policy: Individuals must request a refund 72 hours prior to the date of the course beginning. The amount of the refund will be equivalent to the APTA portion of the registration fee only and if $90 or less will be provided in an APTA voucher.

To Register:
Complete the attached Participant Dossier and submit to the address below by the deadline.

Course Agenda/Content

<table>
<thead>
<tr>
<th>Saturday, March 27, 2013</th>
<th>Sunday, March 28, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 am REGISTRATION</td>
<td>8:00 am Section IV – Performance Assessment in the Clinical Environment</td>
</tr>
<tr>
<td>8:30 am Welcome</td>
<td>10:00 am Section V – Legal, Regulatory, and ADA Issues in Clinical Education</td>
</tr>
<tr>
<td>Section I – The Clinician as Clinical Educator</td>
<td>12:00 pm Lunch (included in registration)</td>
</tr>
<tr>
<td>10:00 am Section II – Readiness to Learn</td>
<td>12:00 pm Lunch (included in registration)</td>
</tr>
<tr>
<td>12:30 pm Lunch (included in registration)</td>
<td>12:45 pm Section VI - Managing the Exceptional Student in Clinical Education</td>
</tr>
<tr>
<td>1:30 pm Section III – Facilitating Learning in the Clinical Environment</td>
<td>2:45 pm Assessment Center Stations 3, 4, 5, 6</td>
</tr>
<tr>
<td>3:45 pm Orientation to Assessment Center and Assessment Center Station 1</td>
<td>4:45 pm Debriefing, Scoring</td>
</tr>
<tr>
<td>4:15 pm Assessment Center Station 2</td>
<td>5:00 pm Adjourn</td>
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<tr>
<td>4:45 pm Adjourn</td>
<td>5:00 pm Adjourn</td>
</tr>
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*Who Should Attend:

Registration Fee:

$.........00 ($......00 after .................)
(Includes the two day course, AM and PM breaks plus lunches on both days, all handout materials and the Assessment Center (PT/PTAs)*

*(Note: Included as part of the fee are APTA’s cost of $90.00 for members, $180.00 for non-physical therapy members and Canadian physiotherapists, and $230 for non-physical therapy providers for the CI Education Manual, CEUs, Assessment Center and Credential (PTs/PTAs only), and Registry on a National Database).  

Make checks payable to:
Mail check, registration form and participant dossier to:

Deadline for Registration: February 28, 2013

Your completed Participant Dossier must be received by the deadline to ensure that you receive a course confirmation and for the sponsor to meet facility deadlines. Please make room reservations directly with the hotel at (____)_________. They are holding a block of rooms at $_____/night until March 8, 2013. Be certain to specify group name “______________----” to receive this reduced rate.

Directions:
Registration Information

Deadline for Registration for the Credentialed Clinical Instructor Program is (insert date).

The following information must be received by the deadline above to ensure that you obtain the necessary confirmation materials:

_________ Participant Dossier (completed and signed by your supervisor)
_________ Agreement of Participation
_________ Copy of current license/registration/certification to practice
_________ Check payable to: ________________________________

Registration Materials (above) should be mailed or faxed to:

Names
Address
Address
City, State Zip Code
Fax:

Any questions about registration of this program should be directed to:

Trainer(s) Name(s)
Phone:
AGREEMENT OF PARTICIPATION

APTA CLINICAL INSTRUCTOR EDUCATION
AND CREDENTIALING PROGRAM

The Clinical Instructor Education and Credentialing Program is being offered by the
___________________________________________________________________.

Successful completion of the program and its Assessment Center for physical therapists and
physical therapist assistants will result in the awarding of Clinical Instructor Credentialing and 1.5 CEU/15 contact hours (please note difference if from TX or OH) from the American Physical Therapy Association.

To be eligible for credentialing, the participant must:

1. Submit a completed Participant Dossier, signed Agreement of Participation, copy of a current license/registration/certification to practice, and appropriate Registration fee prior to beginning the program.
2. Attend each session of the program in its entirety and participate in all program activities.
3. Successfully complete each portion of the Assessment Center if a physical therapist or physical therapist assistant.

NOTE:
If any part of the program is missed, the participant must repeat the entire program to be eligible for CI Credentialing.

Only participants who have completed all program sessions will be permitted to sit for the Assessment Center when completing this program (physical therapists and physical therapist assistants only).

A participant who does not satisfactorily complete the Assessment Center or fails to attend the entire didactic curriculum as part of the program will be notified by the Credentialed Clinical Trainer that he/she has not met the competencies required and is not being recommended for APTA Clinical Instructor credentialing.

Should a participant need to request a refund, he or she must do so within 72 hours prior to the date of the beginning of the course. The refund amount will be equivalent to the APTA portion of the registration fee only.

I have read and understand the above policies and agree to abide by the conditions as stated.

____________________________   _____________________
Participant signature    Date
I. PROGRAM DESCRIPTION

A. The CCIP Trainer Course is designed to prepare individuals to teach and administer the didactic program and assessment centers of the Credentialed Clinical Instructor Program (CCIP). Only Credentialed Clinical Trainers, persons who have successfully passed the CCIP Trainer Course, can teach the Credentialed Clinical Instructor Program.

B. APTA’s CCIP Trainer course is a 3-day instructional course established for the purpose of training individuals to provide the voluntary APTA Credentialed Clinical Instructor Program. Training is based on adult and active experiential learning approaches and focuses on the participant’s ability to teach a valid and reliable curriculum to others. It is presumed that participants will have a command of didactic content related to clinical teaching, supervision, and evaluation upon entering this course. By the end of this course, participants will be expected to demonstrate familiarity with content contained within the Credentialed Clinical Instructor Program and to satisfactorily manage the Assessment Center. In addition, participants will be expected to competently teach selected content by integrating active teaching strategies to different levels of learners and to demonstrate the ability to independently conduct the APTA Credentialed Clinical Instructor Program.

C. Outcomes of the CCIP Trainer course are measured through self-assessment and evaluation by course faculty. Only Credentialed Clinical Trainers may serve as faculty to teach the CCIP Trainer course. Faculty evaluations include assessment of the participant’s performance in multiple dimensions as observed throughout the course and overall recommendations provided by faculty regarding successful attainment of the course criteria. The Credentialed Clinical Instructor Program Advisory Work Group (CCIW) makes the final decision regarding the awarding of Clinical Trainer credentials by determining if the participant has successfully met the criteria to be awarded Credentialed Clinical Trainer status based on faculty evaluations, ability of candidates to accurately self-assess, and the attainment of performance criteria.

1. CCIP Trainer courses can only be provided by APTA trained faculty.

2. Faculty members are required to make recommendations regarding candidates’ performance for Credentialed Clinical Trainer status to the CCIW. Faculty members provide feedback and input into the final performance appraisal for candidates completing the course and are also responsible for providing individual feedback to candidates during a designated time for debriefing.

3. CCIW-approved candidates will receive a certificate from APTA indicating their status as a Credentialed Clinical Trainer for a period of 3 years.
II. CREDENTIALED CLINICAL TRAINER BENEFITS

The benefits to the individual, his/her employer, and the profession by becoming a Credentialed Clinical Trainer include:

A. Support for career enhancement in areas such as promotion, tenure, educational advancement, and career ladder advancement.

B. National recognition as a Credentialed Clinical Trainer, including being listed in an online national database of Credentialed Clinical Trainers qualified to provide the voluntary APTA Credentialed Clinical Instructor Program.

C. Access to trainer resources posted to the password protected CCIP trainer online community, which is managed by APTA’s Clinical Instructor Credentialing staff.

D. Support from APTA’s Clinical Instructor Credentialing staff to assist Credentialed Clinical Trainers in finding partners, where feasible, to co-teach the voluntary APTA Credentialed Clinical Instructor Program.

E. Opportunities to network with other Credentialed Clinical Trainers through an annual Credentialed Clinical Trainer Education Update and Recognition Forum at Combined Sections Meeting.

F. Opportunity, if desired, to receive an honorarium for services (in addition to travel, hotel, food, supplies, and expenses for duplicating materials, if applicable), of a maximum of $1200 per program. If there are multiple trainers teaching the program, the trainers will determine how the honorarium will be divided. Trainers are eligible to receive this honorarium for each course.

1. The particular fee was set to provide a mechanism for the Credentialed Trainer to be able to pay to maintain APTA National, Chapter, and Education Section dues to continue to meet one of the eligibility requirements to maintain status as a Credentialed Clinical Trainer.

2. The only exception to the above honorarium is when the Credentialed Trainer teaches the Credentialed Clinical Instructor Program as a part of an institution's academic program (i.e., Transition DPT). Under this circumstance, the Credentialed Trainer has the latitude to negotiate remuneration for teaching services consistent with other adjunct faculty associated with that institution. Thus, the Trainer is not to be constrained by the $1200 limit which is the maximum honorarium that the Trainer can receive when the program is taught as a continuing education model (for CEUs/contact hours) rather than for academic course credit.

III. ELIGIBILITY CRITERIA FOR APPLYING FOR THE CCIP TRAINER COURSE

All applicants must demonstrate evidence of ALL of the following:

A. Status as a physical therapist or a physical therapist assistant as evidenced by current documentation that meets state regulations to provide physical therapy services as a physical therapist or physical therapist assistant (e.g., licensure, certification, registration), if applicable.

B. Current membership in APTA or International Partners Program.
C. Significant experience in physical therapy clinical education which demonstrates depth and breadth of instruction. Examples of significant experience may include:

1. Minimum 2 years as a CCCE or ACCE/DCE;
2. 3 years combined experience as a CCCE and ACCE/DCE; or
3. 5 years of experience as a CI, and having demonstrated ability to manage exceptional students, to manage ethical/legal issues involving students, to mentor students’ professional development beyond the traditional internship experience, and/or collaboration with the CCCE and/or ACCE/DCE related to clinical education program development, mentoring of less experienced CIs, and/or management of student issues.

D. Experience as a CI for students.

E. APTA Credentialed Clinical Instructor status.

F. Teaching experience including different levels of learners and class size.

G. Commitment and willingness to provide ongoing training of clinical educators for a minimum of 3 years.

H. Professional activities and professional development in clinical education and education.

I. Access to a viable mechanism of support (e.g. consortia, academic institution, employer/clinic facility, Area Health Education Center [AHEC], other) for providing APTA Credentialed Clinical Instructor Programs.

J. Completion of the **Trainer Application** by the stated deadline to include **ALL** of the following:

1. Applicant dossier, including a reference from the applicant’s direct supervisor.
2. Self-assessment form completed by the applicant.
3. Reference form completed by a student/learner that the applicant has supervised or taught (must be submitted in a sealed envelope).
4. Reference form completed by a colleague/peer who has observed the applicant’s performance as a clinical or academic teacher (must be submitted in a sealed envelope). For clinical educators, it is recommended that a reference letter is written by the CCCE and/or DCE/ACCE.

IV. **APPLICATION PROCESS FOR THE CCIP TRAINER COURSE**

A. Coordination of the application process, courses, and credentialing is managed by APTA’s Clinical Instructor Credentialing staff.

B. A call for applicants is made available, based on the need for new Credentialed Clinical Trainers and budget considerations, in APTA publications and outlines the eligibility criteria and application process. This is typically done every 2 years if deemed necessary.
C. Applicants are required to submit completed documentation to APTA’s Clinical Instructor Credentialing staff by specified deadlines.

V. APPLICATION DECISION-MAKING PROCESS

A. Each trainer application is masked and reviewed by a panel of 2 or 3 CCIW members, and rated for acceptance according to specific, weighted criteria established by the CCIW. The criteria include **ALL** of the following:

1. Eligibility Requirements
2. Employment history
3. Professional activities
4. Professional development/continuing education
5. Teaching experience
6. Responses to 3 clinical education scenarios
7. References
8. Applicant’s self-assessment
9. Geographic distribution and needs of the current trainer pool

B. To ensure anonymity, panel members will not review applicants who are from their geographical region.

C. Rating decisions by the panel for inviting applicants to participate in the CCIP Trainer course may be designated as “highly recommend,” “recommend,” “recommend with reservations,” or “not recommend” and must include comments that substantiate their ratings.

D. Ratings must be congruent between panel members for an invitation to be extended to an applicant, or for denial to occur.

E. In all cases, applicants are notified in writing of the panel’s decision by APTA’s Clinical Instructor Credentialing staff.

1. Approved applicants are scheduled for a course by APTA and provided with all course materials, including an **Initial Self-Assessment** and a **Covenant**. The course registration fee is due prior to the course.

2. Applicants who are not recommended to attend the trainer course are notified in writing, by APTA’s Clinical Instructor Credentialing staff on behalf of the CCIW, indicating the areas of deficiencies found in their application. Applicants may choose to reapply for a subsequent course offering.
VI. CREDENTIALING DECISIONS OF THE CCIW

A. Faculty members meet to discuss participants’ performance during the course and agree upon performance ratings based on the observations of all faculty members. Participant ratings on each of the criteria listed above must achieve a score of “adequate” (4 points on a 7-point scale) or above to be considered for Credential Clinical Trainer status. Participant self-assessments will be considered as part of the evaluation process.

B. Following each CCIP Trainer course, course faculty forward the following to APTA’s Clinical Instructor Credentialing staff, who then present this information to the CCIW:

1. **CCIP Trainer Final Participant Self-Assessment** with developmental action plan.

2. **CCIP Trainer Faculty Assessment** on the participant’s performance on the following rated criteria: participant’s comfort with the content, confidence in the delivery of the content, and readiness to independently organize and deliver the entire Credentialed Clinical Instructor Program.

C. Decisions of the CCIW from the review of the participant’s performance assessments for the CCIP Trainer course are as follows:

1. Participant is approved for Credentialed Clinical Trainer status.
   a) The participant is notified and listed in the APTA database of Credentialed Clinical Trainers, with all associated benefits and responsibilities.
   b) Credentialed Clinical Trainer will receive a Letter Awarding Trainer Status and a certificate from APTA, granting an initial 3-year period as a trainer.
   c) The CCIW may prescribe, on a case-by-case basis, remediation to achieve the criteria prior to awarding Credentialed Clinical Trainer status.

2. Participant is NOT approved for Credentialed Clinical Trainer status.
   a) The CCIW notifies the participant via Letter Not Awarding Trainer Status that they have not successfully met the criteria for earning Credentialed Clinical Trainer status. The participant may appeal this decision in writing within 30 days following notification of denial of Trainer status and provide a suggested, written plan for remediation to address deficits identified during the Trainer course.
   b) The individual has the option to repeat the course at full cost. The decision to reapply for a subsequent CCIP Trainer course is left to the candidate and should be attempted only after improved teaching performance and content mastery based on feedback received following the course.

D. Candidates participating in the CCIP Trainer Course are not eligible to teach the Program prior to notification of receiving their Credentialed Clinical Trainer Certificate following the review by the CCIW.
VII. ELIGIBILITY FOR CREDENTIALED CLINICAL TRAINER RENEWAL

A. To be eligible for renewal after the first 3 year period, the Credentialed Clinical Trainer must complete the Trainer Renewal Portfolio documenting ALL of the following:

1. Provide, independently or team-teach, a minimum of 3 voluntary APTA Credentialed Clinical Instructor Programs to a minimum of 30 persons within the 3 years of initial credentialing.

2. Independently teach all 6 sections of the CCIP didactic curriculum and coordinate and manage the Assessment Center (e.g., providing participant directions, answering questions, ensuring participants move through the stations, assisting participants with the review of their scoring) within a 3-year time period.

3. Compilation of CCIP Aggregate Program Evaluation data on CCIPs provided.

4. Provide any additional learning experiences that enhanced his or her capabilities as a Trainer.

5. Review and sign a new covenant.

6. Consent to a minimum of a 5-year commitment to providing the Credentialed Clinical Instructor Program.

7. Maintain membership in APTA or International Partners Program.

8. Maintain access to a viable mechanism of support (e.g., consortia, academic institution, employer/clinical facility, Area Health Education Centers [AHEC], other) to provide Credentialed Clinical Instructor Programs.

9. Ability to manage administrative aspects within specified time frames using proper documentation and forms.

B. To be eligible for additional renewals, the Credentialed Clinical Trainer must complete the Trainer Renewal Portfolio documenting ALL of the following:

1. Provide, independently or team-teach, a minimum of 5 voluntary APTA Credentialed Clinical Instructor Programs to a minimum of 50 persons within the 5 years of Clinical Trainer Credential renewal.

2. Independently teach all 6 sections of the CCIP didactic curriculum twice and coordinate and manage the Assessment Center (e.g., providing participant directions, answering questions, ensuring participants move through the stations, assisting participants with the review of their scoring) within a 5-year time period.

3. Compilation of CCIP Aggregate Program Evaluation data on CCIPs provided.

4. Provide any additional learning experiences that enhanced his or her capabilities as a Trainer.
5. Review and sign a new covenant.

6. Consent to a minimum of a 5-year commitment to providing the Credentialed Clinical Instructor Program.

7. Maintain membership in APTA or International Partners Program.

8. Maintain access to a viable mechanism of support (e.g., consortia, academic institution, employer/clinical facility, Area Health Education Centers [AHEC], other) to provide Credentialed Clinical Instructor Programs.

9. Ability to manage administrative aspects within specified time frames using proper documentation and forms.

VIII. PROCESS FOR RENEWAL OF CREDENTIALED CLINICAL TRAINER STATUS

A. Credentialed Clinical Trainer will have fulfilled all administrative responsibilities as delineated in the Administrative Aspects of the Credentialed Clinical Instructor Program.

B. Based on their renewal cycle, each Credentialed Clinical Trainer will submit a Trainer Renewal Portfolio at least 4 weeks prior to the summer CCIW meeting of their renewal year. The deadline for trainer renewal portfolio submissions will be communicated by January 15 of that year. All trainer renewal portfolios are to be submitted to APTA by email.

C. A late fee of $100.00 will be assessed for any trainer renewal portfolio that is received past the deadline.

IX. CREDENTIALED CLINICAL TRAINER RENEWAL DECISIONS OF THE CCIW

A. The CCIW will review the Clinical Trainer’s portfolio to determine if the individual has met the competencies for Credentialed Clinical Trainer renewal.

B. The CCIW will review Credentialed Clinical Instructor Program participants’ course evaluation in the aggregate as compiled by the Credentialed Clinical Trainer.

C. Outcomes of the CCIW review of Clinical Trainers for renewal are as follows:

1. The Clinical Trainer is renewed for an additional 5 years.
   a) The Clinical Trainer is notified of the decision for renewal as a Credentialed Clinical Trainer for another 5 years within 3 weeks after the CCIW has met to review all documentation.
   b) The Clinical Trainer is retained in the APTA database of Credentialed Clinical Trainers, with all associated benefits and responsibilities.
   c) The Clinical Trainer will be mailed a certificate awarding credentialing status for another 5 years.
2. The Clinical Trainer is **not** approved for renewal status.

   a) Clinical Trainer is notified that Credentialed Clinical Trainer status has been revoked within 3 weeks after the CCIW has met to review all documentation.

   b) Trainers who want to be reconsidered must follow the **Process for Reinstatement Following Revocation of Clinical Trainer Credential.**

3. The Clinical Trainer is awarded a “conditional renewal.”

   a) The CCIW, may, at its discretion, provide the Clinical Trainer with a “conditional renewal” if the Trainer has not met all of the renewal criteria due to extenuating circumstances. Specific conditions will be identified by the CCIW in writing that the Trainer must meet within a specified time period. If those conditions are not met within the parameters provided, then the credential shall be revoked.

   b) The Clinical Trainer will be issued a new Credentialed Clinical Trainer certificate for a period of 6 months to fulfill the conditions that are specified at the time of awarding a “conditional renewal.” During this period of time the Trainer will be required to schedule a program to meet the condition(s), submit the relevant written documentation to demonstrate that the specified condition(s) have been met including program evaluation(s), and to permit time for the CCIW review to review and discuss the documentation to determine Credential Clinical Trainer status.

   c) The CCIW will review written documentation provided by the Clinical Trainer by a date specified in the conditional renewal. The Trainer will identify specifically how he or she has met the conditions specified by the “conditional renewal.” Following a review of the Clinical Trainer’s written documentation within 60 days of submission:

   1) If the CCIW finds that the individual has met the conditions as established by the conditional renewal then the Clinical Trainer will be issued another Credentialed Clinical Trainer certificate for an additional 4.5 years to complete the 5-year cycle.

   2) If the CCIW finds that the individual has not met the conditions as established in the conditional renewal, then the credential will expire on the 6 month date indicated on the conditional renewal certificate. At that time, the Clinical Trainer can no longer provide the CCIP.

   3) If the Clinical Trainer elects **not to fulfill** the conditions as specified in the conditional renewal or **delays in submitting** documentation, then the credential will expire on the 6 month date indicated on the conditional renewal certificate. At that time, the Clinical Trainer can no longer provide the CCIP until such time as written documentation is submitted and a formal review is provided by the CCIW.

   4) During the “conditional renewal” review process (60 days) by the CCIW, the Trainer is not entitled to schedule or teach the Credentialed Clinical Instructor
Program until final disposition of his or her credentialed status has been determined by the CCIW.

5) Conditions that are fulfilled as a result of the awarding of a “conditional renewal” cannot be applied to future portfolio renewal documentation.

D. The CCIW reserves the right to review a Credentialed Clinical Trainer mid-renewal cycle.

* Anything **bolded** in this document references an item of importance or a policy or form that can be found elsewhere.

If you have any questions regarding the content in this document, please contact Clinical Instructor Credentialing staff at ccip@apta.org or 800/999-2782, extension 8528.
The Credentialed Clinical Instructor Program Advisory Work Group (CCIW) reserves the authority to revoke the active status of a credentialed trainer, pending a review of relevant information and a group consensus. Any trainer whose status is in question will be made aware of the situation and asked to provide his or her perspective as an important part of the review process.

Conditions which mandate the revocation of an individual’s status as a Credentialed Clinical Trainer include the following:

- The individual fails to maintain APTA membership. Canadian trainers must maintain participation in APTA’s International Partners Program.
- The individual fails to meet part of the renewal commitment requirements.
- The participant evaluations of the individual’s performance at 2 or more courses are sufficiently adverse, in the judgment of the CCIW, to compel the conclusion that the individual has not satisfactorily demonstrated mastery of presentation and content of the Credentialed Clinical Instructor Program (i.e., presentation scores with more than 50% below “above average” category).
- The CCIW determines (after giving the individual notice and an opportunity to respond to any adverse evidence) that the individual engaged in fraud, misrepresentation, or other irregular behavior in attaining the status of a Credentialed Clinical Trainer or in carrying out responsibilities in connection with the credentialing of clinical instructors.
- The individual fails to complete the renewal portfolio, or voluntarily surrenders their trainer credential status.

Additionally, the CCIW may revoke an individual’s status as a Credentialed Clinical Trainer if reliable evidence indicates that a state licensing authority has taken licensing action against this individual.

Trainer status may also be revoked if the CCIW determines that an individual has plead guilty or nolo contendere to a charge involving a serious crime (i.e., one classified as a felony or punishable by imprisonment for 6 months or more) substantially related to the qualifications, functions, or duties of a physical therapist or physical therapist assistant, has been found guilty of such a crime after a trial, or has been convicted of such a crime.

If you have any questions regarding this policy, please contact Clinical Instructor Credentialing staff at ccip@apta.org or 800/999-2782, extension 8528.
The Credentialed Clinical Instructor Work Group (CCIW) reserves the authority to reinstate the active status of a Credentialed Clinical Trainer, pending a review of relevant information and a group consensus. Trainer reinstatements will be issued for a 3 year term, after which the Credentialed Clinical Trainer will return to a 5 year renewal cycle.

I. An individual whose status as a Credentialed Clinical Trainer was revoked for failure to maintain membership in the APTA may petition the CCIW for reinstatement upon rejoining the APTA. The CCIW shall grant the petition upon satisfying itself that this individual is a member of APTA.

II. An individual whose status as a Credentialed Clinical Trainer was revoked for failure to meet the portfolio commitment requirements; who fails to complete a portfolio renewal; or voluntarily surrenders their credentialed trainer status may petition the CCIW for reinstatement by detailing the circumstances of his/her lapse in teaching or decreased enrollment with a plan to remedy both situations. The CCIW will determine on a case-by-case basis whether the Clinical Trainer may continue to provide the Credentialed Clinical Instructor Program and will specify the conditions and circumstances that the individual must meet in order to be reinstated.

Petition for the CCIW must include an explanation of the deficits listed above, including specific reasons why the individual was unable to meet the established performance criteria for acceptable portfolio renewal requirements or why the portfolio was not submitted.

A. With respect to the Petition for Reinstatement as a Credentialed Clinical Trainer, correspondence must include a comprehensive plan that specifically delineates how the individual will successfully meet the expected performance criteria for the next renewal period to meet the renewal requirements.

B. The individual will resubmit a current portfolio completing those sections that are applicable. Thus, for persons who have not been able to provide CCIP courses during the initial credential or renewal period, Parts I and III will be completed. For persons who have been able to complete a portion of the criteria, Parts I, II and III are to be completed with current information. The CCIW will review the portfolio focusing on the individual’s goals, ongoing professional development in clinical education, and any other related aspects to assist in the decision making process.

C. Upon receipt of this information, members of the CCIW will review the correspondence and portfolio documentation to make a status decision regarding reinstatement of the applicant and the conditions that are to be met if reinstatement is to be awarded to include:

1. Issuing of the Credentialed Clinical Trainer certificate and the dates for which the individual has been renewed. In the case where the individual might be penalized for remaining within the prior scheduled renewal period, the dates for credential renewal
will move forward providing additional time for the individual to be able to meet the criteria.

2. Requiring that the first time that the individual provides the program it will be co-taught with another active Credentialed Clinical Trainer. This will allow the individual to be supported, updated on any changes or documentation, and to share ideas and obtain feedback from another Credentialed Trainer who has been current in providing the CCIP.

3. Option of asking the individual to audit the next available CCIP Trainer course if deemed necessary to ensure currency and competence.

D. An individual whose Credentialed Clinical Trainer status has lapsed or who has voluntarily elected not to submit portfolio documentation, will be permitted only one opportunity to seek reinstatement as a Credentialed Clinical Trainer from the CCIW.

III. An individual who fails to maintain mastery of both content and the presentation of the CCIP, which includes aggregate presentation scores with more than 50% below the “above average” category as supported by participant comments including but not limited to lack of familiarity with the material, inability to answer questions, inability to adequately cover the material in the allotted time, or changing the content or sequence must complete ALL of the following:

A. Petition the CCIW, explaining the deficits listed above.

B. Describe a plan to remediate the deficits that includes an estimated time for remediation. Remediation may include but is not limited to:

   1. Repeating the CCIP Trainer course at the Clinical Trainer’s expense;

   2. Co-teaching with a Credentialed Clinical Trainer willing to mentor those sections of the course that have been critiqued for delivery issues;

   3. Mentoring and assessment by a Credentialed Clinical Trainer for active teaching techniques;

   4. Submission of letters of support in relation to remediation plans;

   5. Other specific requirements as determined by the CCIW.

IV. An individual whose status as a Credentialed Clinical Trainer was revoked on account of fraud, misrepresentation, or irregular behavior may petition the CCIW for reinstatement. The CCIW may grant such a petition if it determines that doing so would be in the best interest of the profession.

An individual whose status as a Credentialed Clinical Trainer was revoked on account of licensing action by state authorities or evidence of his/her commission of a serious crime may petition the CCIW for reinstatement. The CCIW may grant such a petition if it determines that doing so would be in the best interest of the profession.

If you have any questions regarding this policy, please contact Clinical Instructor Credentialing staff at ccip@apta.org or 800/999-2782, extension 8528.
CREDENTIALED CLINICAL INSTRUCTOR PROGRAM (CCIP)

Appeals Process for Denial of Credentialed Clinical Instructor or Trainer Status

I. PROCEDURE FOR REVIEW OF CREDENTIALING DENIALS—JURISDICTION OF CREDENTIALED CLINICAL INSTRUCTOR PROGRAM ADVISORY WORK GROUP (CCIW)

A. Credentialing decisions are based on a participant’s performance during prescribed education programs:

1. Participants of the Credentialed Clinical Instructor Program (CCIP) are recommended for Clinical Instructor Credentialing by Credentialed Clinical Trainers based on their performance and successful completion of the Assessment Center.

2. Participants of the CCIP Trainer Course are credentialed as Clinical Trainers by the CCIW based on faculty evaluations and recommendations, with consideration of participants’ self-assessments.

B. The participant must make appeals for denial of Credentialing in writing to the CCIW within 30 days of notification of the denial. The written request for reconsideration must specify the grounds on which the reconsideration is based and the specific remedy requested.

1. The chair of the CCIW will review the request, including any additional information provided by the participant.

2. The Chair will seek input from the Trainer(s)/Faculty who taught the course.

3. The Chair will present the request for reconsideration and pertinent information to the CCIW.

4. The CCIW will review the request for reconsideration and will notify the participant with the results within 60 days of receipt of the request for reconsideration.

5. Following this process, there is no further appeal mechanism.

II. PROCEDURE FOR REVIEW OF CONSUMER GRIEVANCE

A. Any individual who provides in writing a grievance or concern regarding any aspect of the Credentialed Clinical Instructor Program and/or the Trainer process will be reviewed by the CCIW within 60 days of the receipt of the grievance. The process to be used in responding to this grievance is as follows:

1. Complaints must be submitted in writing to the CCIW.

2. CCIW will review and discuss the complaint within 60 days.
3. CCIW will investigate the facts of the complaint to clarify the issues of all parties involved.

4. Staff will consult APTA legal counsel regarding any legal issues that may be associated with the grievance.

5. Based on the facts of the grievance and consultation of legal counsel the CCIW will render a decision on a case-by-case basis and provide a written response to the individual who filed the grievance.

If you have any questions regarding this policy, please contact Clinical Instructor Credentialing staff at ccip@apta.org or 800/999-2782, extension 8528.
CREDENTIALED CLINICAL INSTRUCTOR PROGRAM (CCIP)

Renewal of Credentialed Trainer Status Portfolio

In accordance with the policies and procedures of the Credentialed Clinical Instructor Program, Credentialed Clinical Trainers are asked to complete the following items as part of the credential renewal process.

If you have not completed any of the items, please indicate in the blank a response of “0” rather than leaving the item blank. For any criteria not met, please explain the circumstances in “Part V: Additional Information/General Comment.” Please do not send an individual curriculum vitae with this portfolio.

Please complete portfolio electronically and submit via email to ccip@apta.org.

PART I – PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>First Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>APTA Membership Number:</td>
<td></td>
</tr>
<tr>
<td>Date Trainer Course Taken:</td>
<td></td>
</tr>
<tr>
<td>State(s) Licensed:</td>
<td></td>
</tr>
<tr>
<td>License Number:</td>
<td></td>
</tr>
<tr>
<td>License Expiration Date:</td>
<td></td>
</tr>
</tbody>
</table>

Have disciplinary actions been taken against your license?  
☐ No  
☐ Yes  
If yes, please explain:

Please select one:  
☐ This is my first time to renew my Trainer credential  
☐ I have renewed my Trainer credential at least once

Contact Information

<table>
<thead>
<tr>
<th>Mailing Address:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>Zip:</td>
<td></td>
</tr>
<tr>
<td>Preferred Phone:</td>
<td></td>
</tr>
<tr>
<td>Preferred Email:</td>
<td></td>
</tr>
</tbody>
</table>
PART II – SELF-ASSESSMENT

1. Please list examples of additional learning experiences in which you have participated to enhance your capabilities as a trainer (eg, continuing education, job promotion, co-training, mentoring):

2. What mechanisms of support are available to you to continue to provide training of Clinical Educators?
   - [ ] Consortia
   - [ ] Area Health Education Center (AHEC)
   - [ ] Academic Institution
   - [ ] Employer/Clinical Facility
   - [ ] Other, please specify
3. a. List two examples of ways that you have used active training techniques in providing the Credentialed Clinical Instructor Program. Please comment on the success of the techniques.

1.

2.

b. May APTA anonymously post your active training examples listed above to the CCIP Community for the benefit of fellow trainers?  ☐ Yes  ☐ No

c. Based on your experience, would you make any changes in the approaches you have used to teach the CCIP considering different levels of learners, class size, discipline represented and program format?
PART III – AGGREGATE SUMMARY PROGRAM EVALUATION

Total the program evaluation information that you have received as a Credentialed Clinical Trainer in the past three years. Enter the aggregate total score numbers in the appropriate boxes in each of the grids provided.

Do not send individual program evaluation summaries with this portfolio.

1. Training/Teaching History

<table>
<thead>
<tr>
<th>INDEPENDENTLY TAUGHT</th>
<th>TEAM TAUGHT</th>
<th>COURSE FAILURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Programs Taught</td>
<td>Number of Participants</td>
<td>Number of Programs Taught</td>
</tr>
</tbody>
</table>

2. Content Management/Sections (Refer to Program Evaluation Form Sections 1 – 6)
   - In column 2, indicate the total number of times you have taught each section as the primary instructor.
   - In column 3, indicate the total (aggregate) number of program participants reporting. (Add the number of participants from all programs where you were the primary instructor for the section).
   - In the last column, total the number of presentation scores received in each category (not activities) and place the number of participants who rated your presentation for each section (Add the total scores for each program evaluation from the Trainer Aggregate Data Evaluation Form).

<table>
<thead>
<tr>
<th>Total # Times Served as the Primary Instructor for the Section</th>
<th>Total # Program Participants Responding</th>
<th>Total the Participants’ Ratings in each Category (from Evaluation Summaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed Sample Item</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician as Clinical Educator</td>
<td>2</td>
<td>Poor:</td>
</tr>
<tr>
<td></td>
<td>52</td>
<td>Excellent:</td>
</tr>
</tbody>
</table>
### Trainer to Complete

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Poor</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Clinician as Clinical Educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Readiness to Learn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Facilitating Learning in the Clinical Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Performance Assessment-The Clinical Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Legal, Regulatory, and ADA Issues in Clinical Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Managing the Exceptional Student and Student with Problems in Clin Ed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 3. Assessment Center

How many times have you coordinated and managed (eg, provided participant directions, answered questions, ensured participants move through the stations, assisted participants with reviewing their scoring) the Assessment Center?

#### 4. Dates of Courses Taught

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
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</thead>
<tbody>
<tr>
<td>3.</td>
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<td>15.</td>
<td>16.</td>
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<td>17.</td>
<td>18.</td>
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<tr>
<td>19.</td>
<td>20.</td>
</tr>
</tbody>
</table>
PART IV – GOALS

Identify two goals and corresponding plan for continued improvement as a Credentialed Clinical Trainer relative to teaching Sections 1 through 6 and the management and coordination of the Assessment Center.

Goal 1:

Plan for Goal 1:
Goal 2:

Plan for Goal 2:

PART V – (OPTIONAL) ADDITIONAL INFORMATION/GENERAL COMMENT

Please provide any additional information that you would like considered as part of your Renewal Portfolio. This may include, but is not limited to, (1) comments related to any renewal requirement for which you would like to provide additional information or support and/or (2) any specific requests for support or mentoring.
PART VI: A COVENANT FOR CREDENTIALED CLINICAL TRAINERS

As I continue in my role as an APTA Credentialed Clinical Trainer, I recognize the importance of the explicit values, which are embodied in the Credentialed Clinical Instructor Program. I agree to support these values with the following behaviors throughout the next five years.

1. I will encourage active participation by qualified participants in the clinical education of students in physical therapy and will encourage their enrollment in the APTA Credentialed Clinical Instructor Program.

2. I will willingly collaborate with my Credentialed Clinical Trainer colleagues to plan and implement Credentialed Clinical Instructor Programs.

3. I will enthusiastically consult with colleagues in the sponsoring institution regarding the specific learning needs of each group of participants, while closely monitoring the integrity and consistency of the courses I teach.

4. I will complete all administrative duties related to my role as a Credentialed Clinical Trainer in a timely and accurate manner.

5. I will negotiate my personal travel and compensation as a Credentialed Clinical Trainer in a manner that reflects a positive and professional image and follow all policies and procedures as established within the program.

6. I will prepare appropriately for all teaching responsibilities, will openly seek and receive feedback on my teaching performance, and will work to consistently improve my performance.

7. I intend to make a minimum 5 year commitment to provide the Credentialed Clinical Instructor Program.

In my role as a Credentialed Clinical Trainer, I agree to represent myself and the APTA’s Credentialed Clinical Instructor Program in an ethical and professional manner.

Signature *(electronic signatures are acceptable)*

Date
I. INTRODUCTION

As part of each Credentialed Clinical Trainer’s responsibility in managing and coordinating the Credentialed Clinical Instructor Program (CCIP), there are inherent timelines, documentation, and payments that must be fulfilled. To assist trainers in better managing these responsibilities while continuing to ensure the high quality of the CCIP, the information below is provided for managing the administrative aspects of the program.

II. PRE-COURSE RESPONSIBILITIES

A. Three Months Prior to Course:

1. Credentialed Clinical Trainers are to provide APTA’s Clinical Instructor Credentialing staff with a completed Course Announcement Form at least 3 months prior to the course start dates.

   a. Course Announcement Forms are to be typed and submitted electronically to ccip@apta.org. Upon receipt, Trainers will receive a message of confirmation.

   b. Following this timeline allows APTA staff to prepare for CCIP courses in a timely manner, which will ensure smooth operations.

2. Advertising the APTA Credentialed Clinical Instructor Program

   If course registration is open to the public, APTA’s Clinical Instructor Credentialing staff will advertise CCIP courses through APTA’s website. Additional advertising done by course sponsors must include the following:

   a. Cancellation/course refund policy: Individuals must cancel their CCIP registration and request a refund 72 hours prior to the start date of the course and the CI course manual must be returned to APTA. The refund amount will be equivalent to the APTA portion of the registration fee only. Refund amounts less than $90.00 will be issued in the form of a credit voucher, applicable towards the purchase of any product from the APTA store or toward registration fees for courses or conferences. Credit vouchers will expire 6 months after the date of issue.

   b. CEU policy: Please be aware that neither the Clinical Instructor Credential nor CEU credit will be awarded to any participant who does not attend the full program. As the course requirements clearly stipulate, individuals must attend all of the program to earn CEUs and the CI Credential (if a physical therapist or physical therapist assistant). Licensees should verify with their state licensing board for acceptance of continuing education units by reviewing the relevant state practice act and/or administrative code. For more information about licensure, visit http://www.apta.org/Licensure/.
B. Four Weeks Prior to Course:

Credentialed Clinical Trainers are responsible for the following administrative functions related to the delivery of the APTA Credentialed Clinical Instructor Program:

1. Collecting and screening Participant Dossiers to ensure applicants meet eligibility criteria.
   a. Electronic completion of Participant Dossiers is a requirement; handwritten dossiers result in a significantly greater amount of typos in the name and/or address fields and often require correcting, reprinting and resending certificates after the course has concluded.
   b. Participant Dossiers must be submitted prior to the program so that the Credentialed Clinical Trainer is able to: review the forms, become familiar with the audience, check that the correct payments have been submitted (member, non-member, non-physical therapy provider), and ensure that the registrant’s supervisor has signed off on the Participant Dossier, which determines the registrant’s eligibility to attend.

2. Collecting all fees associated with the CCIP to APTA per the CCIP Program Fee Policy.

3. Duplicating all materials required for providing the CCIP and the Assessment Center.

4. Arranging for persons on-site to adequately cover all stations of the Assessment Center.

C. Three Weeks Prior to Course: Course Manual Orders, Payments, and Dossiers

1. Completed CCIP Manual Order Forms and Participant Dossiers must be submitted to APTA via email to ccip@apta.org at least 3 weeks prior to the course.
   a. Trainers are encouraged to submit a manual order form first before moving forward with payment. This allows staff to review the form, assess any discounts applied for membership or corporate/group employment, and confirm final payment amount due to APTA.
   b. Orders that are received after the 3 week deadline may be assessed a $100.00 late fee to cover rush processing of the order and expedited shipping charges.
   c. Following the 3 week minimum timeline allows APTA staff enough time to process the manual order, confirm payment, ship the manuals from an offsite vendor, and resolve any problems that may arise related to shipping and delivery. This timeline also ensures adequate time to prepare the online participant program evaluations.

2. All payments must be submitted by mail and received by APTA no less than 3 weeks prior to the course start date. Enclose a copy of the CCIP Manual Order Form with payment and mail in one envelope to APTA. For direct routing, mail to the attention of “CCIP.” To ensure the security of payment information and to be in compliance with Payment Card Industry standards, credit card information may not be emailed or faxed to APTA.

3. In the event of late registrations, extra manuals may be ordered at the nonmember rate. If extra manuals are ordered, payment for each additional manual must be submitted at the time of the order. If extra manuals are not used, they may be returned to APTA after the course for a full refund.
4. It is the responsibility of the Credentialed Clinical Trainer to ensure that payments are provided accurately and in full when ordering CI course manuals prior to APTA fulfilling orders in the specified timeline.

5. If the Credentialed Clinical Trainer decides to allow the sponsor to collect payment, it is still the trainer’s responsibility to ensure that orders are correct and submitted as required by the timeline specified.

6. Forms of payment to APTA that are acceptable include credit cards, checks, and money orders. Purchase orders are not an acceptable form of payment.

7. Credentialed Clinical Trainers have the authority to decide what methods of payment are acceptable for the courses they teach.

III. POST-COURSE RESPONSIBILITIES

A. Within two weeks of course completion, Credentialed Clinical Trainers are to provide the following documentation in a typed and electronic format to ccip@apta.org for processing. Trainers are held responsible for pre- and post-course logistics, including document submission. As such, sponsors also need to be timely in completing their responsibilities for hosting a course.

1. Updated CCIP Manual Order Form. As of November 2016, the CCIP Participant Summary Form is no longer in use. To avoid duplicate data entry, the CCIP Manual Order Form has been re-designed to serve as the official record of participant attendance. After the course, please confirm each participant’s attendance in the final two columns of your original CCIP Manual Order Form (“Attended Course” and “Passed Assessment” columns) and email the updated form to ccip@apta.org. Also indicate the participants who registered for the course but withdrew or were otherwise unable to participate.

2. As of November 2016, participant evaluations are being administered electronically by APTA staff. During the final day of the course, participants will receive an email containing a link to a survey requesting feedback on their CCIP experience. The survey questions are the exact same items that previously appeared on the paper versions of the CCIP Participant Program Evaluation forms. Aggregation of the evaluation results will be conducted by APTA staff. Aggregated results will be sent to trainers approximately 1 week after the course has ended.

3. If there is any financial reconciliation needed, the CCIP Refund Request Form must be completed. Reconciliation may be needed for participant cancellations that meet the Cancellation/Refund Policy, changes in participants, and/or use or return of any extra manuals ordered.

B. File retention

Credentialed Clinical Trainers are required to retain the following files in paper or electronic format:

1. Updated CCIP Manual Order Forms and aggregated participant evaluations should be retained until the Credentialed Clinical Trainer has received renewal of their trainer status.

2. CCIP Refund Request Forms should be maintained until the refund has been issued.
3. Assessment Center response forms for individuals who have successfully completed the course should be maintained until APTA issues certificates.

4. Assessment Center response forms for individuals who did not successfully complete the course should be maintained until all appeals are exhausted.

5. Statement of Confidentiality for all individuals who have attempted the Assessment Center should be maintained for 3 months.

When discarding original documents, all items with identifiable information should be shredded.

C. APTA Post-Course Responsibilities

Once APTA staff have received the post-course materials mentioned above:

1. Any refunds or credits will be processed.

2. CI and CEU Certificates will be sent to participants within 8 weeks.

III. MINIMUM TIMELINE REQUIREMENTS FOR PROGRAM DOCUMENTATION

<table>
<thead>
<tr>
<th>Task to Complete</th>
<th>Facility-Based Program Format (No Marketing)</th>
<th>Open Program Format (Marketing to External Groups)</th>
<th>Assessment Center Only Format</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior to course being held:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disseminate marketing materials</td>
<td>2 months</td>
<td>3-4 months</td>
<td>3 months</td>
</tr>
<tr>
<td>Notify APTA of course via CCIP Course Announcement Form</td>
<td>2 months</td>
<td>3-4 months</td>
<td>3 months</td>
</tr>
<tr>
<td>Close course registration</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Collect Participant Dossiers and finalize all payments</td>
<td>3-4 weeks</td>
<td>3-4 weeks</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Send completed CCIP Course Manual Order Form, payment(s), and Participant Dossiers to APTA</td>
<td>3 weeks</td>
<td>3 weeks</td>
<td>7 weeks</td>
</tr>
<tr>
<td>Manuals mailed to location specified on CCIP Manual Order Form</td>
<td>1-2 weeks</td>
<td>1-2 weeks</td>
<td>5 weeks (participants must have manual at least 3 weeks prior for study)</td>
</tr>
<tr>
<td><strong>Upon completion of course:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Send updated CCIP Manual Order Form (with final two columns completed)</td>
<td>2 weeks</td>
<td>2 weeks</td>
<td>2 weeks</td>
</tr>
<tr>
<td>APTA staff will send aggregated participant evaluations to trainers</td>
<td>1 week</td>
<td>1 week</td>
<td>1 week</td>
</tr>
</tbody>
</table>
V. PAYMENT OPTIONS WITH IMPLICATIONS

<table>
<thead>
<tr>
<th>Payment Options</th>
<th>Processing</th>
<th>Potential Problems/Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acceptable Methods of Payment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit Card</td>
<td>Submit by 3 week deadline</td>
<td>Credit card declined; trainer must go back to let the person know they are not enrolled in the course, unless an alternative payment option is provided.</td>
</tr>
<tr>
<td>Checks/Money Orders</td>
<td>Submit by 3 week deadline</td>
<td><strong>Potential problems:</strong> 1) Amount paid is incorrect due to a calculation error, error in category of payment (PT/PTA or other discipline, member or non-member), or group discount. 2) Check may not clear bank processing. 3) Check not payable to APTA. <strong>Implications:</strong> 1) $100 late fee may be added to total due to cover expedited processing and rush shipping. 2) Processing of certificates may be delayed until amount due is paid in full.</td>
</tr>
<tr>
<td>Corporate Fees (either check or credit card)</td>
<td>Submit by 3 week deadline</td>
<td>When not submitted in time, the participant needs to provide his/her own payment and then get reimbursed by the corporation.</td>
</tr>
<tr>
<td><strong>Unacceptable Method of Payment</strong></td>
<td><strong>This option is NOT acceptable as payment for the CCIP</strong></td>
<td>Delays routinely occurred well beyond the date the CI program was offered.</td>
</tr>
</tbody>
</table>

If you have any questions regarding the content in this document, please contact Clinical Instructor Credentialing staff at ccip@apta.org or 800/999-2782, extension 8528.
Step 1:
If you are interested in offering a Credentialed Clinical Instructor Program (CCIP) course, you will first need to find a Credentialed Clinical Trainer. A list of Credentialed Clinical Trainers, organized by state, may be found on APTA’s website. Reach out to one (or some) to discuss the specifics of your upcoming course and decide on a date and location. You will also need to determine the costs associated with your trainer. If desired, Credentialed Clinical Trainers may request an honorarium of a maximum of $1200 per course. If there are multiple trainers teaching the course, the trainers will determine how the honorarium will be divided. The course sponsor should also cover the trainer’s costs for travel, hotel, food, supplies, and expenses for duplicating materials; these costs are not included in the trainer honorarium.

Step 2:
Once you have decided to offer a CCIP course, please notify APTA by sending a typed Course Announcement Form to ccip@apta.org at least 3 months prior to the course. This form may be found on the CCIP website under the Sponsoring a Course heading. After the form has been submitted, APTA staff will provide additional forms and information to guide you through the process.

Step 3:
Participant registration information should be collected, as per your registration deadline. Completed Participant Dossiers (typed and electronic format) should be collected from each registrant as part of your registration process. Trainers may access this form within the CCIP Trainer Community on the APTA website in the Pre-Course Documents folder.

Step 4:
Complete the CCIP Manual Order Form and e-mail to ccip@apta.org at least 3 weeks prior to the start date of the program. Participant Dossiers should also be submitted at this time. Trainers may access these forms within the CCIP Trainer Community on the APTA website in the Pre-Course Documents folder. Print a copy of the CCIP Manual Order Form and send with payment in one envelope to:

Credentialed Clinical Instructor Program (CCIP)
American Physical Therapy Association
Postprofessional Credentialing Department
1111 N. Fairfax Street
Alexandria, VA 22314

The CCIP Manual Order Form, APTA course fees, and Participant Dossiers must be received by APTA at least 3 weeks prior to the start date of the program to ensure that the manuals will arrive within adequate time (please relay this policy to the sponsor if they are responsible for processing the
payment). Note: in compliance with Payment Card Industry (PCI) standards, payment information may not be e-mailed or faxed to APTA.

Orders and payments received after the 3 week deadline may be assessed a $100.00 late fee.

The APTA course fee is $90.00 for members, $180.00 for non-members, and $230.00 for non-physical therapy providers. Payment for the course can be made by each individual registrant or via one lump sum payment. Payment can be made via check or money order payable to APTA or via credit card. Purchase orders are not accepted as a form of payment for the CCIP.

The order form should include the name of the individual to whom all the course manuals should be shipped, along with their preferred shipping address (street addresses only, NO PO Boxes).

The participant manuals and CI Credential pins will be shipped from APTA’s external warehouse (course participants from disciplines outside of physical therapy are not eligible to receive the CI Credential Pins).

Please note that non-physical therapy providers (i.e. OT, SLP, etc.) are eligible to participate in the CI Education Program only and NOT the Assessment Center. Priority is always given to physical therapists and physical therapist assistants interested in participating in the program. If space is available, then persons from other disciplines may participate and will receive 1.2 CEUs/contact hours* for attending the program. Please review the policies related to persons participating in this program from disciplines outside of physical therapy.

If you are offering only an Assessment Center, you must still complete Steps 1 and 2. To ensure that participants have sufficient time to study the materials in the CI Manual in advance of completing the Assessment Center, the APTA CCIP Manual Order Form, registration fees, and Participant Dossiers must be received by APTA at least 3 weeks prior to the Assessment Center to ensure sufficient time to fulfill the order and mail the manuals to the contact person. It is the contact person or organization that is responsible for distributing the CI Manuals to the individual participants in advance of the program.

After the Program

Participants who successfully complete the program are awarded their CI pin onsite by the trainer, and can expect to receive their CCIP Certificate and CEU* Certificate up to 8 weeks after the post-course materials have been delivered to APTA.

Please submit the following information to APTA within 2 weeks of course completion:

- **UPDATED CCIP Manual Order Form**
  As of November 2016, the CCIP Participant Summary Form is no longer being used. To avoid duplicate data entry, the CCIP Manual Order Form has been re-designed to serve as the official record of participant attendance. After the course, please confirm each participant’s attendance in the final two columns of your original CCIP Manual Order Form (“Attended Course” and “Passed Assessment” columns) and email the updated form to ccip@apta.org. Also indicate the participants who registered for the course but withdrew or were otherwise unable to participate.
While course sponsors may be the ones to submit program forms to APTA, trainers are ultimately held responsible for pre- and post-course logistics, including document submission. As such, sponsors need to be timely in completing their responsibilities for hosting a course. Trainers, please retain copies of the files listed above for your records and for your future portfolio submission.

To request a refund for course payments, please submit a Refund Request Form. Trainers may access this form with the CCIP Trainer Community on the APTA website in the Post-Course Documents folder.

**APTA Post-Course Responsibilities**

Once APTA staff have received the post-course materials mentioned above:

- Participant data will be entered into APTA’s Clinical Instructor database.
- Any refunds or credits will also be processed at this time.
- CI and CEU* Certificates will be sent to participants within 8 weeks.

*Please note: Licensees should verify with their state licensing board for acceptance of continuing education units by reviewing the relevant state practice act and/or administrative code. For more information about licensure, visit [http://www.apta.org/Licensure/](http://www.apta.org/Licensure/).

If you have any questions regarding the content in this document, please contact Clinical Instructor Credentialing staff at ccip@apta.org or 800/999-2782, extension 8528.
Course Announcement Form

Please provide the following information to APTA at least three months before your basic or advanced credentialing course will take place. Payment should be submitted at least three weeks before course start dates to ensure timely delivery of materials. Upon completion, this form may be submitted to ccip@apta.org.

Course level:  □ Basic  
□ Advanced (ACCIP)

Trainer(s):

Course Dates:

Course Location:
  City:
  State:

Course Sponsor(s):

Participant Registration Deadline:

Registration Contact Person:

Registration Contact E-Mail Address:

Registration Contact Phone Number:

Registration for this course is:  □ Open - (open courses will be advertised on the APTA website)  
□ Closed

If you would like APTA to provide additional information already posted online, provide the link here:

If you have any additional comments, instructions or requests, please share them here:

APTA STAFF USE

Order ___________________________  Batch ___________________________
## Manual Order Form

### Directions:
1. This form must be submitted electronically to ccip@apta.org no later than **3 weeks** in advance of the course start date. Per program policy, any forms received after the 3 week deadline may be assessed a $100 late fee.
2. A copy of this form must also be mailed to APTA in advance of the course start date along with payment. In compliance with Payment Card Industry (PCI) standards, **payment information may not be e-mailed to APTA**. For direct routing, please mail to "CCIP, 1111 N. Fairfax Street, Alexandria VA 22314."
3. **After the course**, confirm each participant's attendance in the final columns and email the updated form to ccip@apta.org.

### Trainer Section Assignments

<table>
<thead>
<tr>
<th>Section I:</th>
<th>Section II:</th>
<th>Section III:</th>
<th>Section IV:</th>
<th>Section V:</th>
<th>Section VI:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCIP Course Start Date:</td>
<td>Sponsoring Organization:</td>
<td>Total Amount of Order:</td>
<td>Contact Person:</td>
<td>Primary Phone Number:</td>
<td>E-mail:</td>
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<tr>
<td>(No P.O. Boxes)</td>
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</tbody>
</table>

### Member Price

<table>
<thead>
<tr>
<th></th>
<th>Regular</th>
<th>Non-Member Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>$90.00</td>
<td>$180.00</td>
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</tr>
</tbody>
</table>

### Other Discipline Price

| | Regular |
|-----------|
| $180.00  |

### Corporate discounts for participants from the same employer are available in the following amounts:

- **10% disc 5-9 ppl**
  - Member Price: $81.00
  - Non-Member Price: $162.00

- **15% disc 10-14 ppl**
  - Member Price: $76.50
  - Non-Member Price: $153.00

- **20% disc 15+ ppl**
  - Member Price: $72.00
  - Non-Member Price: $144.00

### Application Table

<table>
<thead>
<tr>
<th>Applicant Name</th>
<th>Employer</th>
<th>APTA Member Number</th>
<th>Member Price</th>
<th>Non-Member Price</th>
<th>Other Discipline Price</th>
<th>Attended Course</th>
<th>Passed Assessment</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### Column Totals

- $ - $ - $ -

### Page 1 Total

- $ -

### Grand Total

- $ -

E-mail: ccip@apta.org  |  Postal Mail: CCIP, 1111 N. Fairfax Street, Alexandria VA 22314
## CREDENTIALED CLINICAL INSTRUCTOR PROGRAM (CCIP)

### Directions:
1. This form must be submitted electronically to ccip@apta.org no later than 3 weeks in advance of the course start date. Per program policy, any forms received after the 3 week deadline may be assessed a $100 late fee.
2. A copy of this form must also be mailed to APTA in advance of the course start date along with payment. In compliance with Payment Card Industry (PCI) standards, **payment information may not be e-mailed to APTA**. For direct routing, please mail to “CCIP, 1111 N. Fairfax Street, Alexandria VA 22314.”
3. **After the course**, confirm each participant’s attendance in the final columns and email the updated form to ccip@apta.org.

### Manual Order Form

**CCIP Course Start Date:**

**Sponsoring Organization:**

**Total Amount of Order:**

**Contact Person:**

**Primary Phone Number:**

**E-mail:**

**Shipping Address:**

(No P.O. Boxes)

### Trainer Section Assignments

### Applicant Name | Employer | APTA Member Number | Member Price | Non-Member Price | Other Discipline Price | Attended Course | Passed Assessment
--- | --- | --- | --- | --- | --- | --- | ---
21
22
23
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43
44
45

| Column Totals | $ - | $ - | $ - | - |

| Page 2 Total | $ | - |
CREDENTIALED CLINICAL INSTRUCTOR PROGRAM (CCIP)

Participant Dossier

Each participant must complete and submit this form electronically to receive CEU credit and the CCIP credential.

Participant Name: ________________________________ DOB: ________________________________

APTA ID Number: ________________________________ (nonmembers leave blank)

APTA members, certificates will be sent to your address on file at APTA. Please verify that your address is correct by visiting http://www.apta.org/apta/profile/MyProfile.aspx and update as needed. Then confirm your address by completing the fields below.

Current Address:
City: __________________________ State: ______ Zip: __________
Email Address: __________________________ Phone: __________________________

Professional Designation: □ PT □ PTA □ Non-PT Provider – (if yes, please specify):

Date graduated from an accredited PT/PTA Program:

Highest earned degree: □ Associate Degree (AA/AS) □ Professional Doctorate (DPT)
□ Baccalaureate/Certificate □ Post-professional Transition DPT (DPT)
□ Professional Master’s (MPT/MSPT) □ Post-professional Doctorate (PhD/EdD/ScD)

Number of years working as a clinician:

Number of years supervising students:

Number of students supervised in the last 5 years: □ 0 □ 1-2 □ 3-5 □ 6-10 □ 11-20 □ More than 20

State(s) in which licensed:
(Please provide a copy of your state practice license)

Do you grant permission for APTA to release your contact information for research purposes? □ Yes □ No

Do you grant permission for APTA to release your contact information for marketing purposes? □ Yes □ No

If necessary, please specify any special accommodations you require to complete this program:

Employer
City/State
Zip Code
Dates
From: __________ To: __________

To be completed by participant’s direct supervisor (e.g., Department Head/Senior Staff/CCCE/Program Director)

1. Applicant demonstrates clinical competence, professional skills, and ethical behavior in clinical practice and/or teaching. □ Yes □ No

2. Applicant demonstrates the maturity and professionalism to serve as a CI. □ Yes □ No

3. Applicant has demonstrated a willingness to work with students by pursuing learning experiences to develop knowledge and skills in the clinical/academic setting. □ Yes □ No

4. Applicant demonstrates a systematic approach to patient/client care and/or job responsibilities. □ Yes □ No

5. Applicant uses critical thinking in the delivery of health services or managing job responsibilities. □ Yes □ No

6. Applicant provides rationale, including evidence, for decision making in patient/client care. □ Yes □ No

7. Applicant demonstrates appropriate time management skills. □ Yes □ No

8. Applicant represents the profession positively by assuming responsibility for professional self-development. □ Yes □ No

9. Applicant interacts effectively with patients, colleagues, and other health professionals to achieve identified goals. □ Yes □ No

Participant’s Signature (electronic acceptable) __________________________ Signature & Title of Director Supervisor (electronic acceptable) __________________________
Discount Fees for Group Participation

The CCIP offers group discounts for participants attending the same program at the same time and employed by the same clinical facility/organization. Please see the Program Registration Fees policy for current group rate discounts and the registration fee structure. Both APTA members and nonmembers are eligible to receive these discounts if the prerequisite qualifications below are met.

Conditions:

Participants from a clinical facility or academic institution, who are employed by the same employer, are eligible to receive group discounts only if all of the following conditions are met:

- A group rate would apply to any one discipline or any combination of disciplines or APTA members or non-members.
- Participant are part-time or full-time employees of the same facility or institution
- Participants register at the same time for the same program
- Participants attend the same program on the same dates

Rationale:

Instituting a group rate for the CCIP provides a strong incentive to any clinical facility or academic program to sponsor 5 or more persons to complete either the CI Education segment of the program (for non-physical therapy providers) or both the CI Education and Credentialing segments of the program (PTs and PTAs). This will move the profession closer toward the goal of having more physical therapist clinical educators complete this program, thereby ensuring greater consistency in the advanced knowledge and skill base of the clinical teacher.

Process:

Clinical Trainers may implement this group rate policy when scheduling and advertising this program. Trainers or sponsors completing the CCIP Manual Order Form must indicate both the registrant’s name and the name of their employer and check off those other individuals from the same facility/organization. The applicable discounted rate should also be indicated for those persons eligible for the discount.

If you have any questions regarding this policy, please contact Clinical Instructor Credentialing staff at ccip@apta.org 800-999-2782, ext. 8528.
Course Refund Policy

It is mandatory that all CCIP registration materials include the program refund policy in writing. The refund policy is as follows:

Individuals must cancel their CCIP registration and request a refund 72 hours prior to the start date of the course and the CI course manual must be returned to APTA. The refund amount will be equivalent to the APTA portion of the registration fee only. Refund amounts less than $90.00 will be issued in the form of a credit voucher, applicable towards the purchase of any product from the APTA store or toward registration fees for courses or conferences. Credit vouchers will expire 6 months after the date of issue.

Refunds:

- Refunds will be issued once the updated CCIP Manual Order Form (with final two columns completed) is returned to APTA after completion of the course.

- Refunds will be issued in the same method as the original payment was received by APTA – either via check or a credit issued to the original credit card – and issued to the original payer.

Credit Vouchers:

- Credit vouchers will be issued once the updated CCIP Manual Order Form (with final two columns completed) is returned to APTA after completion of the course.

- Credits will be issued for payments from individual registrants (refunds will continue to be issued to organizational payers, i.e. universities, hospitals, etc.).

- Credits will expire 6 months after the date of issue.

- Credit vouchers can be used towards the purchase of any items from the APTA store or toward registration fees for APTA courses or conferences.

If you have any questions regarding this policy, please contact Clinical Instructor Credentialing staff at ccip@apta.org or 800/999-2782, extension 8528.
Foreign-educated physical therapists who are not licensed as physical therapists in the United States, its territories, or Canada, are eligible to participate in the CCIP under the following provisions:

1. The participant must be able to read, write, and speak English.
2. The participant must provide a copy of their international license/registration/certification as a physical therapist.
3. The participant is required to complete and submit all parts of the participant dossier form.

The CCIP fee-structure will remain the same ($90.00 for APTA members and $180.00 for non-members). Foreign-educated physical therapists may elect to join the APTA International Partners Program for $50.00 to be eligible for the member rate CCIP fee.

Program fees must be paid in U.S. dollars. Program fees are to be paid via credit card, check, or money order; purchase orders will not be accepted.

Foreign-educated physical therapists will be awarded 1.2 CEUs* for successful completion of the didactic component of the program. The participant need not complete the Assessment Center, and will not earn the Clinical Instructor Credential. The Clinical Instructor Credential is only awarded to physical therapists and physical therapist assistants licensed in the United States, its territories, and Canada.

All other program policies and deadlines remain in effect.

*Please note: Licensees should verify with their state licensing board for acceptance of continuing education units by reviewing the relevant state practice act and/or administrative code. For more information about licensure, visit http://www.apta.org/Licensure/.

If you have any questions regarding this policy, please contact Clinical Instructor Credentialing staff at ccip@apta.org or 800/999-2782, extension 8528.
## TRAINER'S CHECKLIST

<table>
<thead>
<tr>
<th>TIMING</th>
<th>TASK</th>
<th>TRAINER</th>
<th>NOTES/DECISIONS</th>
<th>HOST SITE/ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year</td>
<td>Preliminary discussion ie: CCIP</td>
<td>Days/dates</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Credentialed Clinical Trainer informs host site/organization of items for consideration and discussion</td>
<td>Program duration (2 or 3 days, evenings, two weekends, etc)</td>
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<td>Intended audience</td>
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<td>- Program/assessment center for beginning CI</td>
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<td>- Assessment Center alone for experienced physical therapy CI</td>
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<td></td>
<td></td>
<td>Estimated attendance</td>
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<td></td>
<td>General space requirements</td>
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<td></td>
<td></td>
<td>- large room</td>
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<td>- breakout rooms</td>
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<td>Audiovisual requirements</td>
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<td>- Screen</td>
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<td>- Microphone if needed</td>
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<td>- Podium</td>
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<td>- LCD projection with computer</td>
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<td>Station Managers for Assessment Center</td>
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<td></td>
<td>APTA fees</td>
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<td></td>
<td>- $90/APTA member</td>
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<td>- $180/physical therapy nonmember</td>
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<td>- $90 Canadian Physiotherapist (with APTA International Partners)</td>
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<td>- $230/non-physical therapy participant</td>
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<td>Group Rate Discounts (See policy for 5 or more persons)</td>
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<td>Copying costs</td>
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<td>Estimated attendance</td>
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<tr>
<td>1 year to 6 months</td>
<td>Trainer registers with APTA (800/999-2782 x8528;<a href="mailto:CCIP@apta.org">CCIP@apta.org</a>)</td>
<td>Confirms estimated attendance for ordering CI manuals</td>
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</tbody>
</table>

- **Confirm Program location and space availability**
- **Confirms dates**
- **Confirms structure of**
<table>
<thead>
<tr>
<th>TIMING</th>
<th>TASK</th>
<th>TRAINER</th>
<th>NOTES/DECISIONS</th>
<th>HOST SITE/ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months</td>
<td>Finalize design of program</td>
<td>Trainer sends host site/organization Participant Dossier (electronic) to include in the registration materials</td>
<td>Program duration *2 or 3 days, evenings, etc Program/Assessment Center and/or only the Assessment Center Maximum attendance Space requirements Large room for plenary - breakout room for each Station Finalize Program and Assessment Center schedule. Block times.</td>
<td>Program (2 or 3 days, evenings, several weekends, etc) - Decides upon intended audience - Program and Assessment Center - Assessment Center alone - Confirms Credentialed Clinical Trainer honoraria and reimbursed expenses</td>
</tr>
</tbody>
</table>

- **Program** (2 or 3 days, evenings, several weekends, etc)
  - Decides upon intended audience
    - Program and Assessment Center
    - Assessment Center alone
  - Confirms Credentialed Clinical Trainer honoraria and reimbursed expenses

- **6 months**
  - Finalize design of program
    - Trainer sends host site/organization Participant Dossier (electronic) to include in the registration materials
  - Program duration
    - *2 or 3 days, evenings, etc
  - Program/Assessment Center and/or only the Assessment Center
  - Maximum attendance
  - Space requirements
  - Large room for plenary
    - breakout room for each Station
  - Finalize Program and Assessment Center schedule. Block times.

- **Program registration fees set in advance**
- **Program announcement mailed**
<table>
<thead>
<tr>
<th>TIMING</th>
<th>TASK</th>
<th>TRAINER</th>
<th>NOTES/DECISIONS</th>
<th>HOST SITE/ ORGANIZATION</th>
</tr>
</thead>
</table>
| 3 months | Duplicate materials                       | • Trainer sends host site/organization clean copies of all materials to be duplicated to include:  
  - All Assessment Center  
  - Confidentiality form  
  - Overview of AC  
  - Program evaluation  
  • Trainer sends host site/organization instructions for collating and packaging information | • Program announcements emailed to APTA  
  
  NOTE: Final deadline for registration should be set one month out. |
| 2 months | Discussion between Credentialed Clinical Trainer and host site/organization as needed  
  • Discussion between host site/organization and location as needed | • Order CI Manuals from APTA based on maximum attendance – Complete Excel online APTA CI Manual Order Form with payment  
  (NOTE: if providing the Assessment Center for experienced CIs, they will each need to be mailed a CI Manual at least 4 weeks in advance for review purposes in advance)  
  | • Submit payments to APTA for each CI Manual used  
  - $90 per APTA member  
  (Canadian International Partners)  
  - $180 per physical therapy non-member  
  - $230 per non-physical therapy participant  
  - Group rate discount  
  |  
| 1 month | Finalize and confirm all arrangements     |                                                                         | • Mail CCIP Manuals to experienced physical therapy CIs taking the Assessment Center only  
  • Ensure registration forms are complete: including copies of licenses and APTA membership number with expiration date. Follow-up on incomplete forms.  
  • Collate and package all Assessment Center materials according to  
<p>|</p>
<table>
<thead>
<tr>
<th>TIMING</th>
<th>TASK</th>
<th>TRAINER</th>
<th>NOTES/DECISIONS</th>
<th>HOST SITE/ORGANIZATION</th>
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<td>1 Month (cont)</td>
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<td>directions provided.</td>
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<td>• Reconfirm arrangements at the program site:</td>
<td>• Reconfirm arrangements at the program site:</td>
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<td>- rooms</td>
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<td>- audiovisuals</td>
<td>- audiovisuals</td>
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<td>- food</td>
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<td>• Confirm individuals assisting with:</td>
<td>• Confirm individuals assisting with:</td>
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<td>- registration</td>
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<td>- assessment center</td>
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<td>- other</td>
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<td>2 weeks</td>
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<td>Program and Assessment Center</td>
<td>Program and Assessment Center</td>
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<td>• Finalize master list of program participants with addresses</td>
<td>• Finalize master list of program participants with addresses</td>
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<td>• Duplicate master list for program participants</td>
<td>• Duplicate master list for program participants</td>
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<td></td>
<td>• Divide master list into agreed upon number of groups for ease in negotiating Assessment Center</td>
<td>• Divide master list into agreed upon number of groups for ease in negotiating Assessment Center</td>
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<td></td>
<td></td>
<td></td>
<td>• Make 7 copies of group list for trainer</td>
<td>• Make 7 copies of group list for trainer</td>
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<td></td>
<td>Assessment Center Only</td>
<td>Assessment Center Only</td>
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<td></td>
<td>• Finalize master list of those attending the Assessment Center only</td>
<td>• Finalize master list of those attending the Assessment Center only</td>
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<td></td>
<td></td>
<td></td>
<td>• Divide list into agreed upon number of groups</td>
<td>• Divide list into agreed upon number of groups</td>
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<td></td>
<td>• Make 7 copies of group list for trainer</td>
<td>• Make 7 copies of group list for trainer</td>
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<tr>
<td>TIMING</td>
<td>TASK</td>
<td>TRAINER</td>
<td>NOTES/DECISIONS</td>
<td>HOST SITE/ORGANIZATION</td>
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<td>1 week</td>
<td>• Follow-up as needed with Credentialed Clinical Trainer and host site/organization</td>
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<tr>
<td>last day of program</td>
<td>• Collect Participant Dossiers to send to APTA</td>
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<td></td>
<td>• Collect Confidentiality Statements forms - retain</td>
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<td></td>
<td>• Collect Individual Score Reports from Assessment Center - retain</td>
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<td>within 2 weeks of program</td>
<td>• APTA Information</td>
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<td>• Scan/Email all Participant Dossiers to APTA</td>
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<td></td>
<td>• Complete Participant Summary Form with names of those passing the Assessment Center and those nonphysical therapy providers for CEUs only</td>
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<td>• Compile/complete and send electronic Trainer Aggregate Summary Evaluation Form to APTA and make copies if there were more than 1 Trainer teaching the program</td>
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<td>• Return unused CI Manuals to APTA</td>
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<tr>
<td>Section</td>
<td>Poor</td>
<td>Excellent</td>
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<tr>
<td>I. The Clinician as Clinical Educator</td>
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<tr>
<td>Presenter:</td>
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<td>II. Readiness to Learn</td>
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<td>Presenter:</td>
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<td>III. Facilitating Learning in the Clinical Environment</td>
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<td>Presenter:</td>
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<td>IV. Performance Assessment – The Clinical Environment</td>
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<td>Presenter:</td>
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<td>V. Legal, Regulatory, and ADA Issues in Clinical Education</td>
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<td>Presenter:</td>
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<td>VI. Managing the Exceptional Student and the Student with Problems in Clinical Education</td>
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<td>Presenter:</td>
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<td>VII. Program viewed as a whole</td>
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<td>How well did the sessions build effectively on each other and logically relate to one another?</td>
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<tr>
<td>VIII. Assessment Center</td>
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<td>How well did the assessment center thoroughly address the information presented in the program?</td>
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<td>IX. Course Materials</td>
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<td>How well did the course materials meet your needs?</td>
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</table>

Feedback for the Credentialed Trainer(s):

Comments on the Activities:

What do you feel could have improved this training program? (Feel free to continue on back side of page)
Train the Trainer Course  
APTA Credentialed Clinical Instructor Program  

Final Participant Self-Assessment

Participant Name: __________________________

Instructions: Respond to all questions provided. Circle the appropriate number to respond to questions 1-3 and add comments in the space provided to clarify your response.

1. Indicate your level of knowledge of and comfort with course content in the Credentialed Clinical Instructor Program (CCIP).

   1  2  3  4  5  6  7
   very uncomfortable  adequate  very comfortable

Comments:

2. Indicate your level of confidence in the delivery of course content from the CCIP.

   1  2  3  4  5  6  7
   not confident  adequate  very confident

Comments:

3. Indicate your level of readiness to independently organize and deliver the entire CCIP.

   1  2  3  4  5  6  7
   very unprepared  adequate  very prepared

Comments:
4. Complete the table by responding to the three questions below:
   a. What are your development needs to improve your delivery of the CCIP?
   b. How will you specifically address each of the needs?
   c. What resources or assistance are required to address each need?

<table>
<thead>
<tr>
<th>Developmental Need(s)</th>
<th>Objectives</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: I need additional feedback on how to more effectively deliver the course content with mixed or high level audiences.</td>
<td>Example: I will team teach my first two courses with experienced Credentialed Trainers, seeking feedback on ways to enhance my delivery of course content.</td>
<td>Example: Identify experienced Credentialed Clinical Trainers willing to co-teach the CCIP and provide me with feedback.</td>
</tr>
</tbody>
</table>

5. Check below any additional assistance that APTA could provide for you that would enhance your clinical instructor training development activities.

   _____ Identify Credentialed Clinical Trainers willing to co-teach with new trainers.
   _____ Identify Credentialed Clinical Trainers willing to mentor new trainers.
   _____ Communicate with trainers through APTA Hub community.
   _____ Remain current with revisions to program content and changes in CCIP-related policies as established by the CCIP Advisory Workgroup.
   _____ Provide training updates and opportunities during the annual CSM Trainer Forum.
   _____ Other suggestions (please specify)_________________________________________________
TRAINER COURSE
APTA CREDENTIALED CLINICAL INSTRUCTOR PROGRAM

FACULTY EVALUATION OF PARTICIPANTS

Final Faculty-Assessment  Participant Name: ______________________

Faculty Evaluator: ______________________

Instructions: Respond to all questions provided. Circle the appropriate number to respond to questions 1-3. Comment on the participant in the space provided to clarify your response.

1. Indicate the participant’s level of knowledge of and comfort with course content in the Credentialed Clinical Instructor Program.

   1 2 3 4 5 6 7
   very uncomfortable adequate very comfortable

Comments:

2. Indicate the participant’s level of confidence in the delivery of course content from the Credentialed Clinical Instructor Program (including integration of active teaching strategies and relevance to the level of the learners).

   1 2 3 4 5 6 7
   not confident adequate very confident

Comments:
3. Indicate the participant's level of readiness to independently organize and deliver the entire Credentialed Clinical Instructor Program.

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>1</td>
<td>very unprepared</td>
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<td>3</td>
<td>adequate</td>
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<td>very prepared</td>
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</table>

Comments:

4. Comment on the needs of the participant to teach the Credentialed Clinical Instructor Program

5. General impressions of and comments about the participant