

I-TECH



INTERNATIONAL  
TRAINING &  
EDUCATION  
CENTER ON HIV

# **Basics of Clinical Mentoring**

## **Facilitator Guide**



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## Sample Training Agenda

*NOTE: This schedule is approximate and reflects all nine sessions of this course. The length of sessions will be determined by participant knowledge, number of questions, and amount of discussion. These sessions do not have to be taught over 4 days in 1 week but may be covered across several days within 3 to 4 weeks. The training agenda should be adjusted according to the specific needs of each training.*

<b>Day 1</b>
08:30–09:00 Registration
09:00–09:15 Welcome address
09:15–10:45 Session 1: What is Clinical Mentoring
10:45–11:15 <i>Tea break</i>
11:15–12:00 Session 2: Building Relationships
12:00–13:00 <i>Lunch</i>
13:00–14:30 Session 3: Effective Communication and Feedback Skills (break for tea after 90 minutes)
14:30–15:00 <i>Tea break</i>
15:00–16:00 Session 3: Effective Communication and Feedback Skills (continued)
16:00–16:30 Evaluation and close
<b>Day 2</b>
08:30–08:45 Questions from Day 1
08:45–10:00 Session 4: Theories of Learning
10:00–10:30 <i>Tea break</i>
10:30–11:45 Session 5 : Clinical Teaching Skills
11:45–12:45 Session 6: Clinical Diagnosis and Decision-Making Skills
12:45–13:45 <i>Lunch</i>
13:45–15:15 Session 7: Addressing Systems Issues (break for tea after 90 minutes)
15:15–15:45 <i>Tea break</i>
15:45–16:15 Session 7: Addressing Systems Issues (continued)
16:15–16:45 Evaluation and close
<b>Day 3</b>
08:30–08:45 Questions from Day 2
08:45–10:00 Session 8: Case Studies
10:00–10:30 <i>Tea break</i>
10:30–12:00 Session 8: Case Studies (continued)
12:00–13:00 <i>Lunch</i>
13:00–14:00 Session 9: Program Orientation
14:00–14:30 <i>Tea break</i>
14:30–15:30 Session 9: Program Orientation (continued)
15:30–16:30 Final evaluation and close



# About This Course

## I. Overview

Mentoring is a challenging task that requires flexibility, skill in coordinating disparate stakeholders, excellent communication and relationship-building skills, and the ability to cope with rapid change of direction, in addition to possessing up-to-date clinical knowledge and teaching skills. This 3-day generic curriculum on basic mentoring skills aims to ensure that clinical mentors are well prepared for their work. Country projects can adapt and tailor this curriculum to meet their specific needs.

Topics covered within this curriculum include giving feedback effectively, rapport building, bedside teaching, addressing systems issues, starting a mentoring assignment, and accessing clinical resources. Sessions are designed based on principles of adult learning. They include a variety of participatory exercises and activities designed to build confidence and skills in clinical teaching, as well as provide guidance on how to approach a mentoring assignment.

## II. What will I teach in this course?

The aim of this training course is to provide participants with the skills and knowledge necessary to be an effective clinical mentor.

At the end of the course, it is expected that participants will be able to:

- Define clinical mentoring
- Identify mentoring strategies
- Explain the benefits of clinical mentoring
- Describe how to build a positive relationship with a mentee
- Demonstrate effective feedback and communication skills
- Explain how the principles of adult learning theory apply to clinical mentoring
- Apply the domains of learning to clinical mentoring
- Choose the appropriate mentoring strategy for a given teaching moment
- Identify the principles of evidence-based medicine
- Discuss strategies for addressing common systems issues at health care facilities
- Reflect on personal motivations and beliefs about mentoring

## III. How is this course organized?

The design of this course reflects the assumption that participants are professional health care workers who are well qualified, and who may have a wide variety of experience in the field of clinical mentoring. A variety of approaches to teaching and learning will be adopted, with the underlying assumption that participants are adult learners who will take considerable responsibility for their own learning. The focus will be on active learning and should emphasize the key knowledge and skills needed for individuals who will be serving as clinical mentors.

The course is a facilitator-led program and consists of nine sessions. Sessions include the following teaching/learning methods:

- Lecture
- Case studies
- Role plays
- Large and small group discussions
- Individual work

The sessions may be taught over the course of several days or across several weeks. On average, sessions will last between 1 and 3 hours. Participants will receive a morning, lunch, and afternoon break. Be flexible in your timing. The amount of time for each session will vary depending on participants' experiences with clinical mentoring and knowledge about the concepts you are teaching. If you have several participants who are new clinical mentors, you may need more time to address basic issues related to clinical mentoring for a longer period of time. Take advantage of more experienced participants who can help you train participants who have less knowledge of clinical mentoring.

Note that this curriculum can be used in its entirety, or alternatively, individual sessions may be selected to meet the needs of the audience and/or to accommodate time constraints.

Each session includes suggestions of how the content and timing should be organized. For sessions 1-7, these suggestions are more structured and may be followed exactly as they are laid out. Sessions 8-9 require some planning by the facilitator to adapt the content to the specific training context as well as to the needs of the each group of participants. See the facilitator instructions in each of these sessions for more guidance on session organization.

The knowledge and skills that participants bring to the course are important to the learning process and participants are encouraged to share their knowledge and skills, and to raise issues that they find challenging in their practice.

#### **IV. What ground rules are used during the training course?**

To help ensure that time spent at the training is both productive and enjoyable, there are some rules and procedures that we ask participants to follow. The following information includes details on general procedures for the course and requirements for completion of the course. These ground rules are not meant to constrain participants but to contribute to a quality learning environment for everyone.

##### **A. Identifying expectations**

At the beginning of the course, ask participants what they expect to learn from the course. Record this information on flip chart paper and keep it displayed for the duration of the course. Identify which expectations are within the description of the course and which fall outside. This will help participants understand what the course will and will not cover.

##### **B. Determining group norms**

It is important for course participants to establish and commit to their own group norms on the first morning of the course. Lead a brief brainstorming exercise at the beginning of the course to establish group norms. The following are examples of group norms:

- Respect each other's confidentiality
- Respect each other's contributions, questions, and opinions
- Be on time
- Participate fully in discussions and exercises
- If you must leave a session early, please inform the Course Director or facilitator for that session before the session begins
- Turn off mobile phones

## **V. What are the course materials?**

### **A. Participant Handbook**

Participants will receive a Participant Handbook, which serves as the primary textbook for this course. It was developed to enhance learning and participation in the course. The Participant Handbook contains the following information to help participants succeed in the course:

- Table of contents
- Training schedule
- About this course
- Course sessions:
  - Worksheets
  - Handouts
  - Copies of PowerPoint slides with background information

Facilitators are expected to refer to the Participant Handbook during each session throughout the training course so that participants can follow along.

If the Participant Handbook is not available, facilitators can make copies of all handouts and worksheets from the Facilitator Guide.

### **B. Facilitator Guide**

This Facilitator Guide was developed to enhance teaching and effective facilitation of this course. It contains the following information to help trainers succeed in the course:

- Table of contents
- Training schedule
- About this course
- Course sessions:
  - Session outlines
  - Handouts
  - Worksheets with answers
  - Copies of PowerPoint slides with background information and facilitator instructions

## **VI. How can I teach this course most effectively?**

There are five important things that you can do as a facilitator to help create an effective learning atmosphere for yourself, faculty, participants, and other facilitators.

### **A. Master the content**

Facilitators should thoroughly familiarize themselves with the curriculum. This is especially important because some of the presentations will have fewer speaker notes. As facilitator, you should know: 1) where issues raised in one presentation are discussed at greater depth in a later presentation, 2) the issues that are and are not covered in the 3-day training, and 3) where the curriculum offers trainers choices for presenting or not presenting, based on time and audience level of knowledge. Finally, facilitators also need to know in advance of each day where special preparation is required.

### **B. Prepare**

Prior to implementing the course, you should select methods for conducting introductions, reviewing expectations, and establishing group norms. Identify ice-breakers and energizers to use throughout the course to raise the energy levels of the group.

### **C. Help build an atmosphere of trust and support**

One of the best ways to help build an atmosphere of trust and support is to listen thoughtfully to the ideas of participants, and provide constructive feedback that will help improve everyone's learning. Let someone know if they've said or done something that you like. Learn and use people's names. Look at individuals as they are speaking, nod your head in understanding, or use facial expressions that indicate, "I'm listening." Finally, assist participants if you see they are having a challenging moment. The best learning takes place in a humane environment; help build one!

### **D. Maintain a positive attitude**

There will be times during the course when you might say to yourself, "I'm so tired!" That's okay to say because you will be working hard and expending a lot of energy teaching new ideas to participants. But try to stay positive and productive as you participate in each session. Negativity does not support a quality learning environment.

### **E. Involve others in the learning process**

Participants are the most valuable resource in a training course. They help each other learn through sharing relevant work experiences and providing different perspectives. Ask participants questions, engage them in conversation, and ask them to share relevant examples from their own work experience. Consider fellow facilitators, faculty, and participants as resources, and the learning experience will be enriched for all involved.

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## **Session 1: What Is Clinical Mentoring**

### **Facilitator Guide**

#### **Basics of Clinical Mentoring**



# Session 1: What Is Clinical Mentoring

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**Time: 90 minutes (1 hour, 30 minutes)**

## Learning Objectives

By the end of this session, participants will be able to:

- Define clinical mentoring and distinguish it from supportive supervision
- Understand the rationale for, and objectives of, clinical mentoring
- Outline characteristics of effective mentors
- Explain challenges to mentoring

## Session Overview

Step	Time	Method	Title	Resources
1	5 minutes	Presentation	Session Introduction (slides 1-2)	LCD or overhead projector
2	15 minutes	Brainstorm	Defining Clinical Mentoring (slides 3-6)	LCD or overhead projector Flip chart and markers
3	10 minutes	Presentation	Components of Clinical Mentoring (slides 7-12)	LCD or overhead projector
4	15 minutes	Discussion Presentation	Mentoring vs. supportive supervision (slides 13-15)	LCD or overhead projector Flip chart and markers Handout 1.1
5	10 minutes	Discussion Presentation	Characteristics of effective mentoring (slides 16-17)	LCD or overhead projector Flip chart and markers
6	30 minutes	Activity Presentation	Challenges in Conducting Clinical Mentoring (slides 18-20)	LCD or overhead projector Flip chart and markers
7	5 minutes	Presentation	Key Points (slide 21)	LCD or overhead projector



## Resources Needed

- LCD or overhead projector
- Flip chart and markers



## Handouts

- Handout 1.1: Mentoring vs. Supportive Supervision (Slide 14)

## Key Points

- Clinical mentoring seeks to strengthen district health care systems by providing continuing education to health care workers (HCWs), and working towards creating more efficient clinical settings.
- Clinical mentoring involves relationship-building, identifying areas for improvement, coaching and modeling, advocacy, and data collection and reporting.
- Effective mentors are respectful, teach and learn, are adept at physical diagnosis, and enthusiastic about teaching.

# Training Material

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## Trainer instructions: Step 1 (slides 1-2) – 5 minutes

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Present slides 1-2, Introduction and Learning Objectives, and provide participants an introduction to this session.

<b>Slide 1</b>	 <p><b>Session 1:</b> <b>What is Clinical Mentoring</b></p> <hr/> <p>Basics of Clinical Mentoring</p>	
<b>Slide 2</b>	<p><b>Learning Objectives</b></p> <hr/> <p>By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"><li>■ Define clinical mentoring and distinguish it from supportive supervision</li><li>■ Understand the rationale for, and objectives of, clinical mentoring</li><li>■ Outline characteristics of effective mentors</li><li>■ Understand challenges to mentoring</li></ul>  <p>Session 1: What is Clinical Mentoring</p>	



## Trainer instructions: Step 2 (slides 3–6) – 15 minutes

At slide 3, conduct a group brainstorm on the definition of clinical mentoring, using the slide notes to guide the activity. Use slides 4–6 to summarize the brainstorm and define clinical mentoring.

<b>Slide 3</b>	<p><b>Partner Brainstorm</b></p> <hr/> <p><b>What Is Clinical Mentoring?</b></p>  <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</small></p> <p><small>Session 1: What Is Clinical Mentoring</small></p> <p><small>Slide 3</small></p>	<p><i>Ask participants to discuss with someone next to them what clinical mentoring is. Ask participants to share their definitions with the group. Present the next two slides, which define and provide rationale for clinical mentoring.</i></p>
<b>Slide 4</b>	<p><b>Clinical Mentoring Definition</b></p> <hr/> <p>A sustained, collaborative relationship in which a highly experienced health care provider guides improvement in the quality of care delivered by other providers and the health care systems in which they work.</p> <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</small></p> <p><small>Session 1: What Is Clinical Mentoring</small></p> <p><small>Slide 4</small></p>	<p>There are a variety of definitions for clinical mentoring. The most important components are:</p> <ul style="list-style-type: none"><li>• Clinical mentors are experienced clinician trainers who provide case review, problem solving, quality assurance and continuing education.</li><li>• They provide increased access to hands-on HIV training for health care workers in resource-poor settings.</li><li>• A mentor’s ultimate goal is to help each team member to be the best they can be, and do the best job possible to help maximize the number of positive outcomes for PLHIVs.</li></ul>

## I-TECH's Definition of What Clinical Mentors Do

I-TECH approach includes 5 key components:

- Building relationships
- Identifying areas for improvement
- Responsive coaching and modeling of best practices
- Advocating for environments conducive to good patient care and provider development
- Collecting and reporting on data



Session 1: What is Clinical Mentoring

Slide 5

**Building relationships.** Establishment of a trusting and receptive relationship between the mentor and mentee(s) is the foundation for an effective mentoring experience. This component is ongoing over the course of the mentorship, as the relationship continues to evolve and grow.

**Identifying areas for improvement.** This component involves observation and assessment of existing systems, practices, and policies to identify areas for improvement. I-TECH has developed a number of tools that can help with this assessment phase. Information obtained during this assessment helps to inform the establishment of goals and objectives for the mentorship.

**Responsive coaching and modeling of best practices.** Mentors must demonstrate proper techniques and model good practices. During on-site mentoring, this means examining patients along with the mentee; using appropriate, systemic examination techniques with gloves when appropriate; and hand washing. Mentorship is as much about setting a good example as it is about directly intervening to improve mentee practice.

**Advocating for environments conducive to quality patient care and provider development.** This component relates to technical assistance in support of systems-level changes at the site. Mentors work with colleagues to enhance the development of clinical site infrastructure, systems, and approaches that can support the delivery of comprehensive HIV care. For example, mentors might provide technical assistance in support of proper flow of patients at the facility, advocate for provision of privacy for patients during examination, or help to promote a multidisciplinary approach to HIV care at the site.

**Collecting and reporting on data.** Mentors support the use and integration of patient data into clinical practice, and can help to demonstrate the utility of data collection and reporting to mentees during the mentorship. For example, in Tamil Nadu, data on patients lost to follow-up was collected and discussed with mentees, which led to an analysis of causes and solutions, and ultimately to a decrease in the cases lost. A similar positive result occurred with analysis of time of initiation of ART in TB-HIV co-infected patients. Mentors guide using these 5 steps.

Source: WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained areas. Proceedings of the Planning Consultation on Clinical Mentoring: Approaches and Tools to Support Scaling-up of Antiretroviral Therapy and HIV Care in Low-resource Settings, Geneva, Switzerland, 2005 March 7-8; and the Working Meeting on Clinical Mentoring: Approaches and Tools to Support the Scaling-up of Antiretroviral Therapy and HIV Care in Low-resource Settings, Kampala, Uganda, 2005 June 16-18. World Health Organization; 2006. p. 47.

## Why Clinical Mentoring?

- Decentralization of HIV care and ART
- Strengthening the district health care system
- Task-shifting
- Transitioning to chronic HIV care
- Standardized content and care pathways
- Continuing education



Session 1: What is Clinical Mentoring

Slide 6

**Decentralization:** Decentralization to district health centers and hospitals allows increased access, equity, and better support of adherence to ART.

**Strengthening district health centers:** Decentralizing HIV care and ART requires capacity-building at 1<sup>st</sup> and 2<sup>nd</sup> level facilities so they can provide services that have previously been restricted to specialized referral centers.

**Task shifting:** Tasks can be shifted from more-specialized to less-specialized health care workers—research shows that non-specialist doctors, clinical officers, and nurses can effectively deliver HIV-related clinical services, including ART.

**Transitioning:** Because many resource-constrained countries are starting to provide life-sustaining ART, more people will be engaging with the health care system in an ongoing, chronic care relationship for the rest of their lives. The care system will help them as they work to manage their illnesses, adhere to treatment, and self-manage simple symptoms.

**Standardized content and care pathways:** Standardized, simplified clinical protocols and operating procedures make task-shifting easier. Such protocols should be displayed and easily-referenced.

**Continuing education:** Few countries have a continuing education system, so there is little follow-up with trainees after initial training.

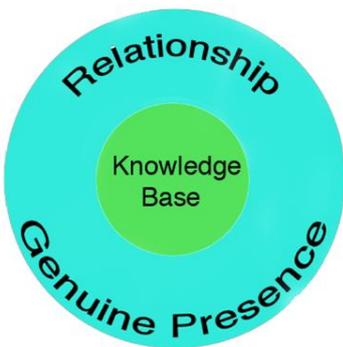
Expertise in managing ART and opportunistic infections is often **not** available in health care teams in various settings that are rapidly scaling up their HIV treatment services.

Source: WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained areas. Proceedings of the Planning Consultation on Clinical Mentoring: Approaches and Tools to Support Scaling-up of Antiretroviral Therapy and HIV Care in Low-resource Settings, Geneva, Switzerland, 2005 March 7-8; and the Working Meeting on Clinical Mentoring: Approaches and Tools to Support the Scaling-up of Antiretroviral Therapy and HIV Care in Low-resource Settings, Kampala, Uganda, 2005 June 16-18. World Health Organization; 2006. p. 4-6.

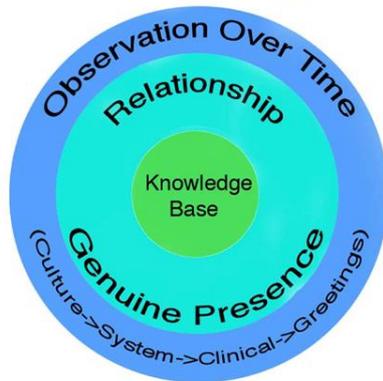


## Trainer instructions: Step 3 (slides 7-12) – 10 minutes

Present slides 7-12 and discuss the components of clinical mentoring.

<b>Slide 7</b>	<p><b>Components of Mentoring (1)</b></p>  <p>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</p> <p>Session 1: What is Clinical Mentoring</p> <p>Slide 7</p>	<ul style="list-style-type: none"><li>• While the clinical mentor should have a superb knowledge base, the next slides show the multifaceted nature of mentoring, and the importance of components outside of clinical knowledge.</li><li>• It is crucial that the mentor have up-to-date information, with a solid base of knowledge about HIV disease management, as care and treatment approaches change rapidly.</li></ul>
<b>Slide 8</b>	<p><b>Components of Mentoring (2)</b></p>  <p>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</p> <p>Session 1: What is Clinical Mentoring</p> <p>Slide 8</p>	<ul style="list-style-type: none"><li>• What you do as a mentor is really all about relationships. You are fully present and empathetic, and you find ways to connect, with heart, to another human being.</li><li>• Building this relationship takes time, and is an ongoing process, even over years of working together.</li><li>• Think about the core values you share with this human being. Many peoples' list includes a commitment to:<ul style="list-style-type: none"><li>• Optimal care for PLHIV</li><li>• Lifelong learning</li><li>• Advocacy of basic human rights and women's rights</li><li>• A credo of ethical medical care</li><li>• The idea that all people have a right to medical care</li></ul></li><li>• It is important to communicate to the mentee that you want to be there. Keep in mind that you are a guest in their space, and this should be respected always.</li></ul>

### Components of Mentoring (3)



Session 1: What is Clinical Mentoring

Slide 9

- As a mentor, you must begin by paying attention. You are making careful observations about what is already going on, at every level. This means learning about the culture and the setting you are visiting.
- You observe the system of care, the teamwork among the staff, and the knowledge and clinical skills of the ones you are mentoring. For each team member there are skills to observe.
  - How does the pharmacist educate the patient?
  - How does the counselor teach adherence?
  - How does the receptionist help the new client feel comfortable?
- There may be opportunities to discuss stigma, confidentiality, etc. These are subtleties that are important to recognize when you are mentoring.
  - How does the health care worker greet the next patient? Do they just yell out the name of the next patient or do they walk out to greet them?

## Components of Mentoring (4)



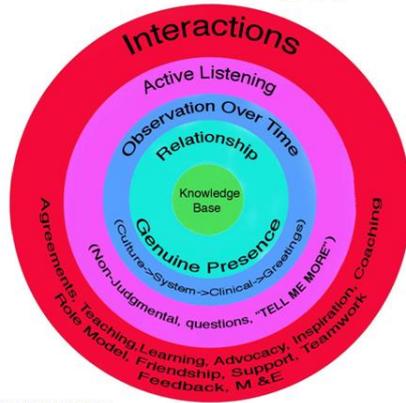
Session 1: What is Clinical Mentoring

Slide 10

- Beyond your observations, you must be actively listening. This means paying attention to the patient, health care worker, pharmacist, counselor, nurse, data entry person.
- Mentors must listen without judgment.
- The question of “why” is integral to good mentoring:
  - “Tell me why you ordered that medication for the side effect.”
  - “Tell me why you decided to order the chest x-ray.”
- Open-ended questions are useful for learning the mentee’s motivation. Open-ended questions are questions that cannot be answered with a single word, and therefore encourage meaningful answers.
- Open-ended questions often begin with “Tell me,” “Why,” or “How.” Compare the following ways of asking the same thing:
  - “You didn’t think cotrimoxazole prophylaxis was indicated for this patient?”
  - “Tell me more about your decision not to start cotrimoxazole prophylaxis with this patient.”

Slide 11

### Components of Mentoring (5)



Session 1: What is Clinical Mentoring

Slide 11

Mentors are role models all the time: The way mentor looks, approaches patients, speaks, etc.

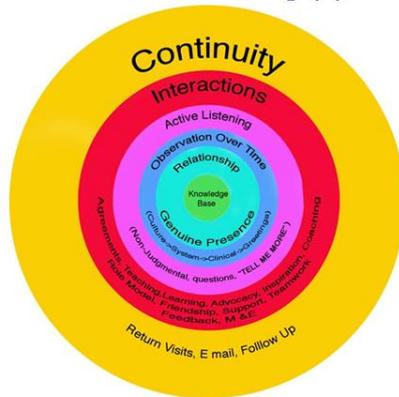
- How you act with patients and colleagues will be noticed.
- In each interaction your relationship and communication skills are crucial.

Feedback is given from mentor to mentee, but also from mentee to mentor.

- Mentors are always learning, the learning does not stop when you are a mentor.

Slide 12

### Components of Mentoring (6)



Session 1: What is Clinical Mentoring

Slide 12

- Growth and learning happen over time. Relationships deepen over time. Ideally there will be return visits, ongoing emails or mobile calls, or some other form of follow-up and continuation, but that is not always feasible.
- In rural areas, mobile consults are one way to achieve continuity. In one I-TECH program, nurses in HIV clinics have the mobile phone numbers of nurse mentors to get immediate answers to questions.



## Trainer instructions: Step 4 (slides 13–15) – 15 minutes

Differentiate between mentoring and supportive supervision. Slide 13 contains a group activity; use the instructions in the slide notes to conduct the activity. Present slide 14 to summarize the activity. Review the diagram on slide 14 and in Handout 1.1 to summarize the activity.

Present the differences between mentoring and preceptorship in slide 15.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 13</b></p>	<p><b>Activity:</b> <b>Mentoring vs. Supportive Supervision (1)</b></p> <p>What activities/duties fall in each category?</p> <p>Which fall into both categories?</p>  <p><small>Session 1: What is Clinical Mentoring</small></p> <p style="text-align: right;"><small>Slide 13</small></p>	<ul style="list-style-type: none"> <li>• Place two pieces of flip chart paper on the wall in the room. One should have the heading “Supportive Supervision” the other “Mentoring.”</li> <li>• Ask participants to call out activities that fit into each category. List them on the respective flip charts. If the activity is something that should fit in both categories, participants should identify it as such, and it should be circled.</li> <li>• Use the diagram on the next slide shows to review key activities that fall into each category and those that fall into both categories.</li> </ul>			
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 14</b></p>	<p><b>Mentoring vs. Supportive Supervision (2)</b></p> <table border="1" data-bbox="308 1151 855 1525"> <tr> <td data-bbox="308 1151 475 1525"> <p><b>Supportive supervision</b></p> <ul style="list-style-type: none"> <li>• Space, equipment, forms</li> <li>• Supply chain management</li> <li>• Training, staffing, other human resource issues</li> <li>• Entry points</li> <li>• Patient satisfaction</li> </ul> </td> <td data-bbox="475 1151 655 1525"> <ul style="list-style-type: none"> <li>• Patient flow and triage</li> <li>• Clinic organization</li> <li>• Patient monitoring and record-keeping</li> <li>• Case mgmt. observation</li> <li>• Team meetings</li> <li>• Review of referral decisions</li> </ul> </td> <td data-bbox="655 1151 855 1525"> <p><b>Clinical mentoring</b></p> <ul style="list-style-type: none"> <li>• Clinical case review</li> <li>• Bedside teaching</li> <li>• Journal club</li> <li>• Morbidity and mortality rounds</li> <li>• Assist with care and referral of complicated cases</li> <li>• Available via distance communication</li> </ul> </td> </tr> </table>  <p><small>Session 1: What is Clinical Mentoring</small></p> <p style="text-align: right;"><small>Slide 14</small></p>	<p><b>Supportive supervision</b></p> <ul style="list-style-type: none"> <li>• Space, equipment, forms</li> <li>• Supply chain management</li> <li>• Training, staffing, other human resource issues</li> <li>• Entry points</li> <li>• Patient satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>• Patient flow and triage</li> <li>• Clinic organization</li> <li>• Patient monitoring and record-keeping</li> <li>• Case mgmt. observation</li> <li>• Team meetings</li> <li>• Review of referral decisions</li> </ul>	<p><b>Clinical mentoring</b></p> <ul style="list-style-type: none"> <li>• Clinical case review</li> <li>• Bedside teaching</li> <li>• Journal club</li> <li>• Morbidity and mortality rounds</li> <li>• Assist with care and referral of complicated cases</li> <li>• Available via distance communication</li> </ul>	<p>See Handout 1.1 for this diagram.</p> <p>Source: WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained areas. Proceedings of the Planning Consultation on Clinical Mentoring: Approaches and Tools to Support Scaling-up of Antiretroviral Therapy and HIV Care in Low-resource Settings, Geneva, Switzerland, 2005 March 7-8; and the Working Meeting on Clinical Mentoring: Approaches and Tools to Support the Scaling-up of Antiretroviral Therapy and HIV Care in Low-resource Settings, Kampala, Uganda, 2005 June 16-18. World Health Organization; 2006. p. 47.</p>
<p><b>Supportive supervision</b></p> <ul style="list-style-type: none"> <li>• Space, equipment, forms</li> <li>• Supply chain management</li> <li>• Training, staffing, other human resource issues</li> <li>• Entry points</li> <li>• Patient satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>• Patient flow and triage</li> <li>• Clinic organization</li> <li>• Patient monitoring and record-keeping</li> <li>• Case mgmt. observation</li> <li>• Team meetings</li> <li>• Review of referral decisions</li> </ul>	<p><b>Clinical mentoring</b></p> <ul style="list-style-type: none"> <li>• Clinical case review</li> <li>• Bedside teaching</li> <li>• Journal club</li> <li>• Morbidity and mortality rounds</li> <li>• Assist with care and referral of complicated cases</li> <li>• Available via distance communication</li> </ul>			





## Supportive supervision

- Space, equipment, forms
- Supply chain management
- Training, staffing, other human resource issues
- Entry points
- Patient satisfaction

- Patient flow and triage
- Clinic organization
- Patient monitoring and record-keeping
- Case management observation
- Team meetings
- Review of referral decisions

## Clinical mentoring

- Clinical case review
- Bedside teaching
- Journal club
- Morbidity and mortality rounds
- Assist with care and referral of complicated cases
- Available via distance communication



## Mentor ≠ Preceptor

### Mentor

- Guides mentee through entire course of training: physical exam to advanced, complex, end-of-life care
- 2-way discussion with open-ended questions
- Teaches by modeling, not only intellectual skills but also empathy/compassion

### Preceptor

- Works alongside student, directs his/her learning by telling him/her what to look for, how to look for it
- Telling, not showing



Session 1: What is Clinical Mentoring

Slide 15

- The “preceptor” model is more directive than the clinical mentoring model.
- Many medical professionals were trained with a preceptor model, so it may be the default teaching style
- Mentoring, however, employs different techniques, and is more of an even, two-way discussion than a question-and-answer session led by the mentor.
- Depending on the level of the mentee, a mentor may need to use the preceptor model to teach a mentee. As the mentee becomes more clinically efficient, the mentor should emphasize mentoring technique more often.



## Trainer instructions: Step 5 (slides 16-17) – 10 minutes

Present slides 16-17, characteristics of a good mentor and positive mentor relationships, in discussion format.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 16</b> <b>Animation Clicks: 5</b></p>	 <h3>Characteristics of a Good Mentor</h3> <ul style="list-style-type: none"> <li>■ Adept at physical diagnosis <ul style="list-style-type: none"> <li>▪ Working knowledge of possible diagnoses and issues that may need addressing</li> </ul> </li> <li>■ Enthusiastic and comfortable incorporating diverse situations/experiences into teaching</li> <li>■ Takes a “back-seat” approach to teaching, avoiding extensive lectures <ul style="list-style-type: none"> <li>▪ Allows mentor to explore and learn on his/her own</li> </ul> </li> <li>■ Understanding of clinical systems to address systemic issues</li> </ul> <p style="font-size: small;">Session 1: What is Clinical Mentoring <span style="float: right;">Slide 16</span></p>	<ul style="list-style-type: none"> <li>• <i>Lead participants in a brainstorm about characteristics of a good mentor.</i></li> <li>• <i>NOTE: This slide is animated, so each click will reveal another characteristic.</i></li> <li>• Remember that mentoring is not just for clinical procedures, but for systems as well.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 17</b> <b>Animation Clicks: 8</b></p>	 <h3>Characteristics of Effective Mentorship Relationships</h3> <ul style="list-style-type: none"> <li>■ Relationship is warm, safe, respectful, trustful</li> <li>■ Both mentor and mentee want to be involved in mentoring relationship</li> <li>■ Mentor listens to learner and the learner knows it</li> <li>■ Mentor/mentee are able to process misunderstandings</li> <li>■ Continuity of the relationship over time</li> <li>■ Power is shared</li> <li>■ Learning is two-way; mentor is interested in learner’s ideas</li> </ul> <p style="font-size: small;">Session 1: What is Clinical Mentoring <span style="float: right;">Slide 17</span></p>	<ul style="list-style-type: none"> <li>• <i>Lead participants in a brainstorm about effective mentor relationships.</i></li> <li>• <i>NOTE: This slide is animated, so each click will reveal another characteristic.</i></li> <li>• Relationship-building continues over the span of the mentorship—even years into the relationship.</li> <li>• Can think about mentoring as a dance between the mentor and mentee—it is fluid, with each person requesting information from the other, back and forth. <ul style="list-style-type: none"> <li>• Mutual learning</li> </ul> </li> </ul>



## Trainer instructions: Step 6 (slides 18–20) – 30 minutes

Conduct the “Challenges in Conducting Clinical Mentoring” activity on slide 18, using the slide notes to guide the activity. Use slides 19–20 to review other challenges to mentoring.

<p>Slide 18</p>	<p><b>Activity</b></p> <p>What are some challenges in conducting clinical mentoring?</p>  <p>Session 1: What is Clinical Mentoring</p> <p>Slide 18</p>	<ul style="list-style-type: none"><li>• Ask participants to brainstorm some of the challenges in conducting clinical mentoring. Record their responses on flip chart paper.</li><li>• When you have a decent list, divide participants into groups of 4 or 5. Assign each group 1 challenge and instruct them to identify strategies for overcoming these challenges. If there are too many challenges, have the group decide which ones are most important and address those.</li><li>• Have each group present its challenge and strategies.</li></ul> <p><i>Examples of challenges:</i></p> <ul style="list-style-type: none"><li>• Being able to assess different learning levels and adjust your teaching accordingly.</li><li>• In a busy clinic setting, there is often not much time to provide teaching or feedback, especially when a patient is in the room.</li><li>• Learning to teach without interfering too much with patient visits.</li><li>• Must be flexible to identify teaching opportunities for each clinical encounter.</li><li>• Staff reacting defensively when you suggest new approaches to their practice.</li></ul> <p><i>The next two slides list some possible challenges to review with participants.</i></p>
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<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 19</b></p>	<p><b>Challenges to Mentoring (1)</b></p> <hr/> <p>Obstacles to health care working (HCW) learning:</p> <ul style="list-style-type: none"> <li>■ Stress due to intra-clinic factors (e.g., heavy patient load, disorganization)</li> <li>■ Personal distractions</li> <li>■ HCWs stressed by mentor's presence in clinic</li> </ul>  <p style="font-size: small;">Session 1: What is Clinical Mentoring <span style="float: right;">Slide 19</span></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 20</b></p>	<p><b>Challenges to Mentoring (2)</b></p> <hr/> <ul style="list-style-type: none"> <li>■ Defensiveness</li> <li>■ Putting on one's "best show," not the typical show, for the visiting mentor</li> <li>■ Bad (as opposed to best) practices</li> <li>■ Varying availability of resources from clinical site to clinical site</li> <li>■ Clinical site infrastructure and systems in need of mentoring</li> </ul>  <p style="font-size: small;">Session 1: What is Clinical Mentoring <span style="float: right;">Slide 20</span></p>	<ul style="list-style-type: none"> <li>• The arrival of a mentor can be a set up for defensiveness in our colleagues, "What? You don't think I know what I am doing?"</li> <li>• We all like to put on our best when someone is watching, but those are not the "day to day" practices we want to help improve.</li> <li>• What to do when we directly observe "bad" as opposed to "best" practices? And what do we do when we encounter unethical practices?</li> <li>• More interpersonal challenges to mentoring will be discussed in the next unit.</li> </ul>



## Trainer instructions: Step 7 (slide 21) – 5 minutes

Review the key points and ask participants if they have any remaining questions.

<p>Slide 21</p>	<p><b>Key Points</b></p> <ul style="list-style-type: none"><li>■ Clinical mentoring seeks to strengthen district health care systems by providing continuing education to HCWs, and working towards creating more efficient clinical settings.</li><li>■ Clinical mentoring involves relationship-building, identifying areas for improvement, coaching and modeling, advocacy, and data collection and reporting.</li><li>■ Effective mentors are respectful, teach and learn, are adept at physical diagnosis, and enthusiastic about teaching.</li></ul>  <p>Session 1: What is Clinical Mentoring</p>	<ul style="list-style-type: none"><li>• <i>Present the key points and ask participants if they have any remaining questions from this presentation</i></li></ul>
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**I-TECH**



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## **Session 2: Building Relationships**

### **Facilitator Guide**

#### **Basics of Clinical Mentoring**



## Session 2: Building Relationships

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**Time: 45 minutes**

### Learning Objectives

By the end of this session, participants will be able to:

- Explain the importance of building a relationship with a mentee that is based on trust, mutual respect, and an understanding of cultural differences
- Identify potential barriers to relationship-building
- Identify techniques for building rapport
- Practice affirming statements

### Session Overview

Step	Time	Method	Title	Resources
1	5 minutes	Presentation	Introduction and Learning Objectives (slides 1-2)	LCD or overhead projector
2	10 minutes	Presentation Activity	Cultivating a Relationship (slides 3-5)	LCD or overhead projector Flip chart and markers Worksheet 2.1
3	5 minutes	Presentation	Rapport (slides 6-7)	LCD or overhead projector
4	15 minutes	Presentation Activity	Affirming Statements (slides 8-11)	LCD or overhead projector Flip chart and markers Worksheet 2.2
5	5 minutes	Presentation	Key Points (slide 12)	LCD or overhead projector



### Resources Needed

- LCD or overhead projector
- Flip chart and markers



## Worksheets

- Worksheet 2.1: Examining Cultural Differences
- Worksheet 2.2: Affirming Statements

## Key Points

- Relationships are the foundation of effective clinical mentoring.
- Strategies to build rapport include listening, patience, eye contact, use of affirming statements.
- There can be barriers to building mentorship relationships based on cultural differences and expectations, as well as personal factors. Mentors can come prepared with strategies to overcome these barriers.

# Training Material

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## Trainer instructions: Step 1 (slides 1-2) – 5 minutes

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Present slides 1–2, Introduction and Learning Objectives, and provide participants an introduction to this session.

<b>Slide 1</b>	 <p><b>Session 2:</b> <b>Building Relationships</b></p> <hr/> <p>Basics of Clinical Mentoring</p>	
<b>Slide 2</b>	<p><b>Learning Objectives</b></p> <hr/> <p>By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"><li>■ Explain the importance of building a relationship with a mentee that is based on trust and mutual respect</li><li>■ Identify potential barriers to relationship-building</li><li>■ Identify techniques for building rapport</li><li>■ Practice affirming statements</li></ul>  <p>Session 2: Building Relationships</p>	



## Trainer instructions: Step 2 (slides 3-5) – 10 minutes

Present slides 3–4 and provide an overview of what building relationships entails. Slide 5 contains an activity to encourage participants to think about cultural differences and how those may affect relationships. Use the instructions in the slides notes and Worksheet 2.1 to conduct this activity.

<p>Slide 3</p> <p>Animation Clicks: 1</p>	<h3>Building a Relationship (1)</h3> <p>Session 2: Building Relationships</p> <p>Slide 3</p>	<ul style="list-style-type: none"> <li>• <i>NOTE: slide is animated - click for arrow to appear</i></li> <li>• Remember this diagram from the last session.</li> <li>• A strong relationship is at the core of effective mentoring.</li> </ul>
<p>Slide 4</p>	<h3>Building a Relationship (2)</h3> <ul style="list-style-type: none"> <li>■ Mentor/mentee relationship can range from a week to months or years.       <ul style="list-style-type: none"> <li>■ It is necessary to find a way to connect with your mentee, even if the time frame is short.</li> <li>■ It is important to understand mentee's social and cultural environment.</li> <li>■ Note that methods of communication will vary according to age, social class, urban vs. rural setting.</li> </ul> </li> </ul> <p>Session 2: Building Relationships</p> <p>Slide 4</p>	

## Activity: Cultural Differences

Think about who you are and what kind of setting (cultural, socioeconomic, ethnic) you are coming from and compare that to your mentees' setting.



Session 2: Building Relationships

Slide 5

- Refer to Worksheet 2.1 and complete the worksheet in pairs.

*Participants should fill out the worksheet and discuss in pairs for 15 minutes.*

- *They should discuss the questions at the bottom of Worksheet 2.1 as well.*

*Debrief the questions at the following questions (also found at the bottom of the worksheet) as a large group:*

1. *How might the differences between your column and the mentee column affect your mentee's attitude:*
  - *Upon meeting you?*
  - *As you begin interacting with him/her?*
  - *As you begin providing feedback about his/her performance?*
2. *How might these differences affect your attitude:*
  - *Before meeting your mentee? Upon meeting him/her?*
  - *As you start building a relationship with him/her?*
3. *When confronted with situations that are not immediately comfortable, what are some steps you, as a mentor, can take in order to overcome the discomfort/mistrust?*
4. *If your columns are more similar than different, what implications might that have for your mentor/mentee relationship?*

*Explain that the following are some steps a mentor can take to overcome discomfort:*

- *Explain what he/she is doing and why.*
- *Be open and nonjudgmental about cultural practices/beliefs.*





## Worksheet 2.1: Examining Cultural Differences

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### Instructions:

- Fill out the chart below for yourself as the mentor. Then fill out the mentee column based on what you generally know about the people you will be mentoring.
- Pair up to discuss your charts and consider the questions below the chart. You will debrief these questions and this activity as a large group once you are finished.

	<b>You, the mentor</b>	<b>Your mentee(s)</b>
<b>Gender</b>		
<b>Race/ ethnicity</b>		
<b>National/ regional origin</b>		
<b>Language</b>		
<b>Age</b>		
<b>Profession</b>		
<b>Level of education</b>		
<b>Religion</b>		
<b>Other: health issues, etc.</b>		

1. How might the differences between your column and the mentee column affect your mentee's attitude:
  - a. Upon meeting you?
  
  - b. As you begin interacting with him/her?
  
  - c. As you begin providing feedback about his/her performance?
  
2. How might these differences affect your attitude:
  - a. Before meeting your mentee? Upon meeting him/her?
  
  - b. As you start building a relationship with him/her?
  
3. When confronted with situations that are not immediately comfortable, what are some steps you, as a mentor can take in order to overcome the discomfort/mistrust?
  
4. If your columns are more similar than different, what implications might that have for your mentor/mentee relationship?

## Trainer instructions: Step 3 (slides 6-7) – 5 minutes

Present slides 6-7 and discuss techniques used in building rapport.

<p>Slide 6</p>	<p><b>Rapport</b></p> <ul style="list-style-type: none"><li>■ Building a comfortable connection so that people can share information</li><li>■ Creating a relationship based on trust and respect</li><li>■ Created through both verbal and nonverbal actions</li></ul>  <p>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</p> <p>Session 2: Building Relationships</p> <p>Slide 6</p>	<ul style="list-style-type: none"><li>• Establishing rapport is the first phase of effective communication, which includes greeting, welcoming, showing that you care, and have time for the mentee.</li></ul>
<p>Slide 7 Animation Clicks: 1</p>	<p><b>Techniques for Building Rapport</b></p>  <ul style="list-style-type: none"><li>■ Shake hands</li><li>■ Introduce yourself</li><li>■ Use same language as mentee</li><li>■ Show patience, do not interrupt</li><li>■ Make eye contact (if appropriate)</li><li>■ Do not attend to other tasks while meeting with mentee</li><li>■ Say “yes”, “um-hum,” or a use a nonverbal gesture so they know you are interested and engaged</li><li>■ Use affirming statements</li></ul> <p>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</p> <p>Session 2: Building Relationships</p> <p>Slide 7</p>	<ul style="list-style-type: none"><li>• Ask participants to brainstorm techniques or strategies for building rapport.</li><li>• NOTE: Slide is animated, and entire list will appear with next click.</li><li>• The next slides will elaborate on affirming statements and will give participants some practice using them.</li></ul>



## Trainer instructions: Step 4 (slides 8-11) – 15 minutes

Present slides 8–10 and explain the components and effect of affirming statements. Use slide 10 to demonstrate what an affirmation dialogue could look like between a mentor and mentee. Slide 11 contains an activity to provide participants a chance to practice using affirming statements. Use the instructions in the slide notes and Worksheet 2.2 to conduct this activity.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 8</b></p>	<p><b>Affirming Statements</b></p> <ul style="list-style-type: none"> <li>■ Affirm: To acknowledge the positive in someone else to support and encourage that person to build upon his or her successes.</li> <li>■ Affirming statements are words of encouragement that increase mentees belief in themselves and their abilities.</li> </ul>  <p style="font-size: small;">Session 2: Building Relationships <span style="float: right;">Slide 8</span></p>	<ul style="list-style-type: none"> <li>• Using affirming statements is one technique used to help build rapport.</li> <li>• Affirmation encourages mentees to build upon their successes.</li> <li>• Modeling affirming statements will both encourage further success among mentees, as well as model behavior that health care workers (HCWs) can (and should) use with their patients.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 9</b></p>	<p><b>Affirming Statements: Examples</b></p> <ul style="list-style-type: none"> <li>■ <i>I can see that you really connect with your patients.</i></li> <li>■ <i>You handled that challenging situation very well.</i></li> <li>■ <i>That was a difficult diagnosis to make—well done!</i></li> <li>■ <i>I like the way that you spoke to the patient and his family.</i></li> </ul>  <p style="font-size: small;">Session 2: Building Relationships <span style="float: right;">Slide 9</span></p>	<p>Directly affirming and supporting the mentee during the mentoring process is an important way of building rapport and reinforcing your relationship, as well as encouraging exploration. Compliments or statements of appreciation and understanding are examples of affirming statements.</p> <ul style="list-style-type: none"> <li>• Affirmations will differ by culture and setting. The point is to appropriately and consistently appreciate the mentee’s strengths and efforts.</li> </ul> <p><i>Ask the mentors for other examples of affirming statements they can think of. Record these on a flip chart.</i></p>

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Slide 10 Animation Clicks: 1</p>	<p><b>Affirmation Dialogues</b></p> <ul style="list-style-type: none"> <li>■ Mentee: I almost forgot to give a physical exam!</li> <li>■ Mentor: But you remembered! You are really improving in that respect.</li>   <li>■ Mentee: I finally felt a connection with Mrs. V.</li> <li>■ Mentor: I noticed that she seemed to trust you!</li>   <li>■ Mentee: I was unsure of how to react to Mr. F's comment.</li> <li>■ Mentor: I liked how you answered in a nonjudgmental way.</li> </ul>  <p style="font-size: small;">Session 2: Building Relationships <span style="float: right;">Slide 10</span></p>	<ul style="list-style-type: none"> <li>• <i>NOTE: Slide is animated, so each example will be revealed with subsequent click.</i></li> <li>• <i>Have two participants read the dialogues on the slide, one as mentor, the other as mentee.</i></li>   <li>• These are three examples of dialogues between a mentor and mentee.</li> <li>• Note how these statements can be used to build mentees' self-confidence.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Slide 11</p>	<p><b>Activity: Affirming Each Other</b></p> <ul style="list-style-type: none"> <li>■ Write down 3-4 positive accomplishments or efforts you have made as a health care worker or in patient care.</li> <li>■ Pair up with a new partner.</li> <li>■ Take turns reading your accomplishments.</li> <li>■ Partner should respond with an affirming statement.</li> </ul>  <p style="font-size: small;">Session 2: Building Relationships <span style="float: right;">Slide 11</span></p>	<ul style="list-style-type: none"> <li>• The accomplishments do not have to be grand accomplishments, but rather can be small positive gains or even efforts that were not completely successful.</li> <li>• Refer to Worksheet 2.2 for this activity</li>   <li>• <i>Ask participants to follow the instructions on the slide.</i></li> <li>• <i>Allow participants 5 minutes to write down their accomplishments.</i></li> <li>• <i>Allow participants 5 minutes to work with a partner responding with affirming statements.</i></li> <li>• <i>Debrief the activity as a large group (allow 5 minutes) by asking:</i> <ul style="list-style-type: none"> <li>• <i>What was it like to hear affirming statements about your accomplishments?</i></li> <li>• <i>What was it like to offer affirming statements?</i></li> <li>• <i>How would this make a mentee feel?</i></li> <li>• <i>Why is it helpful and important to offer affirming statements?</i></li> </ul> </li> </ul>





## Worksheet 2.2: Affirming Statements

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### Instructions:

- Use the space provided below to write down three to four positive accomplishments or efforts you have made as a health care worker in patient care.
- Pair up with the person next to you. Read each of your accomplishments and allow your partner to respond with an affirming statement.
- Switch roles so each partner has the chance to read their accomplishments and provide affirming statements.
- Follow instructions from the facilitator to debrief this activity.

### Positive Accomplishments

1.

2.

3.

4.





## Trainer instructions: Step 5 (slides 12) – 5 minutes

Present the key points and ask participants if they have any further questions about this session.

<b>Slide 12</b>	<p><b>Key Points</b></p> <ul style="list-style-type: none"><li>■ Relationships are the foundation of effective clinical mentoring.</li><li>■ Strategies to build rapport include listening, patience, eye contact, use of affirming statements.</li><li>■ There can be barriers to building mentorship relationships, based on cultural differences and expectations, as well as personal factors. Mentors can come prepared with strategies to overcome these barriers.</li></ul>  <p>Session 2: Building Relationships</p> <p>Slide 12</p>	<p><i>Present the key points and ask if there are any further questions from this session.</i></p>
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## **Session 3: Effective Communication and Feedback Skills**

### **Facilitator Guide**

**Basics of Clinical Mentoring**



## Session 3: Effective Communication and Feedback Skills

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**Time: 150 minutes (2 hours, 30 minutes)**

### Learning Objectives

By the end of this session, participants will be able to:

- Identify the basic principles of feedback
- Explain the important role of feedback in the context of clinical mentoring
- Demonstrate effective communication styles and constructive feedback

### Session Overview

Step	Time	Method	Title	Resources
1	5 minutes	Presentation	Introduction and Learning Objectives (slides 1-2)	LCD or overhead projector
2	10 minutes	Presentation Large group discussion	Communication (slides 3-6)	LCD or Overhead Projector Flip chart and markers
3	45 minutes	Presentation Small group exercise	Active Listening, Reflective Listening, Summarizing (slides 7-16)	LCD or overhead projector Flip chart and markers
4	10 minutes	Presentation Brainstorm	Barriers to Communication (slides 17-18)	LCD or overhead projector Flip chart and markers
5	45 minutes	Presentation Role play Group discussion	Feedback (slides 19-36)	LCD or overhead projector Flip chart and markers Worksheet 3.1 Handout 3.2
6	30 minutes	Role play and discussion activity	Feedback Scenarios (slide 37)	LCD or overhead projector Worksheet 3.3
7	5 minutes	Presentation	Key Points (slide 38-39)	LCD or overhead projector



## Resources Needed

- LCD or overhead projector
- Flip chart and markers



## Worksheets

- Worksheet 3.1: PITC Scenario and Feedback Role Play
- Worksheet 3.3: Feedback Scenarios



## Handouts

- Handout 3.2: Basic Principles of Giving Feedback

## Key Points

- Good communication – both verbal and nonverbal – is essential for an effective mentoring relationship.
- Communication techniques, such as appropriate body language, active/reflective listening, and summarizing, can aid communication.
- Feedback is integral to adult learning, and is a vital component of the clinical mentoring relationship.

# Training Material

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## Trainer instructions: Step 1 (slides 1-2) – 5 minutes

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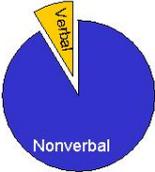
Present slides 1-2, Introduction and Learning Objectives, and provide participants an introduction to this session.

<b>Slide 1</b>	 <p><b>Session 3: Effective Communication and Feedback Skills</b></p> <hr/> <p>Basics of Clinical Mentoring</p>	
<b>Slide 2</b>	<p><b>Learning Objectives</b></p> <hr/> <p>By the end of the session, participants will be able to:</p> <ul style="list-style-type: none"><li>■ Identify the basic principles of feedback</li><li>■ Explain the important role of feedback in the context of clinical mentoring</li><li>■ Demonstrate effective communication styles and constructive feedback</li></ul>  <p><small>Session 3: Effective Communication and Feedback Skills</small></p>	<p>This session will present basic concepts about feedback, but will also try to look at feedback from within a clinical mentoring context.</p> <p><small>Slide 2</small></p>



## Trainer instructions: Step 2 (slides 3–6) – 10 minutes

Slides 3–6 provide an overview of mentor/mentee communication. Slide 5 contains a brief activity on perceptions of nonverbal communication. Use the slide notes to conduct the activity.

<b>Slide 3</b>	<h3>Mentor/Mentee Communication</h3> <ul style="list-style-type: none"><li>■ People like to learn from mentors who are sincere, approachable, and non-judgmental.</li><li>■ These qualities are communicated primarily by facial expressions, followed by tone, and, to a limited extent, by words.</li><li>■ People often remember more about <u>how</u> a subject is communicated than the speaker's knowledge of the subject.</li></ul>   <p>Session 3: Effective Communication and Feedback Skills <span style="float: right;">Slide 3</span></p>	
<b>Slide 4</b>	<h3>Types of Communication</h3> <p>Communication can be either:</p> <ul style="list-style-type: none"><li>■ <b>Verbal:</b> Spoken words</li><li>■ <b>Nonverbal:</b><ul style="list-style-type: none"><li>▪ The way we stand and sit</li><li>▪ Facial expressions</li><li>▪ Silence</li><li>▪ Eye contact</li><li>▪ Gestures (smiling, leaning forward, nodding)</li></ul></li></ul>   <p>Session 3: Effective Communication and Feedback Skills <span style="float: right;">Slide 4</span></p>	<ul style="list-style-type: none"><li>• Note that only 7 to 11% of all communication is verbal, and the rest is nonverbal.</li><li>• Nonverbal communication may not always match a verbal message.</li><li>• Differences in how messages are perceived can lead to confusion.</li></ul> <p><i>Ask participants to provide an example of when someone says one thing but seems to feel a different way.</i></p> <p><i>Some examples are:</i></p> <ul style="list-style-type: none"><li>• <i>Crying while saying, "I am fine."</i></li><li>• <i>Saying that you are listening when you are not making eye contact with the speaker and are looking all around the room while the speaker is speaking.</i></li><li>• <i>Saying that you are not bored or tired when you are yawning.</i></li></ul>

## Activity: Nonverbal Communication

What do these mean?



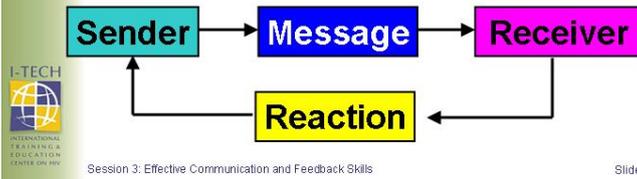
Session 3: Effective Communication and Feedback Skills

Slide 5

- Explain that we're going to do a quick exercise to test our perception of nonverbal communication.
- NOTE: this slide is animated to reveal clip art pictures one-by-one, depicting types of nonverbal communication
- Use the slide animated to reveal the clip-art pictures one-by-one and ask the group to write down the emotion the person in the image is feeling.
- After all images have been revealed, ask participants to share what they recorded for each one. If there are different interpretations of the emotion being expressed, point this out, and mention that at times we should check our perceptions to see if we are on track; for example by saying, "You seem a bit skeptical about this approach. Is that true?"
- Use the following to explain nonverbal communication and debrief this activity:
- We often communicate without words. For example:
  - Drumming
  - Storytelling
  - Drama
  - Visual images
  - Written and spoken language
  - Hand signals
- People use nonverbal communication signs instead of expressing themselves verbally because they may feel uncomfortable expressing emotions such as anger, boredom, confusion verbally.
- This relates to the mentor-mentee relationship in that the clinical mentor needs to be aware both of what the health care worker might be communicating nonverbally to him/her, and what he/she as a mentor is communicating nonverbally to the health care worker.

### Communication Process

- A message sender creates a message for the message receiver.
- The receiver and the sender react, asking for more information and getting answers, to find out whether the message has been understood.



Session 3: Effective Communication and Feedback Skills

Slide 6

Effective communication means that the correct message goes from the sender to the receiver successfully, in the way the sender intended. Just because a message is sent does not mean that it was received accurately.

Effective communication requires the ability of both the sender and the receiver to:

- Listen
- Pay attention
- Perceive what the other is trying to communicate
- Respond verbally or nonverbally; i.e., react

Effective communication is more than just providing information or giving advice. It involves asking questions, listening carefully, trying to understand a mentee concerns or needs, demonstrating a caring attitude, and helping to solve problems.

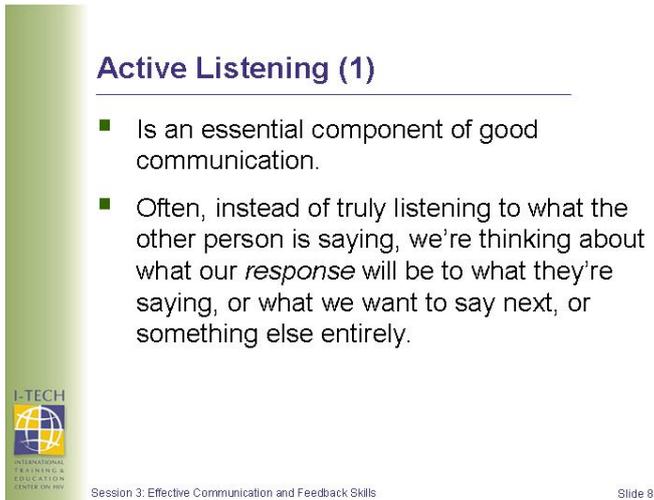
## Trainer instructions: Step 3 (slides 7-16) – 45 minutes

Slides 7-16 discuss three techniques for effective communication: active listening, reflecting, and summarizing.

Slides 8-10 discuss active listening. In slides 8-9, ask participants to name some components of active listening. Conduct this activity in a large group brainstorm format. Slide 10 provides an opportunity for participants to practice active listening. Use the instructions in the slide notes to conduct this activity.

Slides 11-12 provide an overview of reflective listening. It is important to note that reflective listening builds on active listening. The activity in slide 13 provides an opportunity for participants to practice reflective listening. Use the instructions in the slide notes to conduct this activity.

Slides 14-15 present an explanation of the summarizing technique. Slide 16 contains a summarizing activity. Use the slide notes to conduct the activity.

<b>Slide 7</b>		<p><i>Tell participants that they are going to discuss these three techniques in the next few slides, starting with active listening.</i></p>
<b>Slide 8</b>		<p><i>Ask participants to name some components of active listening. Write their responses on a flip chart.</i></p>

## Active Listening (2)



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Slide 9

Ask participants to use this picture to add to the list of components of active listening that you began on the last slide.

Possible answers include:

- Make eye contact.
- Face the speaker.
- Concentrate on the speaker and what he/she is saying.
- Pay attention.
- Demonstrate interest in what is being said.
- Avoid distractions, like phone calls, other people, or paperwork (note that this is a factor related to the environment in which you are holding a conversation – in this picture, the pair has chosen a meeting place that is free of many distractions).

Give participants a minute or two to think of a time that they had to talk to someone who was a bad listener.

Ask for a couple of volunteers to share what made that person a bad listener, and how it made them feel.

### Activity: Active Listening



- Divide into pairs
- Each pair should choose a listener and a speaker



Session 3: Effective Communication and Feedback Skills

Slide 10

*Instruct participants to divide into pairs and ask each pair to decide on a speaker and a listener. Allow each person 1-2 minutes to speak, prompting participants when to switch partners.*

#### Task:

Each speaker should talk for 1-2 minutes about a topic of their choice (it does not have to be work-related), while the facilitator keeps time. The listener cannot say anything, but must convey active listening using nonverbal skills. The pairs should switch roles and repeat the exercise at the facilitator's prompting.

*After the exercise, discuss the following in the larger group:*

- As the speaker, how did it feel to talk for that long without being interrupted?
- When you were the listener, how did it feel to listen? Why?
- How does this exercise apply to your mentoring?

### Reflective Listening (1)

Process of verbally "reflecting" back what someone has said:

- Helps the mentor check whether s/he understands the mentee
- Helps the mentee feel understood and respected as a health care worker



Session 3: Effective Communication and Feedback Skills

Slide 11

Reflective listening builds on active listening.

## Reflective Listening (2)

Confirm that you have understood the mentee by using statements such as:

- “So **you** feel like there’s not enough time to do a complete physical exam.”
- “It sounds like **you’re** concerned about this patient’s ability to adhere to treatment.”
- “**You’re** wondering if this patient should be started on an ART regimen.”



Note that the sample statements include the word “you,” which emphasizes that the mentor is actively listening and reflecting back what the mentee has said. This helps to check for understanding.

## Activity: Reflective Listening



Session 3: Effective Communication and Feedback Skills

Slide 13

- Have the participants get in the same pairs as for the active listening activity. Each pair should choose a first speaker and a listener.
- Refer participants to the list of topics below.
- The speaker will talk to the listener about his/her topic for 2 minutes, while the listener should respond only with reflective listening statements.
- Under normal circumstances, it is natural to mix reflection with other skills, but in this exercise, practice reflecting **only**.
- Group members should switch roles after 2 minutes. Each person should practice speaking, listening, and observing.
- Each group member should pick one topic from the list below (it is okay for group members to use the topic if they like).

### Topics:

- Describe what makes a good friend.
- Describe an accomplishment you are proud of.
- Talk about your earliest memory.
- Describe the best vacation you have ever taken.
- Talk about a scary experience you have had that turned out well.
- Talk about someone you admire and why.
- Describe a childhood experience that you remember fondly.
- If you had a day to do anything you wanted, describe what you would do.

### Debrief:

- Ask participants: How natural did it feel to be a speaker? A reflective listener?

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 14</b></p>	<div style="background-color: #c8e6c9; padding: 5px;"> <p><b>Summarizing (1)</b></p> <hr/> <ul style="list-style-type: none"> <li>■ Process of synthesizing and stating what a mentee has said in order to capture key concerns and issues</li> <li>■ Helps to make sure the message that is sent is the message that is received</li> </ul> </div> <div style="margin-top: 20px;">  <p style="font-size: small;">Session 3: Effective Communication and Feedback Skills</p> </div>	<p>Summarizing is another skill we will practice that may be useful for communication with your mentee.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 15</b></p>	<div style="background-color: #c8e6c9; padding: 5px;"> <p><b>Summarizing (2)</b></p> <hr/> <p>Use summarizing:</p> <ul style="list-style-type: none"> <li>■ To check that you have understood the mentee's story or issue</li> <li>■ When changing topics, closing discussion, or clarifying something</li> <li>■ To collect your thoughts</li> <li>■ To show the mentee that you have heard and respect his/her point of view</li> </ul> </div> <div style="margin-top: 20px;">  <p style="font-size: small;">Session 3: Effective Communication and Feedback Skills</p> </div>	

## Activity: Summarizing



Session 3: Effective Communication and Feedback Skills

Slide 16

- Have the participants get in the same pairs as before. Each pair should choose a first speaker and a listener.
- Refer participants to the list of topics below.
- The speaker should choose a controversial topic about which to speak (or use one of the examples below), uninterrupted, for 2 minutes. Give the participants about a minute to think about what they will say, once they have chosen a topic. The speaker can express his/her opinion, or can just choose a position to support.
- The listener should practice active listening, but should not respond verbally. When the speaker has finished speaking, the listener should summarize what the speaker said, taking about 30 seconds. The pairs should switch roles and repeat the exercise.

### Suggested topics:

- If no gloves are available, should health care workers (HCW) still draw blood, manage deliveries, etc., i.e., without gloves?
- HCWs who test HIV-positive should not be allowed to work in the hospital.
- Women who are HIV-positive should not have children.
- HCWs should be allowed to refuse to take care of HIV-positive patients if they wish.
- Pregnant patients should not have a choice about HIV testing; it should be mandatory.

*Debrief: After all participants have gotten a chance to speak, discuss in a larger group:*

- Was it more difficult to listen quietly when you disagreed with what your partner said?
- As a listener, was it difficult to summarize?
- As a speaker, did the listener summarize correctly?

## **Trainer instructions: Step 4 (slides 17-18) – 10 minutes**

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Slide 17 primarily discusses nonverbal communication barriers. Conduct a group brainstorm about barriers to communication using the picture and slide notes in slide 17. Slide 18 continues the overview of barriers to communication.

## Barriers to Communication (1)



Session 3: Effective Communication and Feedback Skills

Slide 17

Communication can be hindered by a number of things. This picture depicts a scene in which many barriers to communication exist. What are they?

*Ask participants to look at the picture on the slide, and describe any barriers to good communication that they can see in the picture.*

- *Write participant answers on a flip chart.*
- *Use the following questions to help guide the discussion:*
  - *What is the clinician communicating with his body language?*
  - *What is the client communicating with her body language?*
- *Add anything that participants may have missed from the following:*
  - *Dirty office, with other patients' information all over the table.*
  - *Interruptions and distractions, e.g., cell phone calls.*
  - *The door is open and there are people nearby who can hear their interaction, so there is no privacy to ensure confidentiality.*
  - *HCW is not facing the person with whom he is meeting.*

Other ways of not communicating well include:

- Looking out the window.
- Looking at the clock or watch.
- Starting to speak to someone else.
- Shuffling papers.

Negative nonverbal communication can have many consequences, such as:

- Information is not shared, understood.
- The client may ask fewer questions.
- Problem may be difficult to understand.
- Situation may be uncomfortable.
- Lack of adherence to medical appointments and/or treatment.

Note that this picture depicts an HCW with a patient, not a mentor and mentee.

However, the same barriers to communication could exist between a mentor and mentee. Alternatively, this is a scene that a mentor might observe in the clinic and give feedback to a mentee about.

## Barriers to Communication (2)

Other barriers include:

- Talking too much, not giving mentee time to express him or herself
- Being critical and/or judgmental
- Laughing at or humiliating mentee
- Contradicting or arguing with mentee
- Being disrespectful of mentee's beliefs, way of life, method of providing patient care
- Lack of trust or rapport



Session 3: Effective Communication and Feedback Skills

Slide 18

The last slide dealt primarily with nonverbal barriers to communication. This slide lists barriers to communication that are largely verbal. These barriers to communication are avoidable. However, once barriers to communication have surfaced, a significant amount of work may be necessary to overcome them.

## Trainer instructions: Step 5 (slides 19–36) – 45 minutes

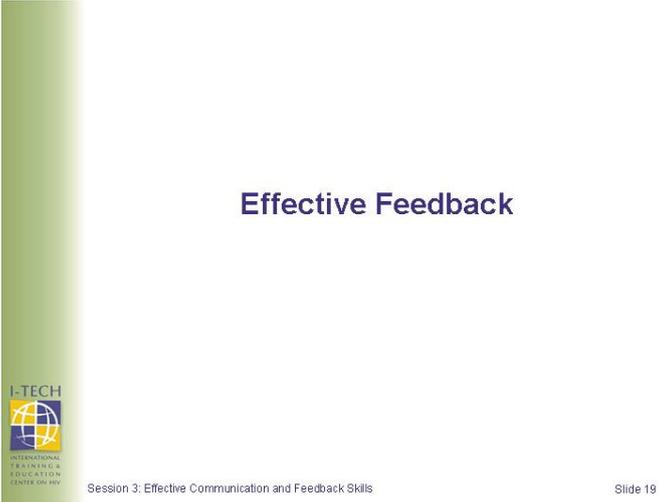
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Present slides 19 and explain that the second half of the session focuses on feedback. Slide 20 provides an opportunity to demonstrate the many different types of communication through the demonstration of a role play. It is a good introduction to this section on feedback. Use the slide notes to conduct the activity.

Slides 21–24 provide an overview of feedback. Slides 21 and 24 both contain discussion activities; use the slide notes to conduct these activities.

Slides 25–30 present approaches to feedback using a PITC scenario and role play. Use the instructions in the slide notes and Worksheet 3.1 to present the information and conduct the activity.

Present the basic principles of feedback in slides 31–36 and refer participants to Handout 3.2 for more information on this topic.

<b>Slide 19</b>	 <p>The slide features a green vertical bar on the left side. The title "Effective Feedback" is centered in a dark blue font. At the bottom left is the I-TECH logo, which includes a globe icon and the text "I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HWY". At the bottom center is the text "Session 3: Effective Communication and Feedback Skills". At the bottom right is the text "Slide 19".</p>	<p><i>Explain to participants that we are transitioning into the topic of feedback. Feedback is a critical component of mentoring, but for feedback to be effective, it must be offered in a way that it can be received by the mentee. The next slide depicts a role play about providing feedback effectively.</i></p>
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## Role Play: Providing Feedback



Session 3: Effective Communication and Feedback Skills

Slide 20

Before the role play, identify two participants and brief them on the following role play:

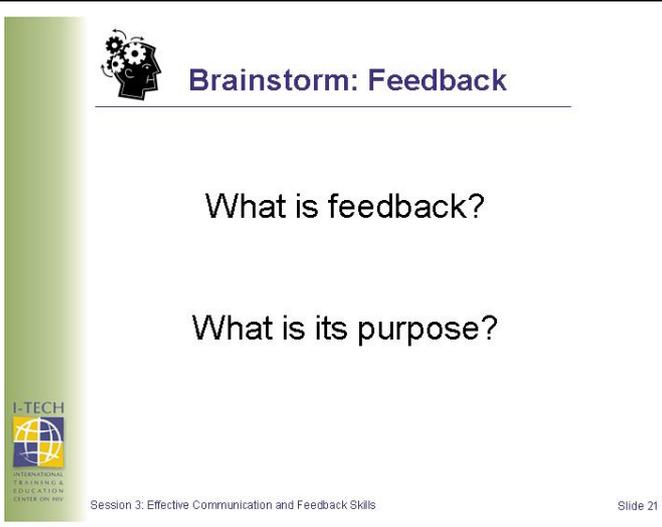
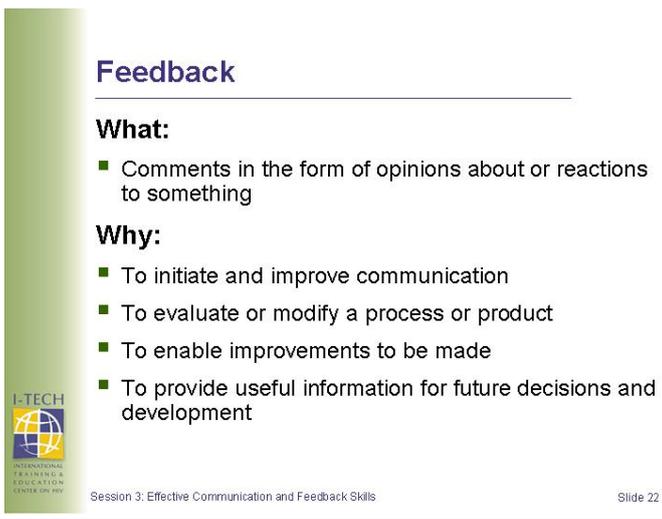
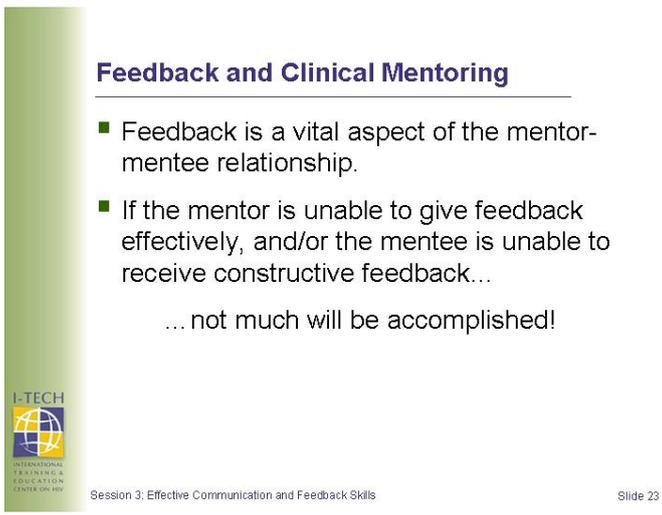
- One participant is the mother-in-law, one is the daughter-in-law.

Scenario/instructions for volunteers:

- The mother-in-law is eating a terrible dish that her daughter-in-law cooked for her, and must respond to the daughter-in-law's questions about how she likes it. (Mother-in-law should nonverbally communicate to the audience that the dish is not very good.)
- The mother-in-law's responses must be truthful, yet not hurt her daughter-in-law's feelings.
- The mother-in-law should make positive comments such as, "The plates are lovely," or, "The food is very hot," in addition to feedback such as, "It's a bit saltier than I prefer."
- Be sure that the daughter-in-law asks several specific questions.

Debrief: After the role play, ask, "What did you observe?"

- Point out that the mother-in-law was honest, yet gentle and careful in how she chose her words. Overall, the interaction was a positive one. Had she chosen different words, however, the interaction could have been very negative.
- Summarize the activity by explaining that the role play is an entertaining way to demonstrate that there are many different ways to communicate, and that our choice of words and how we say something can have a huge impact on whether or not the interaction is positive and effective. This is especially true when giving feedback.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 21</b></p>	 <p><b>Brainstorm: Feedback</b></p> <p>What is feedback?</p> <p>What is its purpose?</p> <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</small></p> <p><small>Session 3: Effective Communication and Feedback Skills</small></p> <p style="text-align: right;"><small>Slide 21</small></p>	<ul style="list-style-type: none"> <li>• Ask participants to brainstorm definitions of the term “feedback” as they understand it.</li> <li>• Write their responses on flip chart paper.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 22</b></p>	 <p><b>Feedback</b></p> <p><b>What:</b></p> <ul style="list-style-type: none"> <li>■ Comments in the form of opinions about or reactions to something</li> </ul> <p><b>Why:</b></p> <ul style="list-style-type: none"> <li>■ To initiate and improve communication</li> <li>■ To evaluate or modify a process or product</li> <li>■ To enable improvements to be made</li> <li>■ To provide useful information for future decisions and development</li> </ul> <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</small></p> <p><small>Session 3: Effective Communication and Feedback Skills</small></p> <p style="text-align: right;"><small>Slide 22</small></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 23</b> <b>Animation Clicks: 3</b></p>	 <p><b>Feedback and Clinical Mentoring</b></p> <ul style="list-style-type: none"> <li>■ Feedback is a vital aspect of the mentor-mentee relationship.</li> <li>■ If the mentor is unable to give feedback effectively, and/or the mentee is unable to receive constructive feedback... ... not much will be accomplished!</li> </ul> <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</small></p> <p><small>Session 3: Effective Communication and Feedback Skills</small></p> <p style="text-align: right;"><small>Slide 23</small></p>	<ul style="list-style-type: none"> <li>• Note that feedback can be positive or critical, but the sole purpose is to improve performance, not punish poor performance</li> </ul>

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 24</b></p>	<p style="text-align: center;"><b>Small Group Discussion: Feedback and Clinical Mentoring</b></p> <hr/> <p style="text-align: center;">What unique factors about the health care setting need to be considered by the mentor when giving feedback to the mentee?</p>  <p style="text-align: center;"><small>Session 3: Effective Communication and Feedback Skills</small></p> <p style="text-align: right;"><small>Slide 24</small></p>	<ul style="list-style-type: none"> <li>• <i>Divide the participants into small groups of 3–4, and ask them to compile a list of factors, based on the question on the slide.</i></li> <li>• <i>After about 5 minutes, come back to a large group and record answers onto a flip chart.</i></li> </ul> <p><i>Possible answers:</i></p> <ul style="list-style-type: none"> <li>• <i><u>Presence of patients</u>: The clinical mentor must not embarrass the health care worker in front of a patient. At the same time, the mentor cannot allow the health care worker to do anything that will endanger the health or well-being of the patient. This means that sometimes feedback is held back until the two can talk in private; in other cases, feedback must be given immediately in a diplomatic, supportive, yet honest way.</i></li> <li>• <i><u>Content and style</u> are both critical in effective communication in a health care setting. The health care worker needs to cover the right information, but also needs to present it in such a way that it can be received by the patient. Feedback from the mentor might involve saying, “The information you covered about how HIV is transmitted was accurate, but I’m not sure the patient was following you.”</i></li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 25</b></p>	<p style="text-align: center;"><b>Two Approaches to Feedback</b></p> <hr/> <p style="text-align: center;">On the following slides, a scenario related to provider-initiated testing and counseling (PITC) will be presented, followed by role plays demonstrating two different approaches to giving feedback to the health care worker.</p>  <p style="text-align: center;"><small>Session 3: Effective Communication and Feedback Skills</small></p> <p style="text-align: right;"><small>Slide 25</small></p>	<ul style="list-style-type: none"> <li>• <i><u>How</u> we give feedback – what we say, how we say it, when we say it – is critical to whether the feedback is effective and achieves the intended effect.</i></li> <li>• <i>Present the PITC case scenario over the next two slides.</i></li> <li>• <i>Then present the two role plays demonstrating two approaches to giving feedback in the next few slides.</i></li> <li>• <i>Refer to Worksheet 3.1 for the scenario, feedback approaches, and discussion questions.</i></li> </ul>



## Worksheet 3.1: PITC Scenario and Feedback Role Play

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### Instructions:

The scenario below is related to provider-initiated testing and counseling (PITC). Consider the two possible approaches to feedback that follow the scenario.

### PITC scenario:

You are a clinical mentor observing a nurse during pretest counseling of a patient. During the risk assessment, the patient reports that she has a husband and two other sexual partners. She does not use condoms with her husband, but uses condoms with one of her other two partners.

The nurse asks about the three partners in a judgmental tone that results in the patient looking visibly uncomfortable in the room.

### How should the clinical mentor provide feedback to the nurse after the visit?

#### Feedback approach #1:

Clinical mentor (with serious facial expression and harsh tone): “Did you realize that you asked about the three partners in a very judgmental way? Did you see how the patient reacted to your questions? It seems that you must have some personal issues related to sex outside of marriage! I’m worried that this patient will be afraid to return to the clinic in the future! This is not how we expect pretest counseling to be carried out... you need to do this better!”

#### Feedback approach #2:

Clinical mentor should use supportive nonverbal body language – a kind expression and tone of voice, etc.

“I just wanted to take a couple of minutes to talk about the last client. I really appreciate the way you engaged with the patient like you did. It was excellent that you asked about the number of partners the patient had and about condom use. A suggestion for next time would be to probe further about the condom use. For example, once the patient reported that she didn’t use condoms with her husband but uses them with one of her other partners, you could specifically ask which partner she uses condoms with—number one, number two, or number three? Ask if she uses condoms sometimes or always with that partner. Ask why she does not use condoms with number one and number two. Ask her if she thinks that she is at risk for HIV when she does not use condoms.

“It’s also extremely important to counsel patients in a manner that doesn’t make the patient uncomfortable with you. If the patient starts to feel uneasy during the visit – like you might be judging them in some way – it’s very likely that she will not disclose information regarding her HIV risk in an honest manner. So even though you may not personally agree with someone’s behavior, our role in counseling is to give the client enough information to show the client how best to keep a low risk profile for acquiring HIV. But ultimately, the patient must make the decision about what behavior she chooses to adopt.

“Do you have questions about what I’ve just talked about? How do you think you can practice being impartial to client’s responses about their behavior in the future?”

**Discussion questions:**

1. What were some differences between these two scenarios?
2. What did the HCW likely learn in the first feedback approach?
3. What did the HCW likely learn in the second feedback approach?

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 26</b></p>	<p><b>PITC Scenario (1)</b></p> <p>You are a clinical mentor observing a nurse during pretest counseling of a patient. During the risk assessment, the patient reports that she has a husband and two other sexual partners. She does not use condoms with her husband, but uses condoms with one of her other two partners.</p>  <p style="font-size: small;">Session 3: Effective Communication and Feedback Skills <span style="float: right;">Slide 26</span></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 27</b></p>	<p><b>PITC Scenario (2)</b></p> <ul style="list-style-type: none"> <li>■ The nurse asks about the three partners in a judgmental tone that results in the patient looking visibly uncomfortable in the room.</li> <li>■ How should the clinical mentor provide feedback to the nurse after the visit?</li> </ul>  <p style="font-size: small;">Session 3: Effective Communication and Feedback Skills <span style="float: right;">Slide 27</span></p>	

## PITC Scenario (3)

### Providing feedback: Approach #1



Session 3: Effective Communication and Feedback Skills

Slide 28

- *Two facilitators should present the role play with one playing the role of a clinical mentor, the other playing the role of the nurse. The clinical mentor should have a serious facial expression and a harsh tone.*
- Clinical mentor: “Did you realize that you asked about the three partners in a very judgmental way? Did you see how the patient reacted to your questions? It seems that you must have some personal issues related to sex outside of marriage! I’m worried that this patient will be afraid to return to the clinic in the future! This is not how we expect pretest counseling to be carried out... You need to do this better!”
- Nurse (embarrassed, ashamed): I’m sorry. I didn’t know what to say. [expand on this if desired]

## PITC Scenario (4)

### Providing feedback: Approach #2



Session 3: Effective Communication and Feedback Skills

Slide 29

Clinical mentor (using supportive nonverbal body language – a kind expression and tone of voice, etc.)

- “I just wanted to take a couple of minutes to talk about the last client. I really appreciate the way you engaged with the patient like you did. It was excellent that you asked about the number of partners the patient had and about condom use. A suggestion for next time would be to probe further about the condom use. For example, once the patient reported that she didn’t use condoms with her husband but uses them with one of her other partners, you could specifically ask which partner she uses condoms with – number one, number two, or number three? Ask if she uses condoms sometimes or always with that partner. Ask why she does not use condoms with number one and number two. Ask her if she thinks that she is at risk for HIV when she does not use condoms.”
- “It’s also extremely important to counsel patients in a manner that doesn’t make the patient uncomfortable with you. If the patient starts to feel uneasy during the visit – like you might be judging them in some way – it’s very likely that she will not disclose information regarding her HIV risk in an honest manner. So even though you may not personally agree with someone’s behavior, our role in counseling is to give the client enough information to show the client how best to keep a low risk profile for acquiring HIV. But ultimately, the patient must make the decision about what behavior she chooses to adopt.”
- “Do you have questions about what I’ve just talked about? How do you think you can practice being impartial to client’s responses about their behavior in the future?”

### Group Discussion

- What were the differences between the two approaches?
- What did the health care worker learn in the 1<sup>st</sup> scenario? The 2<sup>nd</sup>?
- Other thoughts?



Session 3: Effective Communication and Feedback Skills

Slide 30

- Use the questions on this slide (and in Worksheet 3.1) to debrief the role play
- Record participants' responses on flip chart paper.

*Possible responses: Differences between approaches:*

- Different tone.
- Different nonverbal communication techniques.
- More time taken in the second scenario to explain the situation to the health care worker.
- 1<sup>st</sup> approach was very demanding and was not constructive, in that it did not ask the mentee to think of ways to improve.
- 2<sup>nd</sup> approach gave examples of how to improve in the future, and invited the mentee to think of ways to practice the improved counseling behavior.
- In 1<sup>st</sup> scenario, the health care worker only learned that he/she performed poorly, not how he/she could have improved the situation. In the second approach, the health care worker learned a more effective technique for communicating with the patient, and also learned that how he/she communicates with the patient is important, in terms of whether the information is passed effectively.

Remember that the purpose of feedback is not to reprimand, but to help health care workers perform better in their jobs.

### Feedback: Basic Principles (1)

- Ask permission or identify that you are giving feedback.
- Examples:
  - "Can I give you some feedback on that follow-up patient visit?"
  - "I'd like to provide some feedback on what I observed during my visit today."



Session 3: Effective Communication and Feedback Skills

Slide 31

- See Handout 3.2, Principles of Giving Basic Feedback.

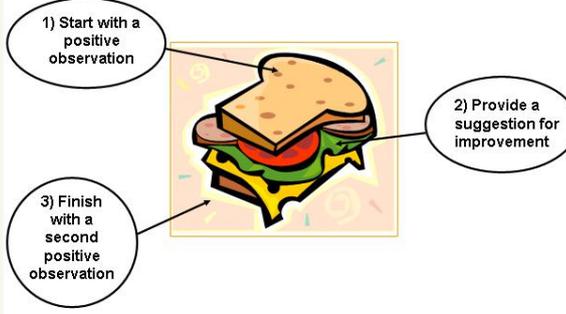


## Handout 3.2: Basic Principles of Giving Feedback

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- Ask permission or identify that you are giving feedback. Examples:
  - “Can I give you some feedback on that follow-up patient visit?”
  - “I’d like to provide some feedback on what I observed during my visit today.”
- Give feedback in a “feedback sandwich.”
  - Start with a positive observation (“It was good that you...”)
  - Provide a constructive critical observation or suggestion for improvement.
  - Finish with a second positive observation or summary statement.
- Use the first person: “I think,” “I saw,” “I noticed.”
- Describe what you observed and be specific. State facts, not opinions, interpretations, or judgments.
- Feedback should address what a person did, not your interpretation of his or her motivation or reason for it.
  - Action: “You skipped several sections of the counseling script.”
  - Interpretation: “You skipped several sections of the counseling script. I know you want to finish because it’s almost lunch time, but...”
- Don’t exaggerate. Avoid terms such as “you always” or “you never.”
- Don’t be judgmental or use labels. Avoid words like “lazy,” “careless,” or “forgetful.”
- When making suggestions for improvement, use statements like, “You may want to consider...” or “Another option is...”
- You can provide feedback any time: during the clinic visit, immediately afterwards, or after you leave the clinic premises.
- Don’t wait too long to give feedback. The closer the feedback is to the actual event, the more likely the HCW will remember the teaching point.
- Certain feedback requires more immediate timing:
  - Example: If you see that the HCW is doing something in error or omitting a very important step during the visit.
- If you provide feedback during a patient encounter:
  - Do not alarm the HCW or patient. Put them both at ease.
  - Be very calm and patient as you explain your recommendation.



<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 32</b></p>	<p><b>Feedback: Basic Principles (2)</b></p> <p>Give feedback in a “feedback sandwich”</p>  <p>1) Start with a positive observation</p> <p>2) Provide a suggestion for improvement</p> <p>3) Finish with a second positive observation</p> <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON NY</small></p> <p><small>Session 3: Effective Communication and Feedback Skills</small></p> <p style="text-align: right;"><small>Slide 32</small></p>	<ul style="list-style-type: none"> <li>The positive observations are the two pieces of bread, while the suggestion for improvement is the filling tucked in between them.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 33</b></p>	<p><b>Feedback: Basic Principles (3)</b></p> <ul style="list-style-type: none"> <li>Use the <b>first person</b>: “I think,” “I saw,” “I noticed.”</li> <li>Describe what you observed and be specific. <b>State facts</b>, not opinions, interpretations, or judgments.</li> <li>Address what a person <b>did</b>... <ul style="list-style-type: none"> <li>“You skipped several sections of the counseling script.”</li> </ul> </li> <li>... <b>not</b> your interpretation of his or her motivation or reason for it. <ul style="list-style-type: none"> <li>“I know you want to finish quickly because it’s almost lunchtime, but you skipped several sections...”</li> </ul> </li> </ul> <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON NY</small></p> <p><small>Session 3: Effective Communication and Feedback Skills</small></p> <p style="text-align: right;"><small>Slide 33</small></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 34</b></p>	<p><b>Feedback: Basic Principles (4)</b></p> <ul style="list-style-type: none"> <li><b>Don’t be judgmental</b> or use labels: <ul style="list-style-type: none"> <li>Avoid words like “lazy,” “careless,” or “forgetful”</li> </ul> </li> <li><b>Don’t exaggerate or generalize</b>: <ul style="list-style-type: none"> <li>Avoid terms such as, “you always,” or “you never”</li> </ul> </li> <li>When making suggestions for improvement, use statements like: <ul style="list-style-type: none"> <li>“You may want to consider...”</li> <li>“Another option is to...”</li> </ul> </li> </ul> <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON NY</small></p> <p><small>Session 3: Effective Communication and Feedback Skills</small></p> <p style="text-align: right;"><small>Slide 34</small></p>	

### When to Give Feedback (1)

- You can provide feedback any time:
  - During a patient encounter
  - Immediately afterward a patient encounter
  - During a review meeting at the end of the day
- **BUT** don't wait too long to give feedback. The closer the feedback is to the actual event, the more likely the health care worker will remember the teaching point



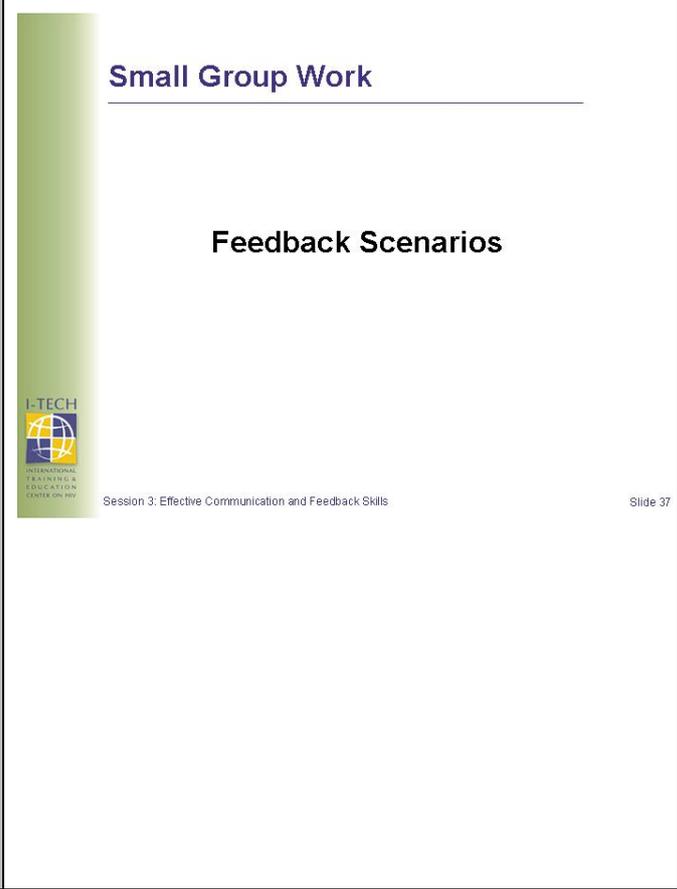
### When to Give Feedback (2)

- Certain feedback requires more immediate timing:
  - Example: If you see that the health care worker is doing something in error or omitting a very important step during the visit.
- If you provide feedback during a patient encounter:
  - Do not alarm the health care worker or patient. Put them both at ease.
  - Be very calm and patient as you explain your recommendation.



## Trainer instructions: Step 6 (slide 37) – 30 minutes

Slide 37 is a summary exercise providing an opportunity to practice the skills discussed in this session. Use Handout 3.2, Worksheet 3.3, and the slide notes in slide 37 to conduct this activity.

<p><b>Slide 37</b></p>	 <p><b>Small Group Work</b></p> <hr/> <p><b>Feedback Scenarios</b></p> <p><small>I-TECH INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HWY</small></p> <p><small>Session 3: Effective Communication and Feedback Skills</small></p> <p><small>Slide 37</small></p>	<ul style="list-style-type: none"><li>• Explain that this final activity provides an opportunity to practice all of the skills we've discussed in this session: giving feedback effectively, nonverbal communication, and active listening.</li><li>• Ask participants to form pairs with somebody that they don't know well.</li><li>• Direct participants to Handout 3.2– Basic Principles of Feedback, and Worksheet 3.3 – Feedback Scenarios.</li><li>• Instruct one member of the pair to play the clinical mentor, the second to play a HCW.</li><li>• Assign two scenarios to each pair.</li><li>• The task is for the mentor to provide feedback to the HCW based on one of the scenarios.</li><li>• Allow about 10 minutes. Switch roles, and repeat with the 2<sup>nd</sup> scenario.</li><li>• Debrief the activity by asking participants:<ul style="list-style-type: none"><li>• "How did it feel to give feedback?"</li><li>• "How did it feel to receive feedback?"</li><li>• "Other thoughts?"</li></ul></li></ul>
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## Worksheet 3.3: Feedback Scenarios

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### Instructions:

- Divide into pairs with somebody you don't know well.
- Refer to Handout 3.2 as needed.
- One member of the pair should play the clinical mentor, the second should play a health care worker (HCW).
- Use the scenarios the facilitator assigns to you.
- Read the scenario together.
- Role play, and provide mentor feedback to the HCW based on the scenario.
- Switch roles, and repeat with the 2nd scenario.

### Scenario 1

**The clinical mentor observed a PITC pretest counseling visit and noticed the following about the HCW she followed:**

- The HCW displayed effective interpersonal skills with the patient.
- The HCW did not reassure the patient of the confidentiality between the client and the HCW.
- The HCW did not document the counseling properly in the patient record.
- The HCW was good about encouraging the patient to return to the clinic for follow-up HIV testing in 3–6 months if her results end up being negative this visit.

### Scenario 2

**The clinical mentor observed a PITC posttest counseling visit for an HIV-infected patient and noticed the following about the HCW he followed:**

- The HCW did not give the client sufficient time to absorb the news about the HIV diagnosis; instead, he immediately started talking about safe sex practices and the need for 100% condom use.
- At the end of the visit, the HCW told the client about services available for HIV patients, CD4 counts, clinical management and follow-up, available support groups, social welfare support, etc.
- The HCW did not cross check the client's health passport, register and lab printout to make sure that the client ID number was consistent for all three.

### Scenario 3

**The clinical mentor observed an antenatal care (ANC) visit and noticed the following about the HCW she followed:**

- The HCW forgot to enquire whether this patient had young children at home who might need HIV testing or to enquire whether her partner had been tested yet.
- The HCW included a thorough explanation of the benefits of PMTCT programs for HIV positive women.
- The HCW told the patient that she should avoid breast feeding and use Lactogen infant formula to feed her baby.

### Scenario 4

**The clinical mentor observed on the labor and delivery (L&D) ward and noticed the following about the HCW she followed:**

- The HCW did not use gloves with every client; he would use gloves only for patients who he thought were HIV positive.
- The midwife indicated that she wanted to perform an episiotomy. She routinely performs an episiotomy for every primigravida that presents to the L & D.
- The HCW reported to give nevirapene (NVP) to the mother and baby at the time of delivery, however failed to note this in the patient record.
- Immediately following the delivery, the HCW helped guide the mother on how to prepare infant formula feeds for her baby since the mother had decided to formula feed prior to her delivery.

### Scenario 5

**The clinical mentor observed a follow-up visit at the antiretroviral therapy (ART) clinic. The patient had been on antiretroviral drugs (ARVs) for 2 months.**

- The HCW asked whether the patient was taking his medications correctly, and the patient responded “yes.” The HCW didn’t ask the patient about when and how he was taking his medications.
- The HCW asked helpful follow-up questions about the patient’s reported headache and numbness/tingling in his feet.
- The HCW did not conduct a neurological examination of the patient.
- The HCW made an appropriate referral to the physician to follow up on the patient’s symptoms.



## Trainer instructions: Step 7 (slides 38–39) – 5 minutes

Present the key points and ask participants if they have any further questions about this session.

<b>Slide 38</b>	<p><b>Key Points (1)</b></p> <ul style="list-style-type: none"><li>■ Good communication—both verbal and nonverbal—is essential for an effective mentoring relationship.</li><li>■ Communication techniques such as appropriate body language, active/reflective listening, and summarizing can aid communication.</li><li>■ Feedback is integral to adult learning, and is a vital component of the clinical mentoring relationship.</li></ul>  <p>Session 3: Effective Communication and Feedback Skills <span style="float: right;">Slide 38</span></p>	
<b>Slide 39</b>	<p><b>Key Points (2)</b></p> <ul style="list-style-type: none"><li>■ Feedback should include both positive and “how to improve” commentary; be descriptive, objective, and nonjudgmental; and focus on the individual’s actions.</li><li>■ While knowledge about a subject is a prerequisite for effective teaching, learning is more often a result of how knowledge is communicated.</li></ul>  <p>Session 3: Effective Communication and Feedback Skills <span style="float: right;">Slide 39</span></p>	



**I-TECH**



INTERNATIONAL  
TRAINING &  
EDUCATION  
CENTER ON HIV

## **Session 4: Theories of Learning**

### **Facilitator Guide**

#### **Basics of Clinical Mentoring**



## Session 4: Theories of Learning

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**Time: 90 minutes (1 hour, 30 minutes)**

### Learning Objectives

By the end of this session, participants will be able to:

- Describe the principles of adult learning theory and the domains of learning
- Explain the application of these theories to clinical mentoring

### Session Overview

Step	Time	Method	Title	Resources
1	5 minutes	Presentation	Introduction and Learning Objectives (slides 1-2)	LCD or overhead projector
2	10 minutes	Presentation Activity	Qualities of Good Teachers (slide 3)	LCD or overhead projector Flip chart and markers
3	30 minutes	Presentation Activity Discussion	Principles of Adult Learning (slides 4-11)	LCD or overhead projector Flip chart and markers
4	10 minutes	Presentation	Learning Styles (slides 12-14)	LCD or overhead projector
5	30 minutes	Presentation Activities	Domains of Learning (slides 15-21)	LCD or overhead projector Worksheet 4.1 Handout 4.2
6	5 minutes	Presentation	Key Points (slide 22)	LCD or overhead projector



### Resources Needed

- LCD or overhead projector
- Flip chart and markers



### Worksheet

- Worksheet 4.1: Domains of Learning Activity



## Handout

- Handout 4.2: Domains of Learning and Learning Objective Verbs

## Key Points

- Adult learning theory should guide mentor instruction.
- Adults are self-directed learners who bring experience to their learning and are motivated by tasks they find meaningful.
- All learning is added to past knowledge, which can influence how learners learn.
- Lessons should incorporate learning objectives from the appropriate level of complexity of all three domains of learning.



## Advance Preparation

- Slide 4: Prepare five flip charts for the activity in slide 4. Each sheet should have one of the principles of adult learning at the top as a title, numbered in the same order as in the slide. Refer to the slide notes for more information and activity instruction.

# Training Material

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## Trainer instructions: Step 1 (slides 1-2) – 5 minutes

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Present slides 1-2, Introduction and Learning Objectives, and provide participants an introduction to this session.

<b>Slide 1</b>	 <p><b>Session 4:</b> <b>Theories of Learning</b></p> <hr/> <p>Basics of Clinical Mentoring</p>	
<b>Slide 2</b>	<p><b>Learning Objectives</b></p> <p>By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"><li>▪ Describe the principles of adult learning theory and the domains of learning</li><li>▪ Explain the application of these theories to clinical mentoring</li></ul>  <p>Session 4: Theories of Learning</p>	



## Trainer instructions: Step 2 (slides 3) – 10 minutes

Present slide 3, Good Teacher Brainstorm, and use the information on the slide and in the speaker notes to lead the activity.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 3</b></p>	<p style="text-align: right;"></p> <h3>Brainstorm: Good Teachers</h3> <ul style="list-style-type: none"><li>■ Consider the teachers you have had in your life:</li><li>■ Who stands out for you as an example of a “good teacher”?</li><li>■ Questions to consider:<ul style="list-style-type: none"><li>▪ What qualities did these good teachers have?</li><li>▪ What did these teachers <b>do</b> that made them “good teachers”?</li><li>▪ What <b>didn't</b> they do that made them such good teachers?</li></ul></li></ul> <p> Session 4: Theories of Learning</p> <p style="text-align: right;">Slide 3</p>	<ul style="list-style-type: none"><li>• <i>Ask participants to get into groups or pairs and to brainstorm the questions on the slide.</i></li><li>• <i>After 5 or 6 minutes, ask each group or pair to report the qualities they identified that make good teachers. Encourage people to name and describe the teachers they are thinking of. Record answers on a flip chart.</i></li><li>• <i>Ask participants to identify the qualities listed on the flip chart that have to do with what the teacher knows. Circle them.</i></li></ul> <p><i>Summarize the activity:</i></p> <ul style="list-style-type: none"><li>• <i>Likely, few items on the list relate to content expertise or technical knowledge. The majority relate to aspects of <u>how</u> the teacher communicated, interpersonal skills, and other qualities such as leadership. Being a good clinical teacher requires more than just expertise in clinical areas.</i></li></ul>
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## Trainer instructions: Step 3 (slides 4–11) – 30 minutes

Review slide 4, principles of adult learning. (This slide is animated, and each principle will appear with a click.) After review, follow instructions for activity in slide 4 notes. Review slides 5–9, which are also animated, to summarize the discussion on principles of adult learning.

Read quote on slide 10 and engage participants in a discussion using questions on slide 11.

<p><b>Slide 4</b> <b>Animation Clicks: 5</b></p>	<div style="background-color: #e0f0e0; padding: 10px;"> <h3 style="text-align: center;">Principles of Adult Learning</h3> <ol style="list-style-type: none"> <li>1. Adults feel anxious if participating in a group make them look weak, either professionally or personally</li> <li>2. Adults bring a great deal of experience and knowledge to any learning situation.</li> <li>3. Adults are decision-makers and self-directed learners.</li> <li>4. Adults are motivated by information or tasks that they find meaningful.</li> <li>5. Adults have many responsibilities and can be impatient when they feel their time has been wasted.</li> </ol> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;">  <p style="font-size: small;">Session 4: Theories of Learning</p> </div> </div>	<ul style="list-style-type: none"> <li>• <i>NOTE: This slide is animated, and each principle will appear with a click.</i></li> <li>• <i>Briefly review the principles here with participants.</i></li> </ul> <p><i>Activity:</i></p> <ul style="list-style-type: none"> <li>• <i>Tape the previously prepared five sheets of flip chart paper to the wall. Each sheet should have one of the principles at the top as a title, numbered in the same order as this list.</i></li> <li>• <i>The participants should visit each poster and write anything that the principle at the top makes them think of. These could be examples from their own life (as learners or teachers), or thoughts about how the principle may relate to or affect their role as a mentor. Participants should read what is written before adding to it to avoid repetition, but should feel free to elaborate on what others have posted.</i></li> <li>• <i>There are no wrong answers, but the activity should get participants thinking about their role as teacher. The facilitator should keep time (1-2 minutes at each station) and instruct participants to change stations after that time.</i></li> <li>• <i>When the participants have rotated to each poster, have everyone stop where he/she is. A volunteer should read everything on the poster, and the facilitator should follow each poster reading the corresponding slide of the next five, which review the principles and give some examples.</i></li> </ul>
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<p><b>Slide 5</b> <b>Animation Clicks: 3</b></p>	<p><b>1. Adults feel anxious if participating in a group makes them look weak</b></p> <ul style="list-style-type: none"> <li>■ Take the time to build a relationship of trust with your mentee before asking him/her to take risks.</li> <li>■ Design feedback sessions, educational exercises, and discussion sessions that help mentees feel: <ul style="list-style-type: none"> <li>▪ Safe to ask questions</li> <li>▪ Confident that they will be respected</li> </ul> </li> <li>■ Assure mentee of the confidentiality of your relationship.</li> </ul>  <p><small>Session 4: Theories of Learning</small></p>	<p><i>NOTE: Slide is animated</i></p>
<p><b>Slide 6</b> <b>Animation Clicks: 2</b></p>	<p><b>2. Adults bring a great deal of experience and knowledge to any learning situation</b></p> <ul style="list-style-type: none"> <li>■ Getting to know your mentees and their experiences and knowledge can help you understand why they do the things they do.</li> <li>■ Show respect for mentees' experiences by listening to their ideas and opinions.</li> </ul>  <p><small>Session 4: Theories of Learning</small></p>	<p><i>NOTE: Slide is animated</i></p> <p>Your mentee will often have a good reason for doing what he/she does, even if that reason is not immediately apparent to you. Try to approach situations from the perspective of understanding and learning about and from your mentee.</p>
<p><b>Slide 7</b> <b>Animation Clicks: 2</b></p>	<p><b>3. Adults are decision makers and self-directed learners</b></p> <ul style="list-style-type: none"> <li>■ Be the “guide on the side” rather than teaching from the podium, acting as someone who knows it all.</li> <li>■ Listen to what mentees want and need, and be flexible in your planning: <ul style="list-style-type: none"> <li>▪ Change your approach if your agenda or method are not working.</li> </ul> </li> </ul>  <p><small>Session 4: Theories of Learning</small></p>	<p><i>NOTE: Slide is animated</i></p> <p><i>Ask participants: How is being a guide vs. an expert different in terms of:</i></p> <ul style="list-style-type: none"> <li>• <i>How teachers communicate with participants? (For example, mentors compared to trainers)</i></li> <li>• <i>How much control mentees have over their learning?</i></li> <li>• <i>Empowering mentees to learn skills they feel confident to use in their work?</i></li> </ul>

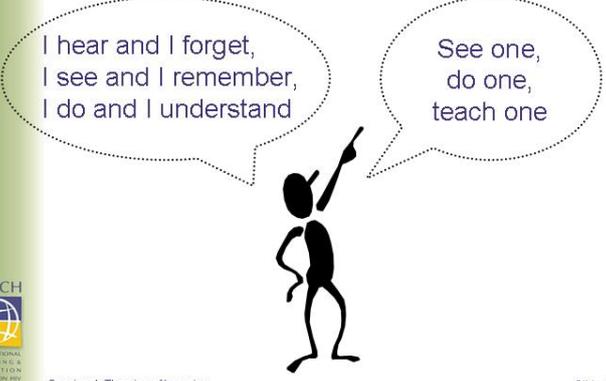
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 8</b> <b>Animation Clicks: 2</b></p>	 <p>Session 4: Theories of Learning</p> <p><b>4. Adults are motivated by information or tasks that they find meaningful</b></p> <ul style="list-style-type: none"> <li>■ Conduct a <b>needs assessment</b> so that you are aware of: <ul style="list-style-type: none"> <li>▪ How much mentees already know</li> <li>▪ What mentees want/need to learn</li> <li>▪ Needs related to learning styles</li> </ul> </li> <li>■ Note that professional and personal needs or issues can affect participants' attention spans: <ul style="list-style-type: none"> <li>▪ May enhance or challenge a person's ability to learn</li> <li>▪ What are some examples?</li> </ul> </li> </ul>	<p><i>NOTE: Slide is animated</i></p> <p><i>Discuss as a large group:</i></p> <p><i>What other themes may come up for mentees that may affect their ability to learn?</i></p> <ul style="list-style-type: none"> <li>• <i>Work-related: Beginning a new job, desire for promotion, new responsibilities in their work, challenges in their job tasks.</i></li> <li>• <i>Personal: Tension in a relationship at home, lack of sleep, sick relative.</i></li> </ul> <p><i>What can you do to address themes in participants' lives?</i></p> <ul style="list-style-type: none"> <li>• <i>Possible answer: Ask for this person's active participation by inviting comments from him/her to get them more involved in the mentoring process.</i></li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 9</b> <b>Animation Clicks: 3</b></p>	 <p>Session 4: Theories of Learning</p> <p><b>5. Adults have many responsibilities &amp; can be impatient when they feel their time has been wasted</b></p> <ul style="list-style-type: none"> <li>■ Limit the length of your visit to what was agreed</li> <li>■ Learn what questions they have about the subject</li> <li>■ Don't cover material they already know unless there is a good reason for review</li> </ul>	<p><i>NOTE: Slide is animated</i></p>

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 10</b></p>	<p><b>Discussion:</b> <b>Experience and Learning</b></p> <p>“To children, experience is something that happens to them; to adults, their experience is who they are. The implication of this for adult education is that in any situation in which an adults’ experience is ignored or devalued, they perceive this as not rejecting just their experience, but rejecting them as persons.”</p> <p style="text-align: right;">—Malcolm Knowles, “Father” of Adult Education</p>  <p style="font-size: small;">Session 4: Theories of Learning</p>	<ul style="list-style-type: none"> <li>• See questions on the next slide – engage participants in a large group discussion about this quote using the questions.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 11</b></p>	<p><b>Discussion Questions</b></p> <ul style="list-style-type: none"> <li>■ If adults define themselves by their experiences, how might this influence how they learn?</li> <li>■ How might this emphasis on experiences influence how you interact with and teach your mentees?</li> </ul>  <p style="font-size: small;">Session 4: Theories of Learning</p>	<ul style="list-style-type: none"> <li>• Conduct a large group discussion using the questions on this slide and referring back to the quote on the previous slide</li> <li>• Allow 5-10 minutes for this discussion</li> <li>• It’s not important that participants articulate what Knowles says but that they explore one of the primary principles of adult learning: The importance of using the experiences of adults in the training classroom. The knowledge they bring to training refers also to their past experiences.</li> </ul>



## Trainer instructions: Step 4 (slides 12-14) – 10 minutes

Review slides 12-14 about learning styles.

<p><b>Slide 12</b></p>	<p><b>People Learn Differently</b></p>  <p>I hear and I forget, I see and I remember, I do and I understand</p> <p>See one, do one, teach one</p> <p><small>I-TECH INTERNATIONAL TEACHING &amp; EDUCATION CENTER ON INC</small></p> <p><small>Session 4: Theories of Learning</small></p> <p><small>Slide 12</small></p>	<p>These are two common mantras in teaching. However, the most important this is to remember that people learn differently.</p> <ul style="list-style-type: none"><li>• Some people will remember everything they hear.</li><li>• Others will not remember anything unless they see it.</li><li>• Sometimes people need to practice a skill before they remember it.</li></ul> <p>Try to incorporate different teaching styles to accommodate your learners.</p>
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### Three Basic Learning Styles

- **Visual:** Learning through watching, observing, and reading
  - Demonstrations, visual examples
- **Auditory:** Learning through listening
  - Case discussions, lectures
- **Kinesthetic:** Learning through doing, practicing, and touching
  - Role plays, practice techniques (i.e., blood draws)



Session 4: Theories of Learning

Slide 13

As much as possible, try to use methods that engage different types of learners since you may not know how your mentee learns best. The more methods that you can incorporate into your teaching moments, the more likely you will cover material in a way that the learner can grasp effectively.

Key factors that lead to changes in physician behavior:<sup>1, 2</sup>

- Instructor assessment of learning needs
- Interaction among learners with opportunities to practice the behaviors
- Sequenced and multifaceted educational activities
- In general, interactive and mixed (didactic/interactive) educational sessions have the most significant effect on professional practice.
- While these studies were conducted with physicians, one can generalize the findings to other health care workers.

Sources:

1: Mazmanian & Davis. "Continuing medical education and the physician as learner: guide to the evidence." *JAMA*. 2002;288:1057-1060.

2: Davis, O'Brien, Freemantle, Wolf, Mazmanian, & Taylor-Vaisey. "Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes?" *JAMA*. 1999;282:867-874.

### Something to Consider...

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“If telling were the same as teaching, we would all be so smart we could hardly stand ourselves.”

—R. Mager

Source: Mager RF. *Preparing Instructional Objectives*. Atlanta: Center for Effective Performance, Inc.; 1997.





## Trainer instructions: Step 5 (slides 15–21) – 30 minutes

Present the domains of learning on slide 15. Conduct the activity on slide 16 using the instructions in the slide notes and Worksheet 4.1. Refer participants to Handout 4.2 as a reference on domains of learning.

Present slides 17–21, discussing implications for mentor practice on each one. Slide 18 includes a small group discussion; use slide notes to conduct the activity. At slide 21, ask participants for implications these theories of adult learning have for mentors.

Slide 15

### Domains of Learning – Learning Objectives



**Cognitive**

Move from simple knowledge recall to more complex processes, like synthesis of information and evaluation.

**LEARNING**



**Affective**

Emphasizes feeling, tone, emotion, or degree of acceptance or rejection.

*A health care worker's values, emotions, attitudes, and beliefs can have a great impact on the care provided.*



**Psychomotor**

Relates to the physical skills and/or performance of motor tasks, moving from observation to mastery of a skill.

*Performance of a lab test or a clinical exam*

  
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Slide 15

- It is important to realize that learning is not simply acquiring facts – learners must feel that what they are doing is important, and must have the relevant skills to provide quality health care.
- According to Bloom at the University of Chicago (1956), learning can be classified into three domains, or categories: cognitive, affective, and psychomotor. Each domain has subcategories that move from simple to more complex processes.
- Some people may be more familiar with the categories “knowledge,” “attitudes,” and “practice,” which are similar to Bloom’s categories, but in Bloom’s system, knowledge is a subcategory within the cognitive domain.
- It is less important to know the names of the domains than it is to understand them to engage mentees in the different domains of learning, which will lead to more holistic and comprehensive training.

Learning Objectives:

- The domains of learning directly relate to defining learning objectives. It is important to cover different domains of learning in mentoring.
- When making learning objectives with mentees, make some that relate to each category.

### Activity: Learning Objective Categorization

Which domain does the learning objective fit in?



Session 4: Theories of Learning

Slide 16

- Refer participants to Worksheet 4.1
- Ask participants to work with the person sitting next to them to complete the worksheet.
- Allow 5-10 minutes to complete the worksheet.
- Discuss participant's answers as a large group. Note: the worksheet in the facilitator guide contains the answers and can be used as a reference during discussion.

*Emphasize to mentors that they will be dealing with mentees at a variety of skills and knowledge levels, and their teaching should reflect that – they should be using objectives for their mentors at the appropriate level of complexity.*

*After activity is complete, refer participants to Handout 4.2 as a resource.*





## Worksheet 4.1: Domains of Learning Activity

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### Instructions:

- Work with the person sitting next to you.
- Read the learning objectives below.
- Determine which of the three domains of learning each objective falls within. Write that domain on the line provided before each objective.
- Discuss as a large group.

### Domains: Cognitive - Affective - Psychomotor

### Learning Objectives

- Cognitive 1. Identify three primary modes of HIV transmission
- Cognitive 2. Explain the difference between HIV and AIDS
- Cognitive 3. Use WHO clinical staging definitions to assist in clinical decision-making
- Cognitive 4. Outline effective strategies for managing nutrition complications in HIV-infected patients
- Cognitive 5. Design an HIV-prevention counseling program based on the MOH counseling standards and guidelines
- Cognitive 6. Evaluate the risk faced by health care workers of contracting HIV on the job
- Affective 7. Ask open-ended questions to elicit information during a counseling session
- Affective 8. Present clients with risk-reduction strategies appropriate to their needs
- Affective 9. Demonstrate ability to provide a client with an HIV-positive result test result in a compassionate and supportive manner
- Affective 10. Integrate professional standards of patient confidentiality into personal life
- Affective 11. Act objectively when solving problems
- Psychomotor 12. Observe correct technique for conducting a pelvic exam
- Psychomotor 13. Describe the steps involved in conducting a rapid HIV test
- Psychomotor 14. Draw blood using universal precautions
- Psychomotor 15. Conduct a thorough physical examination





## Handout 4.2: Domains of Learning & Learning Objective Verbs

The **cognitive domain** relates to knowledge and intellectual skills such as understanding, organizing ideas, analyzing and synthesizing information, applying knowledge, choosing among alternatives in problem solving, and evaluating ideas or actions. Subcategories in the cognitive domain move from simple to more complex cognitive processes. These levels reflect the process through which the learner moves, mastering the lower-level subcategories necessary to proceeding to the next level.

COGNITIVE DOMAIN	ACTION VERBS for OBJECTIVES
<b>Knowledge:</b> recall; the ability to remember information	Describe, define, identify, list, name, recognize, reproduce, state
<b>Comprehension:</b> understanding; the ability to interpret and explain information	Articulate, distinguish, estimate, explain, generalize, infer, interpret, paraphrase, rewrite, summarize, translate
<b>Application:</b> the ability to use information in a new situation, to use knowledge and skills acquired in the classroom to solve problems and create new approaches	Apply, change, construct, demonstrate, modify, operate, predict, prepare, produce, show, solve, use
<b>Analysis:</b> the ability to break down information to understand its structure, to categorize, and to recognize patterns	Analyze, categorize, compare, contrast, differentiate, identify, illustrate, infer, outline, relate, select, separate
<b>Synthesis:</b> the ability to bring together sets of information to create or invent solutions to problems, illustrate relationships between parts of a whole	Compile, create, design, diagnose, diagram, discriminate, explain, generate, modify, organize, plan, relate, reorganize, separate, summarize, write
<b>Evaluation:</b> the ability to make a judgment based upon evidence	Appraise, assess, compare, conclude, contrast, criticize, critique, describe, evaluate, explain, interpret, justify, summarize, support

The **affective domain** relates to the emotional component of learning, and is concerned with changes or growth in interest, attitudes, and values. It emphasizes feeling, tone, emotion, or degree of acceptance or rejection. Subcategories move from more simple affective components – such as receiving and responding to new information – to more complex ones – such as organizing and internalizing values. The affective domain is important to address when training health care providers, as the providers’ values, emotions, attitudes, and beliefs can have a great impact on the type of care provided.

AFFECTIVE DOMAIN	ACTION VERBS for OBJECTIVES
<b>Receiving (willing to listen):</b> awareness, attention to new information	Ask, choose, describe, give, identify, locate, select
<b>Responding (willing to participate):</b> active pursuit of an interest, willingness to respond, motivation	Answer, assist, discuss, greet, help, participate, present, read, report, select, tell
<b>Valuing (willing to be involved):</b> the worth or value a person attaches to a particular object, situation, or behavior; reflects internalization of a set of values	Complete, demonstrate, differentiate, explain, follow, initiate, join, justify, propose, read, share
<b>Organization (willing to be an advocate):</b> the ability to prioritize and organize values	Adhere, alter, arrange, combine, compare, defend, explain, integrate, modify
<b>Internalizing values (willing to change one’s behavior):</b> the ability to act consistently and predictably according to a value system or consistent philosophy	Act, display, influence, listen, modify, perform, propose, question, serve, solve, verify

The **psychomotor domain** relates to the physical skills and/or the performance of motor tasks according to a standard of accuracy, rapidity, or smoothness. Subcategories progress from observation then performance of a procedure, to mastery of a physical skill. Learning is demonstrated by the learner performing the skill to a designated standard or level of proficiency.

PSYCHOMOTOR DOMAIN	ACTION VERBS for OBJECTIVES
<b>Perception:</b> observation of behaviors involved in completing a task	Observe, attend to, ask, describe, participate, answer
<b>Set:</b> becoming mentally prepared to perform the task	Question, explore, consider outcomes, participate, tell, give examples, express confidence
<b>Guided formatting:</b> the early stage in learning a complex skill that includes imitation, performing a task with assistance, and trial and error; adequacy of performance is achieved by practicing	Complete, demonstrate, replicate, share, point out, break down, put together
<b>Mechanism:</b> the intermediate stage in learning a complex skill; learned responses have become habitual and the movements can be performed with some confidence and proficiency (acting without assistance)	Arrange, choose, conduct, construct, design, integrate, organize, perform, modify, refine, respond, vary
<b>Complex overt response:</b> performing automatically with facility and habitually; fine tuning and perfection of the skill or technique	Arrange, choose, conduct, construct, design, integrate, organize, perform, modify, refine



## New Research

- **Preconception:** People acquire new information on top of preexisting knowledge, which is a powerful influence.
- **Knowledge:** Acquiring a body of knowledge is critical for creating understanding, and for high levels of cognitive functioning.
- **Metacognition:** Experts differ from novices in specific cognitive ways—they monitor when they need more information, judge whether new information seems consistent with existing knowledge, and ask what analogies they can use to advance their own understanding.



Session 4: Theories of Learning

Source: *How People Learn: Brain, Mind, Experience, and School*, John D. Bransford, Ann L. Brown, Rodney R. Cocking, Editors

Slide 17

- Three key findings on how people learn have recently emerged from the literature.
- In combination with earlier research and validated practices in education, these findings have important implications for how we approach mentoring. This research provides additional evidence to support the value of needs assessment, adult learning principles.

These concepts will be elaborated in the next few slides.

Source: Bransford JD, Brown AL, Cocking RR, Editors. *How People Learn: Brain, Mind, Experience, and School*.

## New Research: Preconception



Session 4: Theories of Learning

Slide 18

- If knowledge is incorrect or underdeveloped, people may not learn or may learn only to test.
- All new learning involves transfer from previous learning.
- Challenges: Developmental issues in children and primacy in adults.
- **Implications?**

- People have preconceptions about how the world works.
- These initial understandings can have a powerful effect on the integration of new concepts and information. So people learn on *top* of what they already know. Adult learning theory says adults bring their experience to a learning situation. Examples:
  - Thinking the world is flat and envisioning the world as a round pancake.
  - Thinking  $1/8$  is larger than  $1/4$  because 8 is a larger number than 4.
  - Getting a person's name wrong the first time you are introduced and then finding it difficult to remember once corrected.
  - Not understanding/believing germ theory.
- People don't know what they don't know.
- Primacy: the strength of early memories for an elderly person who has forgotten more recent events.
- Need to draw out and work with existing understandings.

*Have participants discuss in small groups:*

- *What are some implications of this in the clinic setting?*
  - *Must consider cultural beliefs and other long-held beliefs that health care workers may hold.*

## New Research: Knowledge

- Ability to integrate new information into existing body of knowledge is the most important factor for assuring transfer of learning from classroom to application in the real world.
- Experts are better able to see patterns, relationships, and discrepancies where the novice sees unrelated pieces of information.

### Implications?



Session 4: Theories of Learning

Slide 19

- Research has shown key differences between experts and novices in how they organize information.
- To develop competencies, learners must: a) have a deep foundation of factual knowledge; b) understand facts and ideas in the context of a conceptual framework; and c) organize knowledge in ways that facilitate retrieval and application.
- Integrating new information into an existing body of knowledge is the most important factor for assuring transfer of learning from classroom to application in the real world.
  - Map with and without border – expert would differ from a novice by knowing where borders might be located because of his/her preexisting knowledge of physical, economic, and political geography (e.g., borders often follow mountain ranges and rivers; main cities are often situated at key transportation sites).
- This finding aligns with the cascade of learning possible in the cognitive domain:
  - knowledge (memorization);
  - understanding (being able to paraphrase);
  - application (solving a problem with new information);
  - analysis (comparing and contrasting ideas);
  - synthesis (modifying or designing a system); and
  - evaluation (defending an idea or opinion).
- Classroom training is important in establishing a body of knowledge upon which to build
- Implications:
  - If experts are better able to see patterns, relationships, and discrepancies, they may need to help novices make patterns out of the unrelated information they are interpreting.

## New Research: Metacognition

- Ability to assess own knowledge, skills, and performance
- Self-reflection, self-assessment, and sense-making:
  - Am I making assumptions?
  - Are my personal values affecting my judgment?
  - What is the source of this information?
  - Could the source affect my interpretation?
  - Am I seeing a pattern?



Session 4: Theories of Learning

Slide 20

- Evidence shows that experts and novices differ in significant ways. Experts monitor when they need more information, judge whether new information seems consistent with existing knowledge, and ask what analogies they can use to advance their own understanding. They question themselves and where they got the information.
- Metacognition can be taught. It often takes the form of an internal dialogue.
- Mentees can be led toward self-reflection, self-assessment, and sense-making.
- Asking mentees to:
  - Predict outcomes
  - Explain one's decision-making process in making a diagnosis
  - Note failure to comprehend
  - Plan ahead
  - Reciprocal teaching in reading
- Implication in clinical training: Mentor should assess mentee's decision-making process, assumptions, biases that affect clinical judgment. The bedside teaching approach is a good example of how/where to do this.

## Implications for Educators

- Range and type of learning objectives
- Innovative learning methods for multiple domains
- Needs assessment
- Place information into conceptual frameworks
- Provide many examples
- Emphasize metacognition
- What else?



Session 4: Theories of Learning

Slide 21

- *Ask participants what other implications these theories of adult learning have for mentors.*



## **Trainer instructions: Step 6 (slide 22) – 5 minutes**

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Review the Key Points and ask participants if they have any remaining questions.

<b>Slide 22</b>	<p><b>Key Points</b></p> <ul style="list-style-type: none"><li>■ Adult learning theory should guide mentor instruction.</li><li>■ Adults are self-directed learners who bring experience to their learning and are motivated by tasks they find meaningful.</li><li>■ All learning is added to past knowledge, which can influence how learners learn.</li><li>■ Lessons should incorporate learning objectives from the appropriate level of complexity of all three domains of learning.</li></ul>  <p><small>INTERNATIONAL TECHNICAL &amp; EDUCATION CENTER ON INC.</small></p> <p><small>Session 4: Theories of Learning</small></p> <p style="text-align: right;"><small>Slide 22</small></p>	
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**I-TECH**



INTERNATIONAL  
TRAINING &  
EDUCATION  
CENTER ON HIV

## **Session 5: Clinical Teaching Skills**

### **Facilitator Guide**

#### **Basics of Clinical Mentoring**



# Session 5: Clinical Teaching Skills

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**Time: 75 minutes (1 hour, 15 minutes)**

## Learning Objectives

By the end of this session, participants will be able to:

- Define a teaching moment
- Use bedside teaching, side-by-side teaching, and case presentations as teaching strategies

## Session Overview

Step	Time	Method	Title	Resources
1	5 minutes	Presentation	Introduction and Learning Objectives (slides 1-2)	LCD or overhead projector
2	10 minutes	Presentation Discussion	Teaching Moments (slides 3-7)	LCD or overhead projector
3	10 minutes	Presentation	Learning Styles, Teaching Techniques (slides 8-11)	LCD or overhead projector
4	30 minutes	Presentation Demonstration	Bedside Teaching (slides 12-17)	LCD or overhead projector Handouts 5.1-5.3
5	5 minutes	Presentation	Side-by-Side Teaching (slides 18-20)	LCD or overhead projector
6	10 minutes	Presentation	Case Presentations (slides 21-24)	LCD or overhead projector Handout 5.4
7	5 minutes	Presentation	Key Points (slide 25)	LCD or overhead projector



## Resources Needed

- LCD or overhead projector



## Handout

- Handout 5.1: Five Steps of Bedside Teaching
- Handout 5.2: Demonstration of Bedside Teaching Approach

- Handout 5.3: A Patient-Centered Approach to Bedside Teaching
- Handout 5.4: : Six Steps for Creating an Effective Case Study

## **Key Points**

- Teaching moments are opportunities to improve clinical skills of a health care worker, can take place in a variety of settings, and mentors should maximize the number of teaching moments at a site visit.
- Bedside and side-by-side teaching reinforce classroom learning, and allow the mentor to model clinical technique, as well as attitudes and behaviors.
- Case studies are an effective tool for clinical teaching.

# Training Material

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## Trainer instructions: Step 1 (slides 1-2) – 5 minutes

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Present slides 1-2, Introduction and Learning Objectives, and provide participants an introduction to this session.

<b>Slide 1</b>	 <p><b>Session 5:</b> <b>Clinical Teaching Skills</b></p> <hr/> <p>Basics of Clinical Mentoring</p>	
<b>Slide 2</b>	<p><b>Learning Objectives</b></p> <hr/> <p>By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"><li>■ Define a teaching moment</li><li>■ Use bedside teaching, side-by-side teaching, and case presentations as teaching strategies</li></ul>  <p>Session 5: Clinical Teaching Moments</p>	<p>Slide 2</p>



## Trainer instructions: Step 2 (slides 3–7) – 10 minutes

Present slide 3, and define a “teaching moment.” This slide is animated, and each example will appear with a click. Have participants brainstorm examples of teaching moments before revealing the examples.

Review slides 4–7 and discuss the content of teaching moments as well as when and how they are used.

<p><b>Slide 3</b> Animation Clicks: 1</p>	<p><b>Teaching Moment</b></p> <ul style="list-style-type: none"> <li>An opportunity to share a piece of information, demonstrate a technique, or expand on the implications of a clinical observation</li> </ul> <p><i>Examples:</i></p> <ul style="list-style-type: none"> <li>Demonstration of a physical exam</li> <li>Allowing mentee to feel/hear/observe something abnormal upon patient examination that you, as mentor, have experienced</li> <li>Ask a mentee to stage the patient according to WHO stages</li> </ul>  <p><small>I-TECH INTERNATIONAL TECHNICAL &amp; EDUCATION CENTER ON HIV</small></p> <p><small>Session 5: Clinical Teaching Moments</small> <span style="float: right;"><small>Slide 3</small></span></p>	<p><i>NOTE: This slide is animated, and the examples will appear with a second click.</i></p> <p><i>Have participants brainstorm examples of teaching moments before revealing the examples given (which will appear all together on the second click).</i></p> <ul style="list-style-type: none"> <li>Teaching moments may involve reminding the health care worker about important side effects to monitor with antiretroviral therapy (ART); it might involve reviewing effective communication skills in a counseling session; or it might involve supporting and motivating the health care worker to build his/her confidence.</li> </ul>
<p><b>Slide 4</b></p>	<p><b>Clinical Teaching Moments: Taking Advantage</b></p> <p>Mentors should seize every opportunity that they can to teach mentees how to deliver the highest quality HIV care services.</p>  <p><small>I-TECH INTERNATIONAL TECHNICAL &amp; EDUCATION CENTER ON HIV</small></p> <p><small>Session 5: Clinical Teaching Moments</small> <span style="float: right;"><small>Slide 4</small></span></p>	

<p style="text-align: center;"><b>Slide 5</b></p>	<p><b>Clinical Teaching Moments: Missed Opportunities</b></p> <ul style="list-style-type: none"> <li>■ Mentor notes mistakes but does not communicate about them to the health care worker (HCW).</li> <li>■ Mentor informs an HCW that errors are being made, but does not provide effective teaching to correct the error.</li> <li>■ Mentor is impatient/unapproachable so that HCW is scared to ask questions regarding his/her work performance.</li> </ul>  <p style="font-size: small;">Session 5: Clinical Teaching Moments <span style="float: right;">Slide 5</span></p>	<p>Unfortunately, there are times when mentors don't allow staff to take full advantage of their presence in the clinic.</p>
<p style="text-align: center;"><b>Slide 6</b></p>	<p><b>When and Where Do Teaching Moments Occur?</b></p> <ul style="list-style-type: none"> <li>■ In a variety of settings: <ul style="list-style-type: none"> <li>■ ART clinics, inpatient medical wards, labor and delivery wards, sessions on voluntary counseling and testing, etc.</li> </ul> </li> <li>■ Anytime: <ul style="list-style-type: none"> <li>■ While a patient is present in the room</li> <li>■ Following a client visit</li> <li>■ Planned for the future</li> </ul> </li> </ul>  <p style="font-size: small;">Session 5: Clinical Teaching Moments <span style="float: right;">Slide 6</span></p>	<p>One way to identify opportunities for teaching moments is to think of where and when they might occur:</p> <ul style="list-style-type: none"> <li>• Can be done while a patient is in the room</li> <li>• Can be done after a patient visit, e.g., in the hallway while waiting for the next patient, or when you're both on a tea break</li> <li>• Can be planned for in the future, e.g., identify a learning need and schedule a date to give a lecture or lunchtime informational session</li> </ul>
<p style="text-align: center;"><b>Slide 7</b></p>	<p><b>Content of a Teaching Moment</b></p> <p>Can be about any aspect of service provision within the clinical setting:</p> <ul style="list-style-type: none"> <li>■ Methodology or process of a counseling session or procedure</li> <li>■ Background on disease pathophysiology</li> <li>■ Patient rapport/interpersonal communication patterns</li> <li>■ Building confidence</li> <li>■ Strategies for maintaining patient confidentiality within the clinic setting</li> <li>■ Suggesting appropriate treatment options</li> </ul>  <p style="font-size: small;">Session 5: Clinical Teaching Moments <span style="float: right;">Slide 7</span></p>	

## Trainer instructions: Step 3 (slides 8–11) – 10 minutes

Review slide 8, Three Basic Learning Styles, and remind participants that learning styles should be considered in how teaching is conducted.

Present slides 9–11 and discuss teaching techniques.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 8</b></p>		<p>This slide should be familiar from the last session, but is presented here again as a reminder.</p> <ul style="list-style-type: none"><li>• Once you've identified a teaching moment and know what you would like to convey to the health care worker, you should think of <b>how</b> you will teach. Each learning style has associated teaching methods.</li><li>• As much as possible, teach in ways that engage multiple learning styles at any given time. The more methods you can incorporate into your teaching moments, the more likely it is you will cover material in a way that the mentee can grasp effectively.</li></ul>
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## Teaching Techniques: TALK

- **Think aloud**
  - To highlight the *process* of expert reasoning
- **Activate the mentee**
  - Promote mentee's initiative and autonomy
- **Listen smart**
  - Efficiently assess validity of mentee's presentation
- **Keep it simple**
  - Model concise communication and rule-based decision making



Session 5: Clinical Teaching Moments

Slide 9

Mentors should not only be teachers, but should “talk the talk and walk the walk” – that is, they should lead by example when interacting with and teaching mentees. The following two slides give specific techniques for teaching mentees effectively.

**Think aloud:** A mentor should make his/her own clinical reasoning transparent. This might involve:

- Explaining the thought process that leads to a diagnosis.
- Verbalizing the treatment options for a challenging case.
- Explaining why a particular course of action is chosen.

**Activate the mentee:**

- Mentors must encourage mentees to be motivated to connect their needs with patients' needs.
- Therefore, an adaptable, collaborative approach to clinical teaching is most effective – mentor must know when to stand back or jump in, while still giving enough freedom to the mentee to grow without hurting themselves or patients.

**Listen smart:**

- It is important for the mentor to efficiently assess the mentee's acquisition, synthesis, and presentation of clinical data, even if the mentor does not have previous knowledge about the patient.

Source: Reilly B. Viewpoint: Inconvenient truths about effective clinical teaching. *Lancet*. 2007. 370:705-711.

### Teaching Techniques: WALK



- Work as a hands-on role model
  - Model the physical experience of treating patients
- Adapt to uncertainty
  - Embrace it as a valuable learning opportunity
- Link learning to caring
  - Demonstrate responsibility and empathy for each patient, and expect mentees to do the same
- Kindle kindness
  - Establish generosity as the standard for each clinical interaction



Session 5: Clinical Teaching Moments

Slide 10

- Work as a hands-on role model:
  - Show the clinical utility of physical examination, the therapeutic value of touching, and the diverse benefits of bedside care.
- Adapt to uncertainty with enthusiasm:
  - Uncertainty is always going to be a part of clinical practice. A mentor must be able to change his/her mind, admit mistakes, etc.
- Link learning to caring:
  - It is important to practice patient-centered teaching (the next slide elaborates on this).

Source: Reilly B. Viewpoint: Inconvenient truths about effective clinical teaching. Lancet. 2007. 370:705-711.

### Patient-Centered Teaching

Patient-centered teaching = Teaching what needs to be taught, for sake of patient

**vs.**

Teacher-centered teaching = Teaching what one knows, even if it does not address the patient's problems

- Treating the disease vs. treating the illness—effective teachers do not prioritize disease (what the patient has), but instead illness (what the patient feels)



Session 5: Clinical Teaching Moments

Slide 11



## Trainer instructions: Step 4 (slides 12–17) – 30 minutes

Review slides 12–15 about Bedside Teaching. On slide 15, review with participants Handout 5.1: Five Steps of Bedside Teaching.

Slide 16 is a demonstration; ask for two volunteers to be the mentor and mentee and refer them to Handout 5.2 for the script. Conclude the step by reviewing slide 17 and referring participants to Handout 5.3: A Patient-Centered Approach to Bedside Teaching.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 12</b></p>	<p><b>Mentoring Strategies</b></p> <ul style="list-style-type: none"> <li>■ Bedside teaching</li> <li>■ Side-by-side mentoring</li> <li>■ Case Presentations</li> </ul>  <p><small>I-TECH INTERNATIONAL TEACHING &amp; EDUCATION CENTER ON HWY</small></p> <p><small>Session 5: Clinical Teaching Moments</small></p> <p style="text-align: right;"><small>Slide 12</small></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 13</b></p>	<p><b>Bedside Teaching (1)</b></p> <ul style="list-style-type: none"> <li>■ Defined as teaching and reinforcing skills at patient's bedside: <ul style="list-style-type: none"> <li>■ A common approach in medical education</li> <li>■ Reinforces classroom learning</li> <li>■ Allows mentor to model important clinical skills, attitudes, and communication in the context of patient care, as well as observe mentee's skills</li> </ul> </li> <li>■ Strengths and weaknesses of mentees become very clear at the bedside</li> </ul>  <p><small>Session 5: Clinical Teaching Moments</small></p> <p style="text-align: right;"><small>Slide 13</small></p>	<ul style="list-style-type: none"> <li>• While bedside teaching implies an inpatient setting, it can easily be adapted for use in a clinic/outpatient setting.</li> <li>• Bedside teaching is an important part of the process of adult learning, as it reinforces classroom learning.</li> <li>• Strengths and weaknesses of mentees become clear at the bedside, because mentors can watch mentees interact with patients. Mentors can experience what mentees do and how they act with patients firsthand, in a way that cannot happen outside of a patient encounter.</li> </ul> <p>*Source: <a href="http://www.oucom.ohiou.edu/fd/mo-nographs/bedside.htm">http://www.oucom.ohiou.edu/fd/mo-nographs/bedside.htm</a></p>

## Bedside Teaching (2)

### Before meeting with the patient:

Mentor and mentee should discuss the purpose and structure of the session:

- Identify appropriate patients
- Set goals for the session
- Agree on roles and expectations
- Discuss expected time frame



Session 5: Clinical Teaching Moments

Slide 14

- Identify appropriate patients: Appropriate patients will be capable of interacting with mentor and mentee, or will have family members present that can interact with them (if possible).
  - It is often helpful to arrange session with patient ahead of time.
- Set goals: What does the mentee wish to learn or practice?
- Agree on roles and expectations: Who will make introductions? Who will take the lead on each aspect of the visit?
- Time frame: This is especially important if there is a tight schedule, or mentor and mentee are seeing multiple patients.

## Bedside Teaching (3)

### Five steps:

1. Get a commitment
2. Probe for supporting evidence
3. Reinforce what was done well
4. Give guidance about errors and omissions
5. Summarize encounter with a general principle



Session 5: Clinical Teaching Moments

Slide 15

See Handout 5.1 and review it as a large group.

Before going through the five steps, the patient should be oriented to everyone in the room and explained the purpose of the session. The mentee should then present the case, without reading from the chart and without interruption from the mentor.

Following that, the five steps of clinical teaching should be employed:

- **Get a commitment.** The mentor asks the mentee to articulate their diagnosis or plan for treatment based upon the patient history and symptoms they have just identified. Asking the mentee to commit to a diagnosis or plan will increase the impact of the teaching session by providing a solid point from which to work.
- **Probe for supporting evidence.** Ask the mentee to explain how they reached their conclusion. Listening to their reasoning will help you respond appropriately to their knowledge level.
- **Reinforce what was done well.** Offer specific feedback rather than a general statement such as, "Good diagnosis." Giving specific comments will provide the mentee with tools to use in similar situations in the future.
- **Give guidance for errors and omissions.** As when offering positive feedback, any corrections should be specific. Care should also be taken to make sure the feedback is constructive and includes specific plans for improvement.
- **Summarize the encounter with a general principle.** Choose one or two general principles that arose from this encounter to become the "take-home message." Summarizing the encounter in this way will help the mentee apply the lessons learned to other situations.
  - These steps can be performed in order, or mixed and matched according to the situation.





## Handout 5.1: Five Steps of Bedside Teaching

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### Step One: Get a Commitment

This pushes the mentee to move beyond his/her level of comfort and makes the teaching encounter more active and more personal. It also shows respect for the learner and fosters an adult learning style. A main goal of getting the learner to commit is to reveal their reasoning, not just to get more information about the case.

Questions to ask:

- “What other diagnoses would you consider in this setting?”
- “What laboratory tests do you think we should get?”
- “How do you think we should treat this patient?”
- “Do you think this patient needs to be hospitalized?”
- “Based on the history you obtained, what parts of the physical should we focus on?”

### Step Two: Probe for Supporting Evidence

It is important to determine that there is an adequate basis for the answer, and to encourage an appropriate reasoning process. Instead of giving a right or wrong response to the commitment the learner has made, ask more questions:

- “What factors in the history and physical support your diagnosis?”
- “Why would you choose that particular medication?”
- “Why do you feel this patient should be hospitalized?”
- “Why do you feel it is important to do that part of the physical in this situation?”

### Step Three: Reinforce What Was Done Well

The simple statement, “That was a good presentation,” is not sufficient. Comments should include specific behaviors that demonstrated knowledge, skills, or attitudes valued by the mentor.

- Your diagnosis of “probable pneumonia” was well supported by your history and physical. You clearly integrated the patient’s history and your physical findings in making that assessment.”
- “Your presentation was well-organized. You had the chief complaint followed by a detailed history of present illness. You included appropriate additional medical history and medications and finished with a focused physical exam.”

## Step Four: Give Guidance about Errors and Omissions

The main idea here is to identify an opportunity for behavior change and provide an alternative strategy. Instead of using extreme terms such as “bad” or “poor,” expressions such as “not best” or “it is preferred” may carry less of a negative value judgment while getting the point across. Comments should also be as specific as possible to the situation, identifying specific behaviors that could be improved upon in the future.

- “In your presentation, you mentioned a temperature in your history but did not tell me the vital signs when you began your physical exam. Following standard patterns in your presentations and notes will help avoid omissions and will improve your communication of medical information.”
- “I agree, at some point, complete pulmonary function testing may be helpful, but right now the patient is acutely ill. The results may not reflect her baseline and may be very difficult for her. We could glean some important information with just a peak flow and a pulse oximeter.”

## Step Five: Teach a General Principle

One of the more challenging – but essential – tasks of this model is for the learner to take information and accurately generalize it to other situations. The teaching principle does not need to be a medical fact, but can be about strategies or procedures. While there is generally not time to have a major teaching session, one or two statements can make a big impact.

- “Deciding whether someone needs to be treated in the hospital for pneumonia is challenging. Fortunately there are some criteria that have been tested which help.”
- “In looking for information on what antibiotics to choose for a disease. I have found it more useful to use an up-to-date handbook than a textbook, which may be several years out of date.”

## Step Six: Conclusion

Time management in clinical teaching is essential. The conclusion defines the end of the teaching interaction and the role of the learner in the next events.

**Demonstration:  
Bedside Teaching Approach**



Session 5: Clinical Teaching Moments

Slide 16

See Handout 5.2 for the script.

*Ask for two volunteers to be the mentor and the mentee.*

*Ask the volunteers to present the scene in front of the group.*

*Debrief the demonstration by discussing:*

- *What did you think about this approach?*
- *Is this an approach you could adopt in your mentoring?*
- *Other reactions?*





## Handout 5.2: Demonstration of Bedside Teaching Approach

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Let us look at a sample presentation in order to help illustrate the steps of the bedside teaching model and their application in a practical setting.

### **Mentoring scenario:**

*You have recently started to work with a physician mentee in an ART clinic. The mentee has just finished seeing a patient and is presenting to you in an empty exam room while the patient waits in a different exam room.*

Mentee: “I just saw Mary Shilonga who is a 27-year-old woman who came in today with a complaint of cough and shortness of breath. This is her initial visit to this facility. She was diagnosed as HIV-positive 3 weeks ago at the health center near her village. A CD4 test was done at the clinic and came back as 48 cells/mL.

“She reports feeling ‘tired and unwell on and off for several months’ now. Mary reports losing at least 5–10 kilos over the past 6 months. She was feeling a little better last month. But 3 weeks ago, she thought she was coming down with a cold and then developed her current symptoms of cough and shortness of breath.

“Over the past 3 weeks, she reports feeling chills, and thinks she has been having fevers on and off. She experiences shortness of breath when she tries to do activities around the house like cooking or cleaning or when she has to walk to the store to do shopping. She has not had any associated chest pain, except when she coughs. She has trouble sleeping at night sometimes due to the cough.

“Mary has three children that live at home with her; she became tearful when she started talking about her family. Her husband left the house 2 weeks ago when he found out that she was HIV-positive.

“Mary is currently not taking any prescription medications for her symptoms or any other chronic conditions. She said that her local traditional healer advised that she drink a specific herbal tea to help with her symptoms. As far as the patient can recall, she has no allergies to medications. She denies use of alcohol or drugs.

“I noted on physical exam that Mary is a thin, uncomfortable-appearing woman who is without respiratory distress at rest. Her temperature is 38.5°C, blood pressure 110/60, heart rate 88, and respiratory rate 18. Her HEENT exam is within normal limits; no sign of oral thrush/lesions/ulcers. Her neck is supple; no signs of generalized lymphadenopathy. Her lung exam reveals faint scattered bilateral crackles. She has no nasal flaring, wheezes, or intercostal retractions. Her neurological, cardiovascular, and abdominal exams are normal. Skin exam is notable for excoriated nodules scattered over arms, legs, and trunk.”

The mentee pauses here and waits for your response.

## Step One: Get a Commitment

### Questions that you pose as the mentor:

**Your questions:** “Based on this information, what would be your priority tasks to follow-up with this patient today?”

**Mentee’s reply:** “I am mostly concerned that Mary might have a respiratory infection and that I will need to start ART for her today.”

**Your reply:** “Okay, what specific infections are you worried about at this juncture?”

**Mentee’s reply:** “Mary could potentially have an opportunistic infection [OIs], such as PCP, pulmonary TB or bacterial pneumonia.”

## Step Two: Probe for Supporting Evidence

**Your reply:** “What elements of your history and physical support these differential diagnoses?”

**Mentee:** “I am suspicious of PCP pneumonia/TB/bacterial pneumonia because of her history of fever, cough, and progressive shortness of breath, especially given her low CD4 count. Also, she is febrile today and had scattered crackles throughout her lung fields.

## Step Three: Reinforce What Was Done Well

**Your feedback:** “Good job. You gave a thorough presentation of this patient visit. I am glad that you are prioritizing Mary’s risks for acquiring OIs given her immune status. The potential diagnoses that you gave were absolutely appropriate. We will definitely want to start talking about ART with Mary. However, we’ll see if we can get this current infection treated first.”

## Step Four: Give Guidance about Errors and Omissions

**Your feedback:** “One thing that might help us with narrowing Mary’s diagnosis is to obtain more information about her cough. You did not mention whether or not Mary has any sputum associated with her cough. Make sure you always note whether patients are expectorating sputum when patients present with the symptom of a cough. So you’ll want to enquire about whether Mary has had any blood-tinged or other colored-sputum. Also, it is important to enquire if she’s had a history of TB, or if anyone in her family has had a recent history of TB, especially given her HIV status.”

## Step Five: Teach a General Principle

**Your input:** “Remember, that in general, opportunistic infections need to be treated or stabilized before starting HIV patients on ART. This helps to avoid dangerous drug-drug interactions between OI treatment regimens and ART regimens. This also helps to prevent patients from being overwhelmed with taking too many medications at once. Adherence to ART by itself is challenging enough.”

## Step Six: Conclusion

**Your input:** “Let’s go back in the room and talk with Mary. You can enquire about the history questions I mentioned. And then we can talk about running additional tests to help determine Mary’s condition and discuss her treatment options for today. Since she was diagnosed with HIV so recently let’s also make sure we spend time answering questions that she may have regarding her condition.”



## Bedside Teaching (5)

### After consultation:

- Review and summarize key points.
  - Solicit questions from mentee, and discuss any identified problems.
  - Offer specific positive and constructive feedback.
  - Agree on an area of improvement and formulate a plan for how to improve.
- After the patient encounter, there should be a debrief session and time for questions and future planning, if possible.
  - Refer to Handout 5.3 for more information on the patient-centered approach to bedside teaching







## Handout 5.3: A Patient-Centered Approach to Bedside Teaching

Adapted from: Linda M. Roth, Ph.D., David L. Gaspar, M.D., John Porcelli, Ph.D., Department of Family Medicine, Wayne State University

### DIAGNOSE PATIENT AND LEARNER

Step	Task	Purpose	Cue	Action	Do	Don't
1	Get a commitment.	Gives <u>learner</u> responsibility for patient care. Encourages information processing within <u>learner's</u> database.	Learner presents case, then stops.	Ask what the learner thinks: "What do you think is going on?" "What would you like to do next?"	<u>Do</u> determine how the learner sees the case. (Allows learner to create his/her own formulation of the problem.)	<u>Don't</u> ask for more data about the patient. <u>Don't</u> provide an answer to the problem.
2	Probe for supporting evidence.	Allows preceptor to diagnose learner.	Learner commits to stance; looks to preceptor for confirmation.	Probe learner's thinking: "What led you to that conclusion?" "What else may be happening here?" "What would you like to do next?"	<u>Do</u> diagnose learner's understanding of the case – gaps and misconceptions, poor reasoning or attitudes.	<u>Don't</u> ask for textbook knowledge.

### TEACH

Step	Task	Purpose	Cue	Action	Do	Don't
3	Choose a single, relevant teaching point.	Focus on specific competencies relevant to this learner working with this patient.	Case decision-making complete or consultation with patient needed.	Provide instruction. The learner (under direction or observation) or preceptor (acting as role model) collects additional information as needed.	<u>Do</u> check for learner agreement with the teaching point.	<u>Don't</u> choose too much to cover.
4	Teach (or reinforce) a general rule.	Remediate any gaps or mistakes in data, knowledge, or missed connections.	Apparent gaps or mistakes in learner thinking.	Draw or elicit generalizations. "Let's list the key features of this problem." "A way of dealing with this problem is..."	<u>Do</u> help the learner generalize from this case to other cases.	<u>Don't</u> slip into anecdotes, idiosyncratic preferences.
5	Reinforce what was done right.	Firmly establish and reinforce knowledge. Reinforce behaviors beneficial to patient, colleague, or clinic.	Teaching point has been delivered.	Provide reinforcement. "Specifically, you did a good job of..., and here's why it is important..."	<u>Do</u> state specifically what was done well and why that is important.	<u>Don't</u> give general praise, "that was good," because the key to effective feedback is <u>specificity</u> .
6	Correct errors.	Teach learner how to correct the learning problem and avoid making the mistake in the future.	Teaching point has been delivered.	Endure correct knowledge has been gained. "What would you do differently to improve your encounter next time?"	<u>Do</u> make recommendations for improving future performance.	<u>Don't</u> avoid confrontation – errors uncorrected will be repeated.

### ONE-MINUTE REFLECTION

Ask: "What did I learn about this learner?" "What did I learn about my teaching?" "How would I perform differently in the future?"

References: Neher, J.O., Gordon, K.C., Meyer, B., and Stevens, N. A five-step "microskills" model of clinical teaching. *J Am Board Fam Pract* 1992; 5:419-24.  
DeRosa, et. al. Strategies for making ambulatory teaching lite: less time and more fulfilling. *Acad Med* 1997; 72(5): 358-61.  
Education document shared with AAMC CGEA Faculty Development SIG, March, 2001. Contact lroth@med.wayne.edu





## Trainer instructions: Step 5 (slides 18–20) – 5 minutes

Review slides 18–20 and discuss side-by-side teaching.

<b>Slide 18</b>	<p><b>Side-by-Side Teaching</b></p> <ul style="list-style-type: none"><li>■ As the name implies, this technique involves working alongside the mentee in clinic.</li><li>■ Mentor and mentee alternate duties of seeing and examining the patients, writing relevant information in patient's health record and ART file, and checking lab results.</li></ul>  <p>Session 5: Clinical Teaching Moments <span style="float: right;">Slide 18</span></p>	<p>This is a particularly useful technique for a busy clinic setting.</p>
<b>Slide 19</b>	<p><b>Side-by-Side Teaching: Benefits</b></p> <ul style="list-style-type: none"><li>■ Mentor can observe mentee at work and identify and address challenges</li><li>■ Mentor acts as a role model when he/she is performing physical exam</li><li>■ Patients are seen more quickly than if the mentee sees the patients alone</li><li>■ Visits are more comprehensive and thorough</li><li>■ Mentors do not feel like they are being watched, but rather supported by a colleague</li></ul>  <p>Session 5: Clinical Teaching Moments <span style="float: right;">Slide 19</span></p>	<ul style="list-style-type: none"><li>• This technique decreases wait times. It can enable patients to get more attention from the health care worker and enable the health care worker to feel a level of empathy that can be hard to convey in a busy clinic setting where they are overwhelmed by patients and are working alone.</li><li>• Promotes a two-way learning environment.</li></ul>
<b>Slide 20</b>	<p>“Example is not the main thing influencing others. It is the only thing.”</p> <p>-Albert Schweitzer</p>  <p>Session 5: Clinical Teaching Moments <span style="float: right;">Slide 20</span></p>	<p>This quote highlights the importance of teaching by modeling. Mentors must model good practices in order for mentees to learn them.</p>



## Trainer instructions: Step 6 (slides 21-24) – 10 minutes

Review slides 21-24, Case Studies and Case Presentations.

<p>Slide 21</p>	<p><b>Case Studies: Defined</b></p> <ul style="list-style-type: none"><li>■ A training methodology that provides learners with an opportunity to apply new skills and knowledge to a simulated “real-life” situation</li><li>■ Allows exploration of various strategies to address complex issues</li><li>■ Requires learners to analyze the scenario, problem solve, and apply what they know to work through the case, much like they would in a clinic setting</li></ul>  <p>Session 5: Clinical Teaching Moments</p>	<ul style="list-style-type: none"><li>• In the case study method, a scenario is presented to learners followed by discussion questions about how to characterize, describe, and/or act on the situation in the scenario.</li><li>• The case study methodology thus enables the learner to develop analytic, problem-solving, and critical thinking skills in order to synthesize relevant information and make decisions.</li></ul>
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<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 22</b></p>	<div style="background-color: #d9ead3; padding: 10px;"> <h3 style="margin: 0;">Case Studies: Rationale</h3> <ul style="list-style-type: none"> <li>■ Case studies are one of the most effective ways to train health care workers in the delivery of ART, particularly in multidisciplinary teams.</li> <li>■ Case studies can be used to role play best practices and effective health care worker behaviors.</li> <li>■ Effective case studies include adequate patient detail and specific decision points.</li> <li>■ Discussion of options is central to case studies.</li> </ul> </div> <div style="text-align: center; margin-top: 10px;">  <p style="font-size: small;">Session 5: Clinical Teaching Moments</p> </div>	<p>Case presentations are a good strategy to supplement bedside and side-by-side teaching. They are an effective way to engage all of the staff in a learning process, and they can be used to promote learning at more complex levels in both the cognitive and affective domains.</p> <p><b>Cognitive:</b></p> <ul style="list-style-type: none"> <li>• Case studies can help to develop higher-level cognitive processes such as comprehension, analysis, application, and evaluation.</li> <li>• The process requires learners to go beyond remembering facts and theories, and apply newly acquired knowledge and skills to multifaceted, complex, “real-life” examples.</li> </ul> <p><b>Affective:</b></p> <ul style="list-style-type: none"> <li>• Includes questions that promote reflection on personal values, attitudes, and emotions.</li> <li>• Case studies can be developed that spark discussion on controversial societal or clinical issues or to foster reflection on values, attitudes, and emotions amongst learners.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 23</b></p>	<div style="background-color: #d9ead3; padding: 10px;"> <h3 style="margin: 0;">Case Presentations (1)</h3> <ul style="list-style-type: none"> <li>■ Invite a staff member to present a difficult or challenging case they have encountered. Presentation should include the following: <ul style="list-style-type: none"> <li>■ Issue patient presented with</li> <li>■ Age, gender, relevant social history</li> <li>■ Medical history</li> <li>■ Current profile: risk, symptoms, medications, HIV status, etc.</li> <li>■ What they did in the situation</li> </ul> </li> </ul> </div> <div style="text-align: center; margin-top: 10px;">  <p style="font-size: small;">Session 5: Clinical Teaching Moments</p> </div>	<ul style="list-style-type: none"> <li>• Case presentations can be used at staff meetings, grand rounds, multidisciplinary team meetings, or in training sessions.</li> <li>• The case that is presented should be a case from the facility, which makes it a realistic and relevant case to the staff. <ul style="list-style-type: none"> <li>• Ensure that confidentiality is maintained.</li> </ul> </li> <li>• Case presentations provide an opportunity for health care workers to practice giving succinct summaries of patients, a skill required in the bedside teaching approach.</li> <li>• Case presentations also allow health care workers to learn from how their colleagues treated patients.</li> </ul>

## Case Presentations (2)

- Thank the staff person. Discuss the case:
  - What was good about the way the case was handled?
  - What recommendations would improve management of the case?
- Provide your own feedback/observations on the case.



Refer to Handout 5.4 as a reference for developing case studies.



## **Handout 5.4: Six Steps for Creating an Effective Case Study**

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*Date:* 2003

*Editors:* Ann Downer, MS, EdD and Sue Swindells, MBBS

*Source:* Developing Clinical Case Studies: A Guide for Teaching

AETC National Resource Center and International AIDS Society-USA

This guide was prepared for the AETC National Resource Center by the International AIDS Society-USA with funding from the U.S. Health Resources Services Administration (HRSA). Copyright International AIDS Society- USA, 2003.

### **Steps:**

Step 1. Identify the Learners and Write Educational Objectives

Step 2. Describe the Patient and Develop Sufficient Case Detail

Step 3. Focus the Learner on Discrete Clinical Decision Points

Step 4. Present Viable Options at Decision Points

Step 5. Analyze Options and Select One Course of Action

Step 6. Introduce New Information and Continue to Next Clinical Decision Point

## Step 1. Identify the Learners and Write Educational Objectives

The development of effective educational material begins with consideration of the learner and his or her learning needs. Needs assessment identifies specific issues that may be challenging, confusing, or controversial to learners. See Table 1 for tips on assessing learners in advance of the teaching session or on-the-spot. If an opportunity does exist to assess learners in advance, it can be accomplished with a short questionnaire, email correspondence, or brief interviews with those planning to participate in the educational activity.

**Table 1. Needs Assessment: Learn More about Your Audience**

**During the planning phase:**

- Send an email query to those likely to attend a session (ask two–three key questions)
- Have a 10-minute phone call with several probable attendees
- Have a discussion with a key informant about the group’s general characteristics
- Write a formal, short needs-assessment questionnaire

**On the spot:**

*As the presentation begins, ask a few key questions; use a show of hands*

- What is your educational training (MD, RN, NP, PA, etc.)?
- How many years have you been an HIV-care practitioner?
- What percent of your caseload is HIV-related?
- Do you work with patients with HIV infection and substance abuse? Injection drug use?

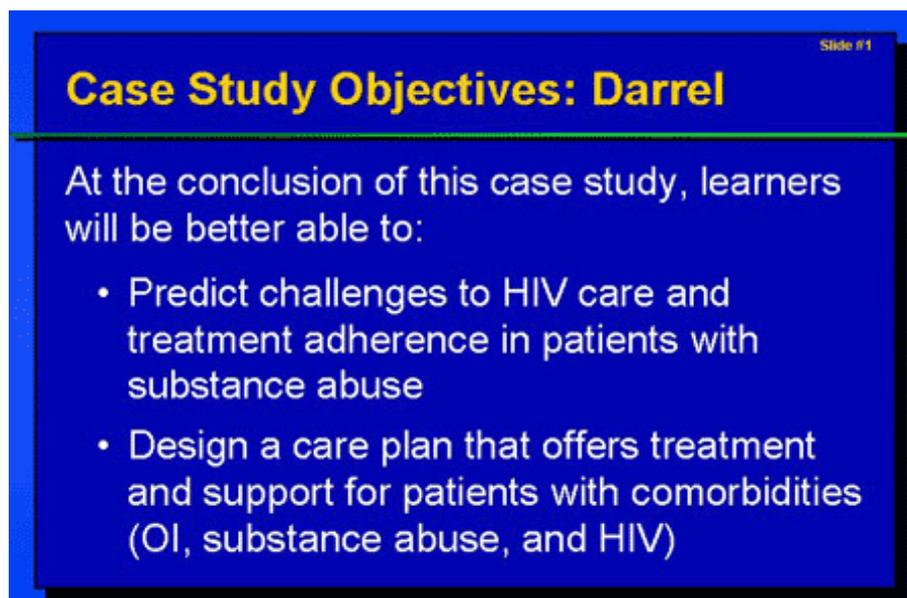
The focus of the case will depend on learners and on the specific skills relevant to their medical practices. For example, say a patient with active substance abuse problems is admitted to the hospital through the emergency department with a diagnosis of PCP. The first clinical decision point the learner is asked to make concerns the discharge plan. The elements of the discharge plan of greatest concern to social workers are different from those of concern to an audience of HIV physicians. The focus of the scenario, therefore, depends on the needs and interests of the learners.

The actual design of a case begins with the creation of specific learning objectives once the learners and topic are defined. It is often more difficult to design objectives to fit an existing patient case scenario than to start with learning objectives and build a new case around them. The specific objectives of the case should be identified even if the case is not part of an activity that carries CME credit (which requires the publication of objectives).

Learning objectives are words, pictures or diagrams that tell others what you intend for your students to learn.<sup>1</sup> The purpose of writing strong learning objectives is to make explicit the expected outcomes of a learning event and to establish accountability between the instructor and learner. Specific measurable objectives are essential for determining outcomes in the activity evaluation. Table 2 describes the elements of strong objectives and Table 3 provides a detailed taxonomy for learning objectives.

<b>Table 2. Writing Strong Objectives</b>
<ul style="list-style-type: none"><li>• Strong objectives are specific. They are constructed by stating a performance that describes specific knowledge, attitudes, or skills that a student should be able to demonstrate following exposure to a learning activity. They do not describe the teaching strategy used to achieve a learning outcome.</li><li>• Strong objectives are measurable. They use active verbs that can be measured by test items, observation, problem-solving exercises, or other evaluation methods. If the performance behavior is covert (will recognize, will identify), then an indicator behavior (will recognize by circling, will identify by underlining) should be stated. See Table 3 for a list of measurable verbs for assessing achievement.</li><li>• Strong objectives are achievable and realistic. They describe expectations of knowledge, attitude, or behavior change that are realistic given the conditions for instruction (ie, time and size of the group).</li></ul> <p style="text-align: right;">Adapted from Mager<sup>1</sup></p>

A case study should have more than one objective. Often a series of objectives are addressed as the case unfolds. The clinical decision points of the case focus on the issues identified in the objectives. The case study included in this guide was designed to address the issue of HIV treatment for patients with drug addiction. The specific educational objectives are listed in Slide 1.



Slide #1

## Case Study Objectives: Darrel

At the conclusion of this case study, learners will be better able to:

- Predict challenges to HIV care and treatment adherence in patients with substance abuse
- Design a care plan that offers treatment and support for patients with comorbidities (OI, substance abuse, and HIV)

## Step 2. Describe the Patient and Develop Sufficient Case Detail

The first part of a case description provides baseline information on the patient and moves the learner toward the first clinical decision point. Key baseline information may include age, sex, HIV infection status, reported symptoms at presentation, recent medical history, relevant social history, findings from physical examination, results of laboratory studies, and findings of diagnostic workup.

The number of elements included in the case description depends on the complexity of the case and the information needed to stage the decision point.

### Tip Box 2. Tips for Creating Effective Slides

- Give each slide a title. Titles help the audience quickly understand the main theme.
- Use as few words as possible to convey your point; help the audience focus on key points.
- Make your text large. Use titles with a minimum 36-point type size and text with a minimum 24-point type size. Do not use a slide that the audience cannot read.
- Use no more than eight words per line of text and no more than six lines of text on each slide.
- Minimize detail on tables and figures.
- Choose strong color contrast between the background and the text. Use light background color for a poorly lit room and dark background for a brightly lit room.
- Text drop shadows should be black or a darker shade of the background color.

In general, the information should be as brief as possible while providing enough detail for the learner to make an informed clinical decision. Slides 2 and 3 describe a patient's substance dependence, HIV status, and PCP treatment in brief but sufficient detail. The information provided is minimal but varied enough to support discussion of a number of common clinical issues, such as adherence to antiretroviral therapy in active substance users and potential drug-drug interactions between heroin or methadone and antiretroviral drugs.

## Case Description: Darrel

- A 40-year-old heroin IDU is diagnosed with PCP and admitted to the hospital
- Treatment includes TMP-SMX and methadone
- HIV serostatus unknown; has had friends die of AIDS. Tests HIV+

## Case Description: Darrel (2)

- Patient does well on PCP therapy
- CD4+ cell count is 25/ $\mu$ L; HIV-1 RNA level is >750,000 copies/mL
- Tests for HCV and HBV are positive
- Expresses interest in continuing methadone treatment

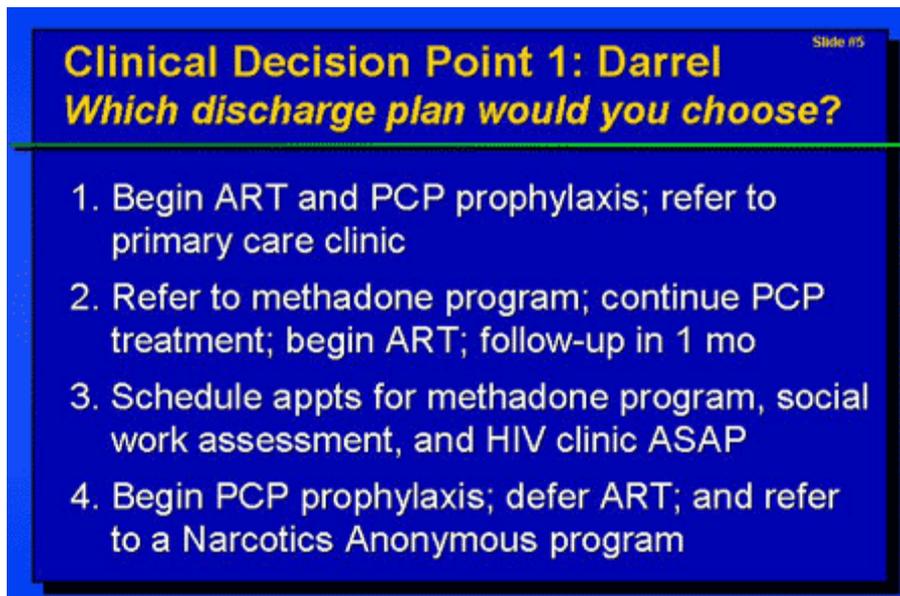
It is important to provide enough information for the learners to make a decision. The patient description shown in Slide 4, if used alone, would not be sufficient to support a clinical decision point. Key information is missing, such as CD4+ cell count and viral load data, as well as any substance abuse or other health issues.

## Insufficient Detail for Case Description

- A 40-year-old HIV-infected man admitted to the hospital with PCP
- Presumptive HIV infection confirmed
- Patient does well on treatment for PCP and is scheduled for discharge

### Step 3. Focus the Learner on Discrete Clinical Decision Points

Once the baseline information has been presented, the case study moves toward a clinical decision point. The purpose of the decision point is to focus learners' attention on discrete opportunities for informed decision making. It is important to develop a well-defined question that addresses an educational objective. In the case example, Darrel is being discharged from the hospital after treatment for PCP, and the learner is asked to select a recommended discharge plan (see Slide 5). The learning objective for this clinical decision point anticipates that the learner will be able to "design a care plan that offers treatment and support for patients with comorbidities (opportunistic infections, substance abuse, HIV)".



Slide #5

**Clinical Decision Point 1: Darrel**  
***Which discharge plan would you choose?***

1. Begin ART and PCP prophylaxis; refer to primary care clinic
2. Refer to methadone program; continue PCP treatment; begin ART; follow-up in 1 mo
3. Schedule appts for methadone program, social work assessment, and HIV clinic ASAP
4. Begin PCP prophylaxis; defer ART; and refer to a Narcotics Anonymous program

If an additional educational objective had specified that the learner will be able to “select an initial antiretroviral regimen for a patient with substance dependence,” then the clinical decision point could be redirected (see Slide 6). In this slightly different patient description, a stable living situation and drug treatment have been arranged, and the elements of the clinical decision change. Instead of focusing the decision on the types of treatment to support the patient upon discharge, the learner could choose among different antiretroviral regimens and weighs potential drug-drug interactions, adverse effects, and adherence challenges.

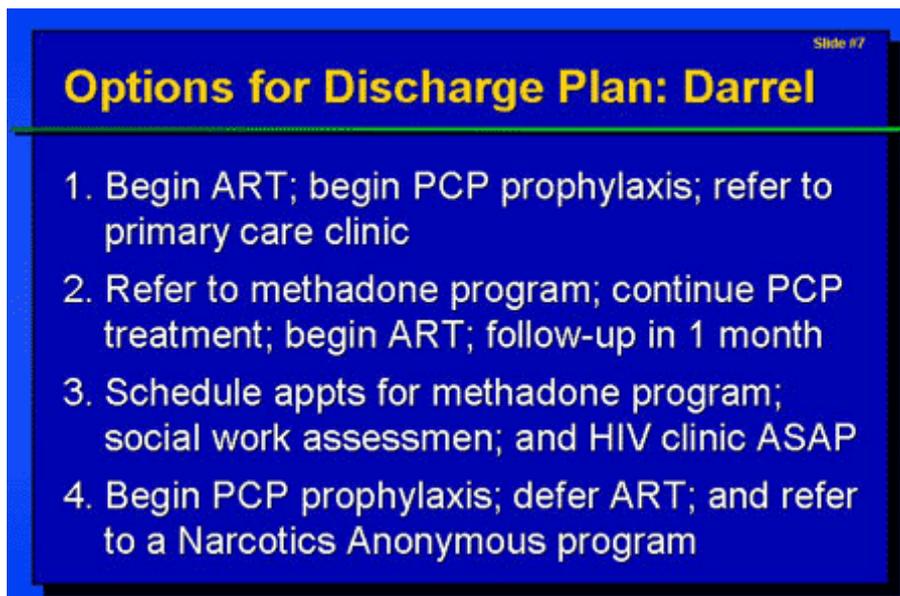
Slide 10

### Different Case Description for Different Discharge Options

- Patient does well on PCP therapy; CD4+ cell count 25/ $\mu$ L; HIV-1 RNA level >750,000 copies/mL
- Patient is placed in residential methadone treatment program and wants to start ART

## Step 4. Present Viable Options at Decision Points

It is important to present a number of relevant, mutually exclusive decision options to the learners. Each choice should be comparable to the others in terms of importance, plausibility, and level of detail. In Slide 7, for example, the options to choose from are balanced and most address the three key elements of the discharge plan: PCP treatment, follow-up HIV care, and substance abuse treatment. While there is often no “right” answer, there should be a clearly “preferred” answer.

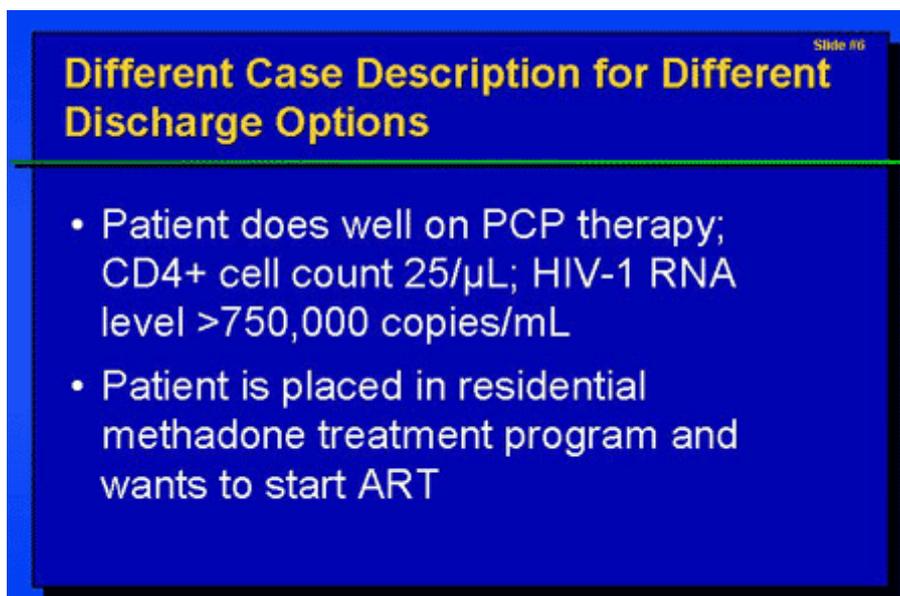


Slide 7

### Options for Discharge Plan: Darrel

1. Begin ART; begin PCP prophylaxis; refer to primary care clinic
2. Refer to methadone program; continue PCP treatment; begin ART; follow-up in 1 month
3. Schedule appts for methadone program; social work assessment; and HIV clinic ASAP
4. Begin PCP prophylaxis; defer ART; and refer to a Narcotics Anonymous program

If, as described in Slide 6, the focus of the clinical decision point had been to select among treatment regimens, the options to choose from would be a list of antiretroviral drug combinations.



Slide 8

### Different Case Description for Different Discharge Options

- Patient does well on PCP therapy; CD4+ cell count 25/μL; HIV-1 RNA level >750,000 copies/mL
- Patient is placed in residential methadone treatment program and wants to start ART

It is important to create options that are grammatically similar and of roughly the same length. For example, the options are comparable in length on Slide 7. The longest option in a multiple choice set is often the preferred one because there is a natural tendency to explain and rationalize the preferred response in greater detail to the learner. This tendency is illustrated in Slide 8. It is also useful to avoid including the options “all of the above” and “none of the above” in multiple choice response sets. Instead, provide the learner with concrete, discrete choices.



Slide 8

### Weak Options for Discharge Plan

1. Begin ART; begin PCP prophylaxis; refer to primary care clinic
2. Refer to methadone program; continue PCP treatment; begin ART
3. Schedule an appointment for a methadone program to address the heroin addiction, an assessment from a social worker, and an appointment at an HIV clinic as soon as possible. Build a support team for the patient
4. None of the above

## Step 5. Analyze Options and Select One Course of Action

In Step 5, the instructor identifies the preferred response from among the multiple choices once learners have had a chance to consider (and possibly vote on) the alternatives. At this point, the case study presentation usually includes a brief lecture segment supporting the relevant clinical issues related to the preferred response. If available, new developments and current data supporting the preferred choice are presented. The current data are discussed in the context of the patient's situation, and the various options are contrasted and weighed.

Slides 9 and 10 illustrate two formats for presenting a preferred option. Slide 9 presents only the preferred option and provides a brief rationale for it. Slide 10 shows the preferred option highlighted to stand out among all the other options.

Slide #9

### Preferred Discharge Plan: Darrel

Option: Schedule appts for methadone program, social work assessment, and HIV clinic ASAP

Why?

- Drug treatment is essential first step
- Deferring ART and building team of care providers may offer best chance for success

Slide #10

### Options for Discharge Plan: Darrel

- Begin ART; begin PCP prophylaxis; refer to primary care clinic
- Refer to methadone program; continue PCP treatment; begin ART; follow-up in 1 mo
- Schedule appts for methadone program, social work assessment, and HIV clinic ASAP
- Begin PCP prophylaxis; defer ART; and refer to a Narcotics Anonymous program

Slides 11 and 12 list a number of factors that support the decision on how care was prioritized for this patient. The discussion could expand on any of these topics. If, as discussed above, the clinical decision point focused on selecting a specific antiretroviral regimen, these slides could present data on drug characteristics and potential interactions with methadone and heroin.

Slide #11

## Factors Limiting Use of HIV Treatment in Substance Users

- Limited access to substance-abuse treatment programs
- Limited access to HIV care
- Complex and inadequately studied drug-drug interactions

(cont'd)

Slide #12

## Factors Limiting HIV Treatment in Substance Users (cont'd)

- Underlying renal and hepatic disease
- Patient↔provider attitudes
- Patient acceptance of and adherence to ART

An important part of presenting the preferred response in Step 5 is the discussion and review of alternative options. This is an opportunity to present data and demonstrate the decision-making process. Slide 13 illustrates one format for presenting each of the options not selected, accompanied by a brief explanation of why, in the context of this case study, another strategy is preferred.

Slide #13

## Options Not Selected: Darrel

Option: Begin ART; begin PCP prophylaxis; refer to primary care clinic

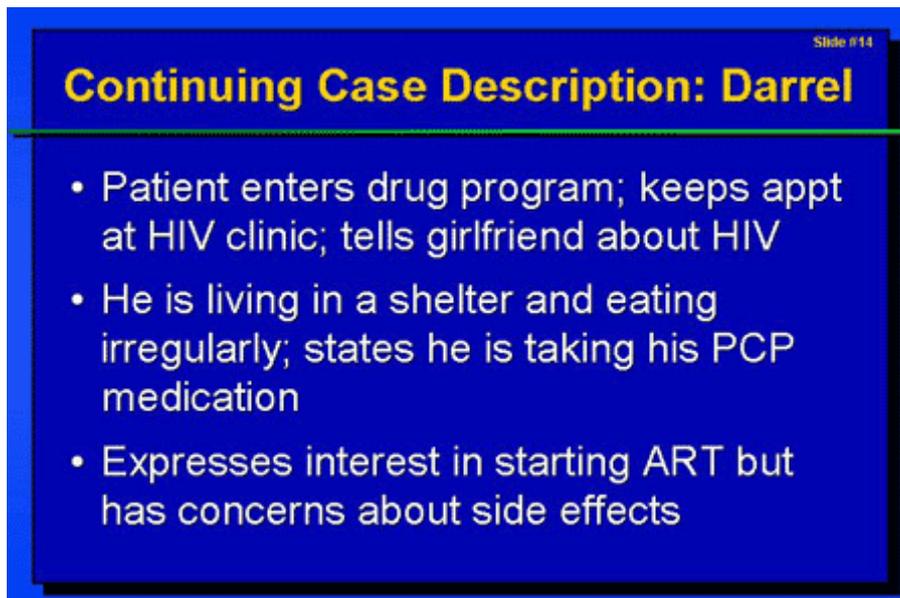
Why not?

- Does not include substance abuse treatment
- Without addiction treatment and more information/support for patient, adherence to ART and to PCP prophylaxis is unlikely

## Step 6. Introduce New Information and Continue to Next Clinical Decision Point

The previous steps describe one cycle of a case study through the resolution of a clinical decision point. The case can be used in its current length as a short vignette, or it can be moved toward a second decision point on the same patient.

Darrel's case can continue with new information from a follow-up appointment (e.g., ongoing symptoms, adverse effects of medication, or laboratory results), leading the learner to another clinical decision point. These points can be designed to address either the same or different educational objectives. Slide 14 describes the next encounter with Darrel in the case study, and sets the stage for the second clinical decision point on Slide 15. The patient now has entered a methadone treatment program and attended an HIV clinic. Although his living situation remains unstable, he is interested in starting antiretroviral therapy. The treatment recommendation options listed on Slide 16 lead the discussion to adherence issues among substance users. One option is to set and meet an adherence goal before beginning antiretroviral therapy, such as getting a note on attendance from the methadone clinic, attending three HIV clinic appointments, or completing a trial drug regimen with jelly beans.



Slide #14

### Continuing Case Description: Darrel

- Patient enters drug program; keeps appt at HIV clinic; tells girlfriend about HIV
- He is living in a shelter and eating irregularly; states he is taking his PCP medication
- Expresses interest in starting ART but has concerns about side effects

## Clinical Decision Point 2: Darrel

Slide #15

What is your recommendation on beginning ART?

## Options for Treatment: Darrel

Slide #16

Choose the best option:

1. Meet goal before starting ART (ie, regular clinic visits, trial regimen with candy)
2. Begin ART with lamivudine/zidovudine and lopinavir/ritonavir
3. Begin ART with abacavir/zidovudine/lamivudine

The issue of adherence in substance users is likely to spark controversy and debate among the audience and evoke personal and professional attitudes toward substance users. This example demonstrates the importance of good facilitation skills in addition to traditional teaching/instructing skills. Inexperienced instructors make two common mistakes in facilitating discussion. They sometimes fail to provide the direction and leadership that a learning group needs or they become over-involved in the discussion and unable to maintain the critical role of facilitator. Some facilitation strategies are offered in Table 4.

One benefit of following a single patient through a number of decision points is that it allows an audience or learner to quickly assimilate new information since the patient history is already known. Use of a continuing case reflects realistic dynamics of patient care. However, shorter vignettes with one or two brief decisions points have advantages, too. They may move a learner quickly through a variety of clinical situations.

**Table 4. Strategies for Optimizing Group Discussion**

**Table 4. Strategies for Optimizing Group Discussion**

- Briefly clarify the purpose at the outset.
- Establish norms for group interaction at the outset; request ideas or suggest guidelines (ground rules) for effective small or large group functioning. Summarize or ask someone in the group to summarize the ground rules before moving on to another topic.
- Model the norms throughout (i.e., respect for differences of approach or opinion when no single correct course of action is determined).
- Do not reply or respond to each comment. Move to the next person wishing to comment or turn to the group for a response.
- Use the experience of the group as a resource for teaching.
- Actively invite ideas and suggestions.
- Plan your time to allow for real interaction.
- Do not introduce a controversial or emotionally laden topic without allowing sufficient time for a full discussion and resolution. If pressed for time, it is better to skip such content than to cut off discussion before opinions are expressed, full discussion has occurred, and a summary of points or ideas has been offered.
- Create a psychologically safe climate for learning that is free of threat and judgment. Showing patience and respect for differences of opinion, questions, comments, and responses and by avoiding disapproving, sarcastic or condescending reactions.

## References

1. Mager RF. Preparing Instructional Objectives. Atlanta: Center for Effective Performance, Inc.; 1997.

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## Trainer instructions: Step 7 (slide 25) – 5 minutes

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Review the Key Points and ask participants if they have any remaining questions.

<b>Slide 25</b>	<p><b>Key Points</b></p> <ul style="list-style-type: none"><li>■ Teaching moments are opportunities to improve clinical skills of a health care worker, can take place in a variety of settings, and mentors should maximize the number of teaching moments at a site visit.</li><li>■ Bedside and side-by-side teaching reinforce classroom learning, and allow the mentor to model clinical technique, as well as attitudes and behaviors.</li><li>■ Case studies are an effective tool for clinical teaching.</li></ul> <p></p> <p><small>Session 5: Clinical Teaching Moments</small></p>	
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**I-TECH**



INTERNATIONAL  
TRAINING &  
EDUCATION  
CENTER ON HIV

**Session 6: Clinical Diagnosis and  
Decision-Making Skills**

**Facilitator Guide**

**Basics of Clinical Mentoring**



# Session 6: Clinical Diagnosis and Decision-Making Skills

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**Time: 1 hour (60 minutes)**

## Learning Objectives

By the end of this session, participants will be able to:

- Identify concepts of evidence-based medicine
- Identify common errors in clinical reasoning that should be avoided

## Session Overview

Step	Time	Method	Title	Resources
1	5 minutes	Presentation	Introduction and Learning Objectives (slides 1-2)	LCD or overhead projector
2	15 minutes	Presentation	Evidence-Based Medicine (slides 3-8)	LCD or overhead projector Handout 6.1
3	5 minutes	Presentation	Key Points (slide 9)	LCD or overhead projector
4	35 minutes	Activity	Case Study (slides 10-17)	LCD or overhead projector Worksheet 6.2



## Resources Needed

- LCD or overhead projector
- Flip chart and markers



## Handouts

- Handout 6.1: Avoiding Errors in Clinical Reasoning



## Worksheets

- Worksheet 6.2: Clinical Decision-Making Case Study

## Key Points

- Resource-poor settings may lack diagnostic technology that mentors are accustomed to, so clinical reasoning skills are important.
- Nine principles of evidence-based medicine guide the clinician in diagnosis, emphasizing the most common and/or fatal potential causes, and avoiding errors in clinical reasoning.

# Training Material

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## Trainer instructions: Step 1 (slides 1-2) – 5 minutes

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Present slides 1-2, Introduction and Learning Objectives, and provide participants an introduction to this session.

<b>Slide 1</b>	 <p><b>Session 6:</b> <b>Clinical Diagnosis and Decision-Making Skills</b></p> <hr/> <p>Basics of Clinical Mentoring</p>	
<b>Slide 2</b>	 <p><b>Learning Objectives</b></p> <hr/> <p>By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"><li>■ Identify concepts of evidence-based medicine</li><li>■ Identify common errors in clinical reasoning that should be avoided</li></ul>  <p>Session 6: Clinical Diagnosis and Decision-Making Skills</p> <p>Slide 2</p>	



## Trainer instructions: Step 2 (slides 3–8) – 15 minutes

Present slides 3–8, Evidence-Based Medicine. Refer participants to Handout 6.1 for a list of the principles contained in these slides.

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 3</b></p>	<p><b>Evidence-Based Medicine</b></p> <ul style="list-style-type: none"> <li>■ Because mentors are placed in resource-poor settings, some of the diagnostic technologies and tests that they may be accustomed to using are lacking.</li> <li>■ Developing clinical reasoning and diagnosis skills using a patient’s history and physical exam is crucial.</li> </ul>  <p style="font-size: small;">Session 6: Clinical Diagnosis and Decision-Making Skills <span style="float: right;">Slide 3</span></p>	<p>In addition, these are principles that should be taught to/reviewed with mentees so as to improve their clinical diagnosis skills.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 4</b></p>	<p><b>Evidence-Based Medicine: Principles (1)</b></p> <p>1. Occam’s Razor:</p> <ul style="list-style-type: none"> <li>■ Advises choosing the simplest hypothesis to explains a set of clinical findings</li> <li>■ The caveat is that in immunocompromised patients, more than one pathological process may be at work.</li> </ul>  <p style="font-size: small;">Session 6: Clinical Diagnosis and Decision-Making Skills <span style="float: right;">Slide 4</span></p>	<p>See Handout 6.1 for a list of the principles contained on this slide and the following slides.</p>

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 5</b></p>	<p><b>Evidence-Based Medicine: Principles (2)</b></p> <p>2. Sutton's Law: Consider local common causes for a set of symptoms before considering uncommon causes.</p> <p>3. In contrast to Sutton's Law, consider conditions that might kill a patient quickly, even if they are uncommon.</p> <p><i>When planning treatment, cover the most common causes <b>and</b> the most serious (life-threatening) possible causes.</i></p>  <p><small>Session 6: Clinical Diagnosis and Decision-Making Skills</small> <span style="float: right;"><small>Slide 5</small></span></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 6</b></p>	<p><b>Evidence-Based Medicine: Principles (3)</b></p> <p>4. Avoid premature closure of the diagnostic process—start with a broad differential diagnosis and do not eliminate possibilities without sufficient evidence.</p> <p>5. Don't be overconfident about your differential diagnoses—ask questions to disprove as well as confirm the hypothesized diagnoses.</p> <p>6. Know what you don't know, and seek out help from a book, a consultant, the Internet.</p>  <p><small>Session 6: Clinical Diagnosis and Decision-Making Skills</small> <span style="float: right;"><small>Slide 6</small></span></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 7</b></p>	<p><b>Evidence-Based Medicine: Principles (4)</b></p> <p>7. Common diseases often have uncommon presentations, and uncommon diseases can look like very common ones. Just because a clinical presentation looks similar to Illness X does not mean that Illness X is the cause.</p> <p>8. Correlation ≠ causation. Just because two findings occur together does not mean that one caused the other.</p>  <p><small>Session 6: Clinical Diagnosis and Decision-Making Skills</small> <span style="float: right;"><small>Slide 7</small></span></p>	

**Evidence-Based Medicine: Principles (6)**

- 9. Remember that it is common to over-diagnose conditions that we have recently seen, especially ones that are dramatic.





## Handout 6.1: Avoiding Errors in Clinical Reasoning

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- **Occam's razor** advises choosing the simplest hypothesis that explains a set of clinical findings. HOWEVER, keep in mind that when dealing with an immunocompromised patient, there may be more than one pathological process occurring at the same time in the same or in different organs.
- **Sutton's law** (named after a famous bank robber who explained that he robbed banks because "that's where the money is") suggests that a clinician consider common causes in the local region for a patient's symptoms before considering uncommon causes.
- Plan your initial empiric or syndromic treatment so that you cover the most common causes and the most serious (life threatening) possible causes.
- In contrast to Sutton's law, consider what could kill a patient rapidly, even if that diagnosis may be uncommon.
- Avoid premature closure of your diagnostic process. Start out with a broad differential diagnosis and don't prematurely eliminate possibilities without sufficient evidence.
- Don't be overconfident. Seek reasons why your decisions may be wrong and consider alternative hypotheses. Ask questions that would disprove as well as prove your current hypothesis.
- Know what you don't know. Seek the missing information (e.g., from a book, a consultant, from the Internet).
- Common diseases sometimes have uncommon presentations and uncommon diseases can sometimes look like very common ones. Just because a clinical presentation looks similar to or is "representative of" a particular illness does not prove that the cause is due to that illness.
- Remember that we tend to over diagnose conditions that we have recently seen, especially those that were particularly dramatic or in which we made a mistake that we want to avoid in the future.
- Correlation  $\neq$  causation. Just because two findings occur together, doesn't necessarily mean that one caused the other.



## Trainer instructions: Step 3 (slide 9) – 5 minutes

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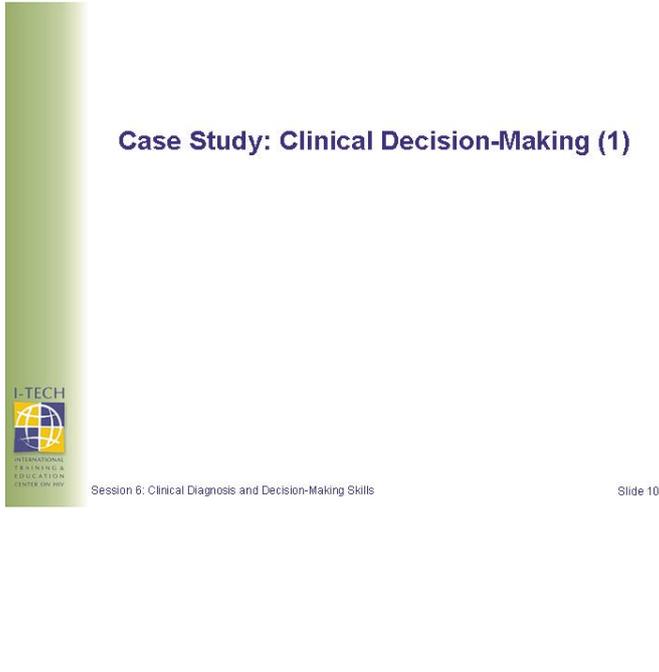
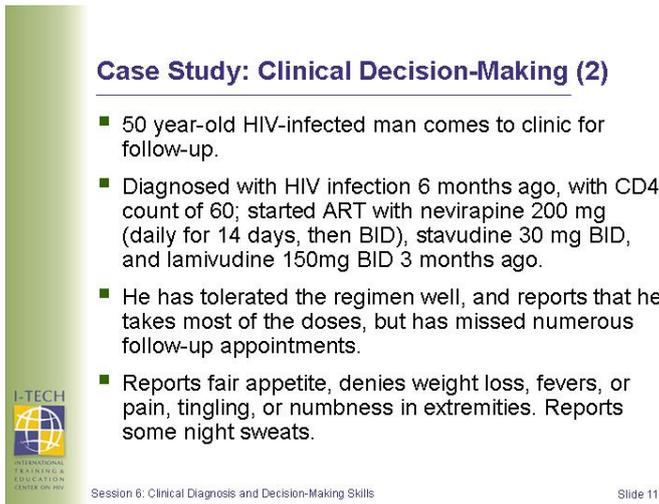
Review the Key Points and ask participants if they have any remaining questions.

<p><b>Slide 9</b></p>	<p><b>Key Points</b></p> <ul style="list-style-type: none"><li>■ Resource-poor settings may lack diagnostic technology that mentors are accustomed to, so clinical reasoning skills are important.</li><li>■ Nine principles of evidence-based medicine guide the clinician in diagnosis, emphasizing the most common and/or fatal potential causes and avoiding errors in clinical reasoning.</li></ul>  <p>Session 6: Clinical Diagnosis and Decision-Making Skills</p> <p>Slide 9</p>	<p><i>Review the key points and ask participants if they have any remaining questions.</i></p> <p><i>Present the case study in the following slides</i></p>
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## Trainer instructions: Step 4 (slides 10–17) – 35 minutes

Slides 10–14 present a case study with questions for participants. Refer to the slide notes and Worksheet 6.2 to conduct this activity.

<p><b>Slide 10</b></p>	 <p><b>Case Study: Clinical Decision-Making (1)</b></p>	<p>See Worksheet 6.2 for case study.</p> <ul style="list-style-type: none"> <li>• <i>The case is structured to include pauses in the narrative to allow learners to practice clinical decision-making.</i></li> <li>• <i>Divide participants into groups of 3-4 and refer them to Worksheet 6.2, which contains the case study and questions.</i></li> <li>• <i>Ask participants not to look ahead at the remaining slides in their Participant Handbook while working on this activity. Note that the remaining slides contain the answers to the questions.</i></li> <li>• <i>Give the groups 20 minutes to answer questions and then reconvene to review slides 15-17, which contain the answers and relate the case to clinical decision-making principles.</i></li> </ul>
<p><b>Slide 11</b></p>	 <p><b>Case Study: Clinical Decision-Making (2)</b></p> <ul style="list-style-type: none"> <li>■ 50 year-old HIV-infected man comes to clinic for follow-up.</li> <li>■ Diagnosed with HIV infection 6 months ago, with CD4 count of 60; started ART with nevirapine 200 mg (daily for 14 days, then BID), stavudine 30 mg BID, and lamivudine 150mg BID 3 months ago.</li> <li>■ He has tolerated the regimen well, and reports that he takes most of the doses, but has missed numerous follow-up appointments.</li> <li>■ Reports fair appetite, denies weight loss, fevers, or pain, tingling, or numbness in extremities. Reports some night sweats.</li> </ul>	

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 12</b></p>	<p><b>Case Study: Clinical Decision-Making (3)</b></p> <ul style="list-style-type: none"> <li>■ Chart reveals some anemia at baseline, hemoglobin of 10. His chemistries and liver enzymes were normal before starting ART. He had reported some discolorations on his skin, but there is no further mention of this in the notes.</li> <li>■ In addition to ART, he is taking cotrimoxazole, 1 double-strength tablet daily. He denies medication allergies.</li> <li>■ His vital signs appear normal in the triage nurse's note from today. Can he get his meds and go home?</li> <li>■ How should you proceed? Is the visit over?</li> </ul>  <p style="font-size: small;">Session 6: Clinical Diagnosis and Decision-Making Skills <span style="float: right;">Slide 12</span></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 13</b></p>	<p><b>Case Study: Clinical Decision-Making (4)</b></p> <ul style="list-style-type: none"> <li>■ You decide to do a quick physical exam, since it has been a while since he saw a clinician.</li> <li>■ You find: <ul style="list-style-type: none"> <li>■ A flat, oval, violaceous lesion on his hard palate that he was unaware of.</li> <li>■ 10–15 hyperpigmented, flat, non-tender lesions scattered across his torso, back, and both arms.</li> <li>■ A few hyperpigmented, flat, nodular lesions scattered on his legs.</li> </ul> </li> <li>■ His lungs are clear to auscultation and percussion, cardiac rate and rhythm are regular, no cardiac murmurs.</li> </ul>  <p style="font-size: small;">Session 6: Clinical Diagnosis and Decision-Making Skills <span style="float: right;">Slide 13</span></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 14</b></p>	<p><b>Case Study: Clinical Decision-Making (5)</b></p> <ul style="list-style-type: none"> <li>■ Abdomen is soft and non-tender to palpation. Liver edge is soft and non-distended, and you don't appreciate splenomegaly.</li> <li>■ Cranial nerves are normal. Examination of all four extremities shows intact pinprick and light touch sensation and 5/5 strength. His biceps, patellar, and heel deep tendon reflexes are 2+ and symmetric.</li> <li>■ <b>What is your preliminary diagnosis?</b></li> <li>■ <b>Do you think the patient is taking his ART?</b></li> <li>■ <b>What testing would you like to perform?</b></li> <li>■ <b>How did performing a physical exam change your management of this patient?</b></li> </ul>  <p style="font-size: small;">Session 6: Clinical Diagnosis and Decision-Making Skills <span style="float: right;">Slide 14</span></p>	





## Worksheet 6.2: Clinical Decision-Making Case Study

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### Case:

50 year-old HIV-infected man comes to clinic for a follow-up visit. He was diagnosed with HIV infection 6 months ago, and had a CD4 count of 60. He started antiretroviral therapy (ART) with nevirapine 200 mg (daily for 14 days, then BID), stavudine 30 mg BID, and lamivudine 150 mg BID 3 months ago. He has tolerated the regimen well, and reports that he takes most of the doses, but has missed numerous follow-up appointments. He reports a fair appetite, denies weight loss, fevers, pain, or tingling or numbness in his extremities. He reports some night sweats. His chart reveals some anemia at baseline (hemoglobin of 10). His chemistries and liver enzymes were normal before starting ART. He had reported some discoloration on his skin, but there is no further mention of this in the notes. In addition to ART, he is taking cotrimoxazole, 1 double-strength tablet daily. He denies medication allergies. His vital signs appear normal in the triage nurse's note from today. Can he get his meds and go home?

### Question:

**1. How should you proceed? Is the visit over?**

- *Perform a physical exam because the patient has not seen a clinician in awhile.*

### Case (continued):

You decide to do a quick physical exam, since it has been a while since he saw a clinician. You find a flat, oval, violaceous lesion on his hard palate that he was unaware of; 10–15 hyperpigmented, flat, non-tender lesions scattered across his torso, back, and both arms; a few hyperpigmented, flat, nodular lesions scattered on his legs. His lungs are clear to auscultation and percussion, and his cardiac rate and rhythm are regular with no cardiac murmurs. His abdomen is soft and non-tender to palpation. His liver edge is soft and non-distended, and you don't notice any signs of splenomegaly. Cranial nerves are normal. Examination of all four extremities shows intact pinprick and light touch sensation and 5/5 strength. His biceps, patellar, and heel deep tendon reflexes are 2+ and symmetric.

### Questions:

**2. What is your preliminary diagnosis?**

- *Kaposi sarcoma (KS), in addition to AIDS. It is likely that the patient had KS at the time ART was started because he complained of similar lesions at the time. These may have been misdiagnosed at the time, or the patient may not have been thoroughly examined.*

**3. Do you think the patient is taking his antiretroviral medications (ARVs)?**

- *The ARVs he is picking up every month may not be getting into his system, either because of poor adherence or he is not absorbing them from his GI tract. He may need chemotherapy in addition to ART to control his disease.*

**4. What testing would you like to perform?**

- *Obtain a CD4 count to see if he is experiencing immunologic recovery on ART; inquire about his adherence; inquire about symptoms of malabsorption; and obtain a chest x-ray to look for signs of pulmonary KS (usually a nodular infiltrate).*

**5. How did performing a physical exam change your management of this patient?**

- *KS would have been missed had the examiner trusted the chart and the patient's self-report, and not performed an independent physical exam.*

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 15</b></p>	 <p><b>Case Study: Clinical Decision-Making (6)</b></p> <ul style="list-style-type: none"> <li>■ <b>Preliminary diagnosis:</b> Kaposi sarcoma (KS) in addition to AIDS. It is likely that the patient had KS at the time ART was started because he complained of similar lesions at the time. These may have been misdiagnosed at the time, or the patient may not have been thoroughly examined.</li> <li>■ <b>Is the patient taking his ART?</b> The ART he is picking up every month may not be getting into his system, either because of poor adherence or he is not absorbing it from his GI tract. He may need chemotherapy in addition to ART to control his disease.</li> </ul> <p style="font-size: small;">Session 6: Clinical Diagnosis and Decision-Making Skills <span style="float: right;">Slide 15</span></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 16</b></p>	 <p><b>Case Study: Clinical Decision-Making (7)</b></p> <ul style="list-style-type: none"> <li>■ <b>Next testing steps:</b> Obtain a CD4 count to see if he is experiencing immunologic recovery on ART; inquire about his adherence; inquire about symptoms of malabsorption; and obtain a chest x-ray to look for signs of pulmonary KS (usually a nodular infiltrate).</li> <li>■ <b>How did a physical exam change the management of this patient?</b> KS would have been missed had the examiner trusted the chart and the patient's self-report, and not performed an independent physical exam.</li> </ul> <p style="font-size: small;">Session 6: Clinical Diagnosis and Decision-Making Skills <span style="float: right;">Slide 16</span></p>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 17</b></p>	 <p><b>Case Study and Principles</b></p> <ul style="list-style-type: none"> <li>■ How does this case illustrate some of the principles we discussed in this session? <ul style="list-style-type: none"> <li>▪ Occam's Razor</li> <li>▪ Sutton's Law</li> <li>▪ Avoid premature closure of the diagnostic process</li> <li>▪ Don't be overconfident about your differential diagnoses</li> <li>▪ Know what you don't know, and seek out help from a book, a consultant, the Internet</li> </ul> </li> </ul> <p style="font-size: small;">Session 6: Clinical Diagnosis and Decision-Making Skills <span style="float: right;">Slide 17</span></p>	<p><i>Summarize the activity and this session.</i></p>



**I-TECH**



INTERNATIONAL  
TRAINING &  
EDUCATION  
CENTER ON HIV

## **Session 7: Addressing Systems Issues**

### **Facilitator Guide**

#### **Basics of Clinical Mentoring**



# Session 7: Addressing Systems Issues

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**Time: 120 minutes (2 hours)**

## Learning Objectives

By the end of this session, participants will be able to:

- Identify common systems issues that exist in health care facilities
- Describe strategies to address common systems issues

## Session Overview

Step	Time	Method	Title	Resources
1	5 minutes	Presentation	Introduction and Learning Objectives (slides 1-2)	LCD or overhead projector
2	5 minutes	Presentation	Systems Issues Overview (slides 3-4)	LCD or overhead projector
3	100 minutes	Presentation Activity	Categories of Systems Issues (slides 5-25)	LCD or overhead projector Flip chart and markers Handout 7.1
4	5 minutes	Presentation	Characteristics of a Good Mentor (slide 26)	LCD or overhead projector
5	5 minutes	Presentation	Key Points (slide 27)	LCD or overhead projector



## Resources Needed

- LCD or overhead projector
- Flip chart and markers



## Handouts

- Handout 7.1: Systems Issues

## Key Points

- Strengthening systems in the health care facility to support care and treatment is an important aspect of clinical mentoring.
- Systems issues in a health care facility are classified in the following categories: patient capacity, supplies, confidentiality, records/organization, and quality of care.

# Training Material



## Trainer instructions: Step 1 (slides 1-2) – 5 minutes

Present slides 1-2, Introduction and Learning Objectives, and provide participants an introduction to this session.

<b>Slide 1</b>	 <p><b>Session 7: Addressing Systems Issues</b></p> <hr/> <p>Basics of Clinical Mentoring</p>	<p>The systems issues in this session are taken from “Strategies for Addressing Real-Life Situations in Clinical Mentoring: Adult ART Clinics” in the Tools and Resources for Mentors section of the Clinical Mentoring Toolkit.</p>
<b>Slide 2</b>	 <p><b>Learning Objectives</b></p> <p>By the end of this session, participants will be able to:</p> <ul style="list-style-type: none"><li>■ Identify common systems issues that exist in health care facilities</li><li>■ Describe strategies to address common systems issues</li></ul> <p><small>Session 7: Addressing Systems Issues</small></p>	<p><small>Slide 2</small></p>



## Trainer instructions: Step 2 (slides 3–4) – 5 minutes

Present slides 3–4, which provide an overview of systems issues and categories.

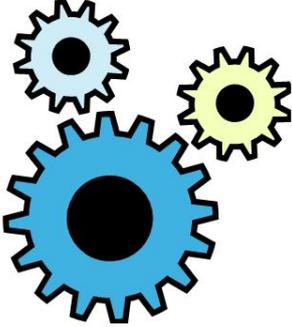
<b>Slide 3</b>	<h3>Systems Issues</h3> <ul style="list-style-type: none"><li>■ Mentoring is not just about teaching health care workers how to better administer care, but also about strengthening systems in the health care facility that support care and treatment.</li><li>■ Examples of systems issues that can affect patient care and treatment:<ul style="list-style-type: none"><li>▪ Bottlenecks in patient flow</li><li>▪ Missing safety equipment (e.g., gloves)</li><li>▪ Lack of privacy for patients</li><li>▪ No system for filing patients' medical records</li></ul></li></ul>  <p>Session 7: Addressing Systems Issues</p> <p>Slide 3</p>	
<b>Slide 4</b>	<h3>Systems Issues: Categories</h3> <p>Systems issues in a health care facility can be classified into a several categories:</p> <ul style="list-style-type: none"><li>■ Patient capacity</li><li>■ Supplies</li><li>■ Confidentiality</li><li>■ Records/organization</li><li>■ Quality of care</li></ul>    <p>Session 7: Addressing Systems Issues</p> <p>Slide 4</p>	<p>Patient capacity refers to the number of patients that are able to be seen in a clinic, based on the number of doctors, nurses, and ancillary staff work in the clinic.</p>



## Trainer instructions: Step 3 (slides 5–25) – 100 minutes

Present slide 5 and explain the small group activity. Refer participants to Handout 7.1 and use the slide notes to conduct the activity. Allow approximately 60 minutes for this activity.

Present slides 6–25 to summarize the activity and review solutions to systems issues.

<p><b>Slide 5</b></p>	<p><b>Activity: Systems Issues</b></p>  <p><small>I-TECH INTERNATIONAL TECHNICAL &amp; EDUCATION CENTER ON HWY</small></p> <p><small>Session 7: Addressing Systems Issues</small></p> <p><small>Slide 5</small></p>	<ul style="list-style-type: none"><li>• <i>Divide participants into small groups of 3–4 people and refer them to Handout 7.1: Systems Issues.</i></li><li>• <i>Assign each group at least three of the issues listed in the handout; if the group of participants is large, more than one small group can work on the same set of issues.</i></li><li>• <i>Provide each small group with one piece of flip chart paper for every issue they are working on.</i></li><li>• <i>Ask participants to brainstorm solutions to each of the issues they were assigned and to record them on the flipchart paper.</i></li><li>• <i>Allow enough time for groups to read their issues, brainstorm solutions that clinical mentors might be able to implement, and write their proposed response on flip chart paper (approximately 20 minutes)</i></li><li>• <i>In front of the large group, members of the small groups should present their proposed solutions.</i></li><li>• <i>After each group presents, ask other participants if they have other solutions that were not listed.</i></li><li>• <i>Present the following slides to summarize the activity and reinforce solutions.</i></li></ul>
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## Handout 7.1: Systems Issues

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### 1. Capacity Issue

Long patient queues make providing effective clinical mentoring difficult.

### 2. Supply Issue #1

Lack of general equipment at clinic (e.g., no exam table, no access to water, no electricity).

### 3. Supply Issue #2

Universal precautions: Lack of equipment, such as gloves or masks, or improper use of available equipment.

### 4. Supply Issue #3

First-line ART regimen is out of stock and cannot be replenished for another week.

### 5. Confidentiality Issue

Lack of privacy for patients during encounter with health care worker (e.g., two or three patients seen in same room, lack of confidentiality in waiting room) leads to poor adherence to follow-up care.

### 6. Records/Organization Issue #1

No system in place to track patients who default on ART.

### 7. Records/Organization Issue #2

Providers are not documenting clinical information in the patient's chart.

### 8. Quality of Care Issue #1

Lack of quality assurance methods, e.g., fellow providers are prescribing ARV medications incorrectly.

### 9. Quality of Care Issue #2

Follow-up visit only takes ART into account; no attention is given to general medical health.

### 10. Quality of Care Issue #3

An inadequate number of clinicians are qualified to deliver ART, resulting in unmanageable patient loads.

### 11. Quality of Care Issue #4

Health care worker discrimination towards patients leads to patients avoiding follow-up visits.



<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 6</b></p>	<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 15%; text-align: center;">  </div> <div style="width: 80%;"> <h2 style="margin: 0;">Capacity</h2> <hr style="border: 0.5px solid black;"/> <p><b>Issue:</b></p> <ul style="list-style-type: none"> <li>■ Long patient queues make providing effective clinical mentoring difficult.</li> </ul> <p><b>Strategies:</b></p> <ul style="list-style-type: none"> <li>■ Mentors can sit side-by-side with mentees and assist with part of the clinic visit. For example, while mentee does focused physical exam, mentor can assist with recording the visit in the patient's record.</li> <li>■ Consider shifting some ART tasks, like taking history, to mid-level providers.</li> </ul> </div> <div style="width: 10%; text-align: right;">  </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <p style="font-size: small;">Session 7: Addressing Systems Issues</p> <p style="font-size: small;">Slide 6</p> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 7</b></p>	<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 15%; text-align: center;">  </div> <div style="width: 80%;"> <h2 style="margin: 0;">Capacity (cont.)</h2> <hr style="border: 0.5px solid black;"/> <ul style="list-style-type: none"> <li>■ Investigate whether stable patients coming in for ART refills could return at a longer interval, perhaps each 2–3 months.</li> <li>■ Implement a triage system to “fast track” patients that are returning just for medication refill vs. those who have symptoms. Fast track patients should not have to see a clinician.</li> </ul> </div> <div style="width: 10%; text-align: right;">  </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <p style="font-size: small;">Session 7: Addressing Systems Issues</p> <p style="font-size: small;">Slide 7</p> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 8</b></p>	<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 15%; text-align: center;">  </div> <div style="width: 80%;"> <h2 style="margin: 0;">Supplies #1</h2> <hr style="border: 0.5px solid black;"/> <p><b>Issue:</b></p> <ul style="list-style-type: none"> <li>■ Lack of general equipment at clinic (e.g., no exam table, no access to water, no electricity)</li> </ul> <p><b>Strategies:</b></p> <ul style="list-style-type: none"> <li>■ Think creatively to solve such problems: <ul style="list-style-type: none"> <li>■ No electricity: Optimize use of rooms with natural light sources as exam rooms</li> <li>■ No water: Get liquid sanitizers for clinic staff hand hygiene</li> <li>■ No exam table: Perform exams with patient seated</li> </ul> </li> </ul> </div> <div style="width: 10%; text-align: right;">  </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <p style="font-size: small;">Session 7: Addressing Systems Issues</p> <p style="font-size: small;">Slide 8</p> </div>	

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 9</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: right;">  </div> </div> <h2 style="text-decoration: underline;">Supplies #2</h2> <p>Issue:</p> <ul style="list-style-type: none"> <li>■ Universal precautions: Lack of equipment, such as gloves or masks, or improper use of available equipment</li> </ul> <p>Strategies:</p> <ul style="list-style-type: none"> <li>■ Request gloves and masks from Medical Director, Health Bureau, or appropriate health care authority</li> <li>■ Mentors should model proper use of masks and gloves to encourage use and decrease stigma</li> </ul> <div style="display: flex; justify-content: space-between; align-items: flex-end; margin-top: 20px;"> <p><small>Session 7: Addressing Systems Issues</small></p> <p><small>Slide 9</small></p> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 10</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: right;">  </div> </div> <h2 style="text-decoration: underline;">Supplies #2 (cont.)</h2> <ul style="list-style-type: none"> <li>■ Display infection control information, such as posters describing cough etiquette.</li> <li>■ If the mentor is coming from a well-resourced setting, s/he can consider bringing reusable N95 masks and gloves. <ul style="list-style-type: none"> <li>▪ While this is not sustainable, it demonstrates a commitment to infection control that may spark discussions that could lead to more sustainable interventions in the future.</li> </ul> </li> </ul> <div style="display: flex; justify-content: space-between; align-items: flex-end; margin-top: 20px;"> <p><small>Session 7: Addressing Systems Issues</small></p> <p><small>Slide 10</small></p> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 11</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: right;">  </div> </div> <h2 style="text-decoration: underline;">Supplies #3</h2> <p>Issue:</p> <ul style="list-style-type: none"> <li>■ First-line ART regimen is out-of-stock and cannot be replenished for another week</li> </ul> <p>Strategies:</p> <ul style="list-style-type: none"> <li>■ Logistics issues: <ul style="list-style-type: none"> <li>▪ One-time event or ongoing problem?</li> <li>▪ Is there a clear weak link in the supply chain? Is the demand at the clinic greater than the supply (i.e., an underestimate of patients on ART)?</li> <li>▪ Are drug stocks being stolen?</li> </ul> </li> <li>■ Establish a buffer stock, stored separately and monitored for expiration date, to be used in case of stock-outs.</li> </ul> <div style="display: flex; justify-content: space-between; align-items: flex-end; margin-top: 20px;"> <p><small>Session 7: Addressing Systems Issues</small></p> <p><small>Slide 11</small></p> </div>	<p>There are two issues: 1) logistics, and 2) patient care.</p>

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 12</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: center;"> <h3>Supplies #3 (cont.)</h3>  </div> </div> <ul style="list-style-type: none"> <li>■ Patient care issues: <ul style="list-style-type: none"> <li>■ Temporary substitution of available alternative drugs may be considered, but must be supervised by a clinician (preferably an MD) with ART experience.</li> <li>■ Neighboring districts may have stocks of ART—engage the pharmacist in the district to help locate meds in other districts.</li> </ul> </li> </ul> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <small>Session 7: Addressing Systems Issues</small> <small>Slide 12</small> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 13</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: center;"> <h3>Confidentiality</h3>  </div> </div> <p>Issue:</p> <ul style="list-style-type: none"> <li>■ Lack of privacy for patients during encounter with HCW (e.g., 2–3 patients seen in same room, lack of confidentiality in waiting room) leads to poor adherence to follow-up care</li> </ul> <p>Strategies:</p> <ul style="list-style-type: none"> <li>■ Set up screens, sheets, or other barriers between patients to provide a degree of visual privacy.</li> <li>■ Implement trainings for all clinic staff on the importance of confidentiality.</li> </ul> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <small>Session 7: Addressing Systems Issues</small> <small>Slide 13</small> </div>	<p>HCW = health care worker.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 14</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: center;"> <h3>Confidentiality (cont.)</h3>  </div> </div> <ul style="list-style-type: none"> <li>■ Put up posters explaining the importance of confidentiality in the waiting rooms to educate patients.</li> <li>■ Organize community meetings to discuss the role of stigma as a barrier for accessing care.</li> <li>■ Use number system for patients—patients are referred to by their patient number throughout their clinic visit, allowing for better patient anonymity.</li> </ul> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 10px;"> <small>Session 7: Addressing Systems Issues</small> <small>Slide 14</small> </div>	

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 15</b></p>	<div style="background-color: #e0f0e0; padding: 10px;"> <h3 style="margin: 0;">Records/Organization #1 </h3> <p>Issue:</p> <ul style="list-style-type: none"> <li>■ No system in place to track patients who default on ART</li> </ul> <p>Strategies:</p> <ul style="list-style-type: none"> <li>■ Help set up defaulter tracking systems within the clinic setting               <ul style="list-style-type: none"> <li>■ Start by assigning each patient a specific date and time for a follow-up appointment</li> </ul> </li> </ul> </div> <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 10px;"> <span>Session 7: Addressing Systems Issues</span> <span>Slide 15</span> </div>	<ul style="list-style-type: none"> <li>• In clinics that have the capacity to develop databases, a database could be developed to track defaulters.</li> <li>• In some clinic settings, pharmacy staff can easily identify defaulters via a computerized electronic medical records system.</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 16</b></p>	<div style="background-color: #e0f0e0; padding: 10px;"> <h3 style="margin: 0;">Records/Organization #1 (cont.) </h3> <ul style="list-style-type: none"> <li>■ Train a member of the multidisciplinary team to make a daily list of patients who miss their clinic appointments.</li> <li>■ Set up system for follow-up of patients in the community by using outreach workers, e.g., nurses, counselors, PLHIV, etc.</li> </ul> </div> <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 10px;"> <span>Session 7: Addressing Systems Issues</span> <span>Slide 16</span> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 17</b></p>	<div style="background-color: #e0f0e0; padding: 10px;"> <h3 style="margin: 0;">Records/Organization #2 </h3> <p>Issue:</p> <ul style="list-style-type: none"> <li>■ Providers are not documenting clinical information in the patient's chart.</li> </ul> <p>Strategies:</p> <ul style="list-style-type: none"> <li>■ Emphasize the importance of thorough documentation to improve clinic management, avoid harm to patients, and provide accurate outcome data to MOH and funders.</li> <li>■ Create a documentation checklist to help health care workers remember to record information.</li> </ul> </div> <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 10px;"> <span>Session 7: Addressing Systems Issues</span> <span>Slide 17</span> </div>	<p>Documentation checklists can exist as wall charts, pocket cards, or standardized pre-printed visit forms.</p>

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 18</b></p>	<p><b>Records/Organization #2 (cont.)</b></p> <ul style="list-style-type: none"> <li>■ If they are not already implemented, introduce flow sheets for monitoring ART services, tracking medication, etc.</li> <li>■ Train health care workers about timely documentation of HIV activities, e.g., charting after each patient encounter or at specific times during the day.</li> </ul>  <p style="font-size: small;">Session 7: Addressing Systems Issues <span style="float: right;">Slide 18</span></p>	<p>When introducing new forms, make sure the MOH does not already have ones that they use.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 19</b></p>	<p><b>Quality of Care #1</b></p>  <p>Issue:</p> <ul style="list-style-type: none"> <li>■ Lack of quality assurance methods, e.g., fellow providers are prescribing ARV medications incorrectly.</li> <li>■ Strategies: <ul style="list-style-type: none"> <li>■ Institute an ART committee of experts to review patient information gathered at intake visit and recommend a treatment regimen.</li> <li>■ Institute regular case conference meetings for all prescribing clinicians to review all new or changed regimens.</li> </ul> </li> </ul>  <p style="font-size: small;">Session 7: Addressing Systems Issues <span style="float: right;">Slide 19</span></p>	<p>Solutions presented here can be mixed and matched; they are not mutually exclusive.</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 20</b></p>	<p><b>Quality of Care #1 (cont.)</b></p>  <ul style="list-style-type: none"> <li>■ Organize a chart review system to identify common problem topics to be addressed in teaching sessions, catch mistakes early. <ul style="list-style-type: none"> <li>■ Chart review should be a regular (monthly) part of the facility routine, with participation by every member of the multidisciplinary team.</li> </ul> </li> <li>■ At the end of the day or week, have clinicians gather for a case conference to go over new regimens started or changes made.</li> <li>■ Refresher trainings and supportive supervision can assist in improving quality of care and services.</li> </ul>  <p style="font-size: small;">Session 7: Addressing Systems Issues <span style="float: right;">Slide 20</span></p>	

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 21</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: center;"> <h2 style="color: #4F81BD;">Quality of Care #2</h2>  </div> </div> <p><b>Issue:</b></p> <ul style="list-style-type: none"> <li>■ Follow-up visit only takes ART into account; no attention to general medical health</li> </ul> <p><b>Strategies:</b></p> <ul style="list-style-type: none"> <li>■ Reinforce importance of conducting quick interim history, review of systems, and targeted exam, vital signs</li> <li>■ Reinforce importance of reviewing the patient's chart for non-ART related medical problems, and including questions targeting these conditions in the systems review</li> </ul> <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Session 7: Addressing Systems Issues</span> <span>Slide 21</span> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 22</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: center;"> <h2 style="color: #4F81BD;">Quality of Care #2</h2>  </div> </div> <ul style="list-style-type: none"> <li>■ Reinforce the importance of including “prevention for positives” strategies at each visit; e.g., smoking cessation, decreasing substance use, safer sex practices to prevent STDs, etc.</li> </ul> <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Session 7: Addressing Systems Issues</span> <span>Slide 22</span> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 23</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: center;"> <h2 style="color: #4F81BD;">Quality of Care #3</h2>  </div> </div> <p><b>Issue:</b></p> <ul style="list-style-type: none"> <li>■ An inadequate number of clinicians are qualified to deliver ART, resulting in unmanageable patient loads</li> </ul> <p><b>Strategies:</b></p> <ul style="list-style-type: none"> <li>■ Locate the source of the problem: Is it a lack of clinicians, or are they distracted with competing priorities? <ul style="list-style-type: none"> <li>▪ Task shifting may free up valuable clinician time</li> <li>▪ Often, nurses and mid-level providers are highly skilled, and could manage “fast-track” or stable patients, or assume other tasks</li> </ul> </li> </ul> <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Session 7: Addressing Systems Issues</span> <span>Slide 23</span> </div>	

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 24</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="background-color: #c8e6c9; padding: 10px; width: 100px;">  </div> <div style="flex-grow: 1;"> <h3 style="margin: 0;">Quality of Care #3 (cont.)</h3> <ul style="list-style-type: none"> <li>■ If lack of HIV knowledge is the problem, provide onsite training or explore HIV programs that clinicians can attend to increase the number of trained health care workers in the facility.</li> <li>■ Advocate with hospital authorities to have clinicians from other departments/disciplines assist in the HIV clinic when they are done with other duties.</li> </ul> </div> <div style="text-align: right;">  </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <span>Session 7: Addressing Systems Issues</span> <span>Slide 24</span> </div>	
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>Slide 25</b></p>	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="background-color: #c8e6c9; padding: 10px; width: 100px;">  </div> <div style="flex-grow: 1;"> <h3 style="margin: 0;">Quality of Care #4</h3> <p>Issue:</p> <ul style="list-style-type: none"> <li>■ HCW discrimination towards patients leads to patients avoiding follow-up visits</li> <li>■ Strategies: <ul style="list-style-type: none"> <li>■ Staff education about stigma and discrimination can help decrease stigma, e.g., staff in-services, role plays, I-TECH video education packages</li> <li>■ Address staff burnout, which can be a factor resulting in discrimination—mentor can motivate and advocate for staff</li> </ul> </li> </ul> </div> <div style="text-align: right;">  </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <span>Session 7: Addressing Systems Issues</span> <span>Slide 25</span> </div>	<ul style="list-style-type: none"> <li>• HCW = health care worker.</li> <li>• Also, provide onsite or explore off-site “Care for Caregivers” training.</li> </ul>



## Trainer instructions: Step 4 (slide 26) – 5 minutes

Present slide 26, Characteristics of a Good Mentor, and relate them to systems issues presented earlier.

<b>Slide 26</b>	<p><b>Characteristics of a Good Mentor</b></p> <ul style="list-style-type: none"><li>■ Understanding of clinical systems, in order to address systemic issues</li><li>■ Enthusiastic and comfortable incorporating diverse situations/experiences into teaching</li><li>■ Adept at physical diagnosis<ul style="list-style-type: none"><li>▪ Working knowledge of possible diagnoses and issues that may need addressing</li></ul></li></ul> <p></p> <p>Session 7: Addressing Systems Issues <span style="float: right;">Slide 26</span></p>	<p><i>Review these characteristics that allow a mentor to be successful. These deal directly with systems issues.</i></p>
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## Trainer instructions: Step 5 (slide 27) – 5 minutes

Review the Key Points and ask participants if they have any remaining questions.

<b>Slide 27</b>	<p><b>Key Points</b></p> <ul style="list-style-type: none"><li>■ Strengthening systems in the health care facility to support care and treatment is an important aspect of clinical mentoring</li><li>■ Systems issues in a health care facility are classified in the following categories: patient capacity, supplies, confidentiality, records/organization, and quality of care</li></ul>  <p>INTERNATIONAL TRAINING &amp; EDUCATION CENTER ON HIV</p> <p>Session 7: Addressing Systems Issues</p>	
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**I-TECH**



INTERNATIONAL  
TRAINING &  
EDUCATION  
CENTER ON HIV

## **Session 8: Case Studies**

### **Facilitator Guide**

#### **Basics of Clinical Mentoring**



## Session 8: Case Studies

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Time: 1/2 day\*

### Learning Objective

By the end of this session, participants will be able to:

- Apply the clinical mentoring skills and techniques learned in this course to real-life clinical mentoring case studies

### Session Overview

Step	Time	Method	Title	Resources
1	1/2 day*	Activity	Case Studies (no slides)	Flip chart and markers Worksheets 8.1–8.13

*\*This session is organized differently than the other sessions of this training. The format in which this session is organized is determined by the facilitators for each training. See trainer instructions below for more information.*



### Resources Needed

- Flip chart and markers



### Worksheets

- Worksheet 8.1: Universal Precautions
- Worksheet 8.2: Opportunistic Infections – Basic I
- Worksheet 8.3: Opportunistic Infections – Basic II
- Worksheet 8.4: Opportunistic Infections – Advanced
- Worksheet 8.5: Palliative Care
- Worksheet 8.6: Pediatrics – Basic I
- Worksheet 8.7: Pediatrics – Basic II
- Worksheet 8.8: Pediatrics – Advanced I
- Worksheet 8.9: Pediatrics – Advanced II
- Worksheet 8.10: Prevention of Mother-to-Child Transmission I
- Worksheet 8.11: Prevention of Mother-to-Child Transmission II
- Worksheet 8.12: Sexually Transmitted Infections – Basic I
- Worksheet 8.13: Sexually Transmitted Infections – Basic II



## Trainer instructions

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### Overview

Session 8 is intended to be about a half day session (the first half of the last day of training) allowing participants the opportunity to apply what they have learned the past 2 days to clinical mentoring case studies. There are 13 case studies in worksheet format included in this Facilitator Guide and in the Participant Handbook. The worksheets in the facilitator guide include possible answers after each question in italics (these are not included in the participant handbook).

Day 3 of case studies can be organized in a number of ways. There are four different options listed below of how the case studies could be facilitated. Consider the number of participants, time available, and room restrictions to determine the best method of conducting this activity. Review the options listed below and adapt as appropriate. To provide variety in the day, more than one facilitation method should be used. Once the methods of how to conduct this activity are determined, adjust the lunch and tea breaks in the training agenda as necessary. These case studies can also be pulled out of this training format and used in individual teaching moments.

For each case, ask participants to think about how this scenario may play out in their settings and what other considerations they may have. Encourage participants to really think about the mentoring moments within these cases and how they can apply the lessons learned to their setting. Be sure to encourage everyone to speak and participate.

### Facilitation Options

#### Option 1: Small group discussion

- Divide participants into four groups.
- Divide the case studies among each group.
- Ask groups to work cooperatively to complete their assigned case study worksheets.
- Allow adequate time for groups to complete their small group work.
- Bring groups back together as a large group.
- Ask groups to take turns presenting the cases to the larger group, one case/group at a time. The small groups should read the case and then discuss the answers as a large group, asking everyone in the large group for input for the answers.

#### Option 2: Individual work

- Refer participants to the case study worksheets in their participant handbook.
- Ask participants to work on the cases individually.
- Allow participants adequate time to complete the cases.
- Break participants into small groups or come back together as a large group.
- Ask participants to discuss the cases and answers they came up with as a group.

### **Option 3: Large group discussion**

- Read through the case studies and accompanying questions as a large group.
- Ask participants to brainstorm answers to the questions.
- Record the group's answers on flip chart paper, and ask participants to record their answers on their worksheets.

### **Option 4: Role play**

- Divide participants into pairs.
- Assign the pairs each a case study.
- Inform participants that they should read through the case together and then role play the case as a pair.
- Each person should identify which role they will play and should answer the questions provided during the role play.
- Allow adequate time for participants to role play the case.
- Bring the participants back together as a large group to discuss the cases and role plays.
- Ask participants if they have any questions on the cases studies.





## Worksheet 8.1: Universal Precautions Case Study

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### Case

You are mentoring nurses in a hospital ward. A 42-year old patient was admitted to the hospital medical ward with a prolonged cough, weight loss, and night sweats. You suspect tuberculosis (TB) treatment failure, because he was started on anti-TB therapy (ATT) 3 months ago. The nurse proceeds to collect a sputum sample wearing a surgical mask.

### Questions

**1. What are your top concerns regarding medical diagnosis?**

- *Pulmonary multidrug-resistant TB (MDR TB).*
- *Extensively drug-resistant TB (XDR TB) – (higher suspicion in particular geographic locations, depending on case rates).*
- *TB/HIV coinfection – HIV-infected people have a higher risk of having or developing active TB, one of the major opportunistic infections (OIs) causing death in people living with HIV (PLHIV). HIV infection influences the clinical progression of TB and its treatment. Offering HIV testing and counseling should be a routine procedure in health care settings that deal with patients who have active TB.*

**2. Were universal precautions appropriately followed for this patient?**

- *No. The patient should have been isolated from other patients, especially if MDR TB is suspected, which may be untreatable. Ideally, a mask, such as the N95 mask or a mask that fits more snugly around nose and mouth, would have been more protective for nurse to use during the sputum collection procedure. A paper or cloth mask can get wet in as little as 10 minutes, allowing bacteria to pass through it. If mask is not tight over the nose and mouth, unfiltered air will be sucked in around the nose and cheeks.*

### Case (continued)

You talk with the nurses at the nurses' station, and enquire why they did not isolate the patient. They reply that they never considered isolating the patient because the windows are open at the far end of the ward.

### Question

**3. How would you respond to this situation?**

- *Schedule an in-service training to teach staff about infection control measures according to national policy/World Health Organization (WHO) guidelines. Emphasize the need to implement TB control measures given that drug resistant TB cases are increasing.*
- *Suggest setting up an isolation area for TB patients, ideally in an area close to windows/highly ventilated corridors. Recommend proper placement of fans within the ward; also,*

*opening windows and doors in the waiting rooms/areas is a simple and easy way to institute one aspect of infection control.*

- *Encourage clinic staff to meet with the hospital management to discuss the importance of having gloves and other infection control equipment available to staff.*
- *Discuss the possibility of introducing protective masks, like N95 masks, into the workplace. Explore whether the management team would be willing to provide masks for health care workers. It should be noted that this can be controversial if health care workers are reluctant to wear masks. Sometimes providers refuse to wear masks because they think that patients find this to be discriminatory.*



## Worksheet 8.2: Opportunistic Infections Case Study – Basic I

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### Case

A 44-year old man is seen the exam room by the clinic doctor near the end of the day. He presented to clinic that morning with a 2-week history of worsening shortness of breath. He has had a head cold with nasal congestion and a lot of sputum for several days, but today his cough is dry. He feels weak, shaky and short of breath at rest. He started running a fever yesterday and has pain on the right side of his chest. He has a headache and his appetite is poor. He has not been out of bed much in the past several days, because he gets dizzy when he stands. He smokes about 10 cigarettes per day, when he can get them.

His last CD4 count was 165 and he is not yet taking antiretroviral therapy (ART) because he is on his last month of treatment for pulmonary TB, which he has adhered to faithfully. His only other medicine is sulfamethoxazole/trimethoprim which he takes “most days” for PCP prophylaxis. The patient is able to provide this history himself, and although he is weak, does not appear to be acutely short of breath. The mentor and the clinic doctor examine the patient. He appears weak and pale. His skin and mucous membranes are dry. His vital signs are as follows: pulse – 120 at rest, blood pressure – 88/54, respirations – 24, temperature – 39°C. A chest exam reveals a few scattered coarse crackles, with predominance at the right base. The doctor seeing the patient and the clinical mentor agree upon a diagnosis of pneumonia, and decide that the patient needs to be admitted. In this hospital, the clinic doctors do not follow the admitted patients. The clinic doctor has called the admitting doctor who will come to see the patient as soon as she can. The clinic doctor is ready to move on to the next patient.

### Questions

**1. What should the mentor suggest the clinic doctor do while waiting for the patient to be admitted?**

- *The patient is not stable, and should not be kept waiting for further diagnostic and therapeutic interventions.*
- *He appears to be dehydrated. His dizziness on standing, elevated pulse, low blood pressure, and dry mucous membranes all suggest dehydration. The cough, which has gone from wet to dry, may also indicate dehydration. He should get started on an IV drip in the clinic, if available, or be transferred to the casualty department if IV fluids are not available in clinic.*
- *A chest x-ray should be ordered, as it may help determine the presence and type of pneumonia.*
- *If available, the patient’s oxygen saturation should be checked to determine if oxygen therapy is warranted acutely. If possible, checking the reading at rest and following 1 minute of exercise can be useful, as patients with early *Pneumocystis (carinii) jiroveci* pneumonia (PCP) may be fairly comfortable at rest, but become profoundly hypoxic with exercise.*
- *Diagnostic laboratory studies should be ordered, as available and per protocol for the setting, including blood and sputum cultures (may not be possible), sputum for silver*

*stain to look for PCP (again, may not be available, or may not be possible if patient is not producing sputum), blood cell count (CBC), and a routine chemistry panel.*

- *Broad spectrum IV antibiotics, such as ceftriaxone, should be administered as soon as possible, either in the clinic or in the casualty department. They should not be delayed awaiting the patient's admission. If necessary, they can be given IM, but IV is the preferred approach. Also, because this patient's CD4 count is under 200, PCP must be considered. It seems unlikely that this will be the cause because he has been taking prophylaxis well (3 times weekly is usually adequate for adults), but it would be prudent to consider before initiating treatment for PCP at this time, until further diagnostic information is available.*

## **2. What valuable lesson can be taught from this scenario?**

- *Patients do not always fit into appointment time frames. Although the doctor in this case has drawn the right conclusion – that his patient has pneumonia and requires admission – the patient remains the clinic doctor's responsibility until he is in the hands of the admitting doctor. The clinic doctor must continue the workup of the patient and initiate what might be life-saving treatment before moving on to the next case. In most instances, simply writing orders for the nurses to get things started can free up the clinician to see other patients while the nurses attend to the sick patient.*
- *Another important feature of this case is that this sick, ill-appearing gentleman has waited all day to be seen. In this setting, it would be appropriate for the mentor to question the triage system in the clinic and to be sure that sicker patients are seen soon after they present at the clinic.*



## Worksheet 8.3: Opportunistic Infections Case Study – Basic II

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### Case

A 27-year old man is brought to clinic by his sister. He tested positive for HIV 2 years ago and came to the HIV clinic once shortly after testing, but never returned. His CD4 count at that single visit was 118. His sister, who is also a patient at the clinic, brought him in because of a headache, which has gradually increased over the past 3 weeks. The problem first started as neck stiffness and then became a generalized dull pain in the whole head. Today the pain is excruciating. The man has difficulty sitting, is irritable and he does not want to talk. Physical examination shows an emaciated man with oral thrush. He is not disoriented but is drowsy. Deep tendon reflexes are brisk and equal. There are no lateralizing signs on his neurological exam. Fundoscopic examination reveals bilateral papilledema.

### Questions

- 1. What is the most likely serious opportunistic infection affecting this man?**
  - *The headache, without lateralizing signs, is characteristic of cryptococcal meningitis, a late manifestation of AIDS. With this 3 week history of acute CNS illness and a positive HIV test, cryptococcal meningitis always is the most likely cause. A CD4 count is not necessary because it almost always will be <100 in this situation.*
- 2. How does one diagnose this illness?**
  - *A serologic test for cryptococcal antibody test helps with the diagnosis, if available.*
  - *The definitive diagnosis is found by examination of the cerebrospinal fluid.*
- 3. Will a CT scan be helpful?**
  - *A CT scan usually does not help in the diagnosis. In areas where there is a high incidence of cryptococcal disease, CT scans are not necessary. If another process, such as CNS lymphoma or toxoplasmosis is suspected, usually because of lateralizing signs on neurologic exam, a CT scan would be useful.*
- 4. Does the papilledema make a difference in this case?**
  - *Unfortunately, with papilledema present, one should be wary of doing a lumbar puncture. In cryptococcal meningitis, however, a lumbar puncture is not dangerous, and it may in fact be lifesaving by lowering the intracranial pressure, and there is no danger of uncal herniation.*

### Case (continued)

You and the mentee decide to perform a lumbar puncture. You decide to run the following routine tests: VDRL, glucose, protein, cell count, culture, gram stain and India ink stain.

## Questions

### 5. What benefits can a lumbar puncture offer?

- Often in cryptococcal meningitis, the spinal fluid exits the needle under high pressure (>250 mm of water). If the pressure is over 250, remove up to 60 cc each day to prevent permanent damage from the high intracranial pressure. The recovery will be faster with much less pain if daily lumbar punctures are done. A headache is the best indication for more fluid to be removed.

### 6. What treatment options are preferred?

- Because of the severity of this infection, IV amphotericin B for the first 21 days is better than fluconazole. The alternative treatment is high dose fluconazole (800 mg/day p.o. for the first 21 days). The dose for the remaining 5 weeks (a total of 8 weeks of treatment is necessary) is fluconazole 400 mg/day. He should be on prophylactic fluconazole at 200 mg daily until his CD4 count is above 100 for 3 months, or in accordance with local secondary prophylactic guidelines.

## Case (continued)

The mentee asks you to do the lumbar procedure because he has to go to a meeting. You've noticed a pattern developing with the mentee. Whenever there is a major procedure to work on, he makes an excuse to leave and asks you to do the procedure instead.

## Questions

### 7. How would you handle this situation?

- Ask to speak with the doctor outside of the patient exam room. Tell him that you have noticed a pattern of him trying to avoid doing procedures. Ask him why this is. Explore whether mentee is afraid of doing procedures, is threatened by your presence, does not think procedures are important, etc.
- Reassure the mentee that you are there to work side by side with him to help him with various aspects of clinical HIV management. You are not there to judge him. But also remind him that you are not there to do his work either. The mentee will miss out on several good learning opportunities if the mentor does all of the procedures.
- Encourage the mentee to do the lumbar puncture today.



## Worksheet 8.4: Opportunistic Infections Case Study – Advanced

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### Case

A 35-year old woman presents to the always busy adult HIV clinic for a routine follow-up appointment and medication refill. She denies any problems with her medications and a review of her medical passport indicates that she picks up her medications in a timely fashion each month. Her CD4 count is now 235, up from 27 when she started ART 12 months ago. Her weight is unchanged. She tells the male doctor who is working with the mentor that day that she has no problems or concerns. She is sent to the nurse for routine, scheduled blood tests. The nurse comes back to the doctor to report that the patient complained to her about severe vaginal itching, and that she has been bleeding after having sex. The doctor, who was just leaving for lunch, tells the nurse to have the patient come back in a month if she continues to have these problems.

At this point, the mentor intervenes, suggesting that the patient could be seen after lunch, and that a more specific history and vaginal exam are indicated. The patient returns and a more detailed history reveals that she has had a moderate white vaginal discharge for 2 weeks accompanied by itching, and she has been having some irregular vaginal bleeding for 4 months with spotting or mild bleeding every time she has intercourse. Sex has become painful in the past month. Other than her husband, she has had only one sexual partner; he is a truck driver who is home only one or two nights each week. They have three healthy children. Her last regular period ended 3 days ago.

### Questions

- 1. Should the mentor have intervened in this case or should the patient have been allowed to come back in a month?**
  - *Some might argue that in a busy HIV clinic this problem might have been best treated with a topical antifungal cream or oral fluconazole, if the latter was available and an approved indication for the local setting. This approach, however would not address the issue of bleeding. It may be that the clinic is not equipped to perform the indicated pelvic exam. If this is the case, the patient could be referred to the outpatient GYN department, but this risks her having to return another day or deciding not to follow up on the issue, since the first doctor did not seem very concerned about it.*
  - *The case illustrates an example of how a busy day might prevent doctors from taking a full history or doing the indicated parts of an exam. The doctor in this case cannot be faulted for failing to ask more questions about symptoms of which he was not initially informed. When the nurse came to him, however, with the problem that she obviously was taking seriously, he should have been more prepared to look into the problems. The mentor was correct to step up and suggest that the patient be seen. Another approach might have been to ask the doctor what he was thinking the patient's problem was and to probe more deeply about the bleeding, which might have prompted the doctor to make the decision to have the patient return that day to be further evaluated.*

## Case (continued)

The doctor decides to perform a pelvic exam. Fortunately, the clinic is equipped to provide this service. The exam reveals some flat warts on the patient's vulva. There are white exudates on the walls of the vagina and a white curd-like discharge is present. There is no blood in the vault but the cervix is very friable and begins to bleed during the exam. The doctor tells the patient that her cervix looks a little unusual and asks her if she has ever had a Pap smear. Her reply is, "What is a Pap smear?" The mentor who has been reviewing the patient's medical passport is unable to find any notations regarding a Pap smear. The doctor performs the Pap smear, although these are not usually done in the clinic. The doctor also asks permission to take samples for a routine sexually transmitted infections (STI) check-up, completes the exam, and then permits the patient to get dressed. The doctor then checks that the patient's contact information is correct and asks her return in 1 month to get the results of her tests. Also, an antifungal vaginal cream is prescribed for the patient.

## Questions

### 2. What factors put this patient at risk for cervical cancer?

- *She has flat warts on her vulvae, which suggest the presence of HPV infection. Specifically, HPV types 16 and 18 are associated with both warts and cervical cancer (slide 198 in the OI curriculum in the Toolkit). Unfortunately, her symptoms of vaginal spotting and newly painful intercourse are suggestive of a more invasive or advanced process involving the cervix. Other infections should be ruled out and she should be screened or treated for other causes of cervicitis. Although she has had only two sexual partners, her husband may have had more, which may have put her at risk for infection with HPV and other STIs, including her HIV infection. His job, which keeps him on the road, away from home for long periods, allows the opportunity for him to have sexual partners other than his wife, thus increasing his and her risk for STIs.*

### 3. What can the mentor do at this point to help this patient and the clinic?

- *Because Pap smears are not routinely done in this clinic, there is a great risk that the test result could be lost or mishandled. At this point, the mentor could step out of the typical mentoring role to ensure that the specimen is properly handled and gets to the lab intact.*
- *The patient has been on ART for a year, but has never had a Pap smear. Because HIV clinics can be very busy, it can be difficult to get everything done. This woman should have had a Pap smear done or should have been referred for one. This woman with HIV infection is at increased risk of developing cervical dysplasia and cervical cancer. Efforts should be made to screen for treatable precancerous changes early on, to prevent the development of cancer, which is often untreatable in many developing world settings. The mentor might be able to help the clinic develop a system for performing pelvic exams and Pap smears more routinely, or a system to ensure these at-risk patients get proper referrals and follow-up care.*



## Worksheet 8.5: Palliative Care Case Study

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### Case

Tewodros is a 45-year old man who was first diagnosed with HIV about 4 years ago. He is married and has four small children. He works in the city but his family is living several hundred kilometers from the city in a rather remote area. For 3 months, Tewodros has been taking D4T/3TC and EFV. His initial response was good and his CD4 count that was initially 50 was improving. He also noted that he had increased energy level and significant weight gain.

However, now at month four, he returns to the clinic and you note a change in his condition. He is now complaining of severe pain in his feet. He said he lost his job because he had trouble standing, which is required for his job. He is feeling very depressed about this, especially since he does not know how he can take care of his family without a job. He said that he does not want to take his medicines anymore because of this.

You are mentoring a senior physician in the clinic. When the patient reports his symptoms of pain and depression, the physician writes him a prescription for ibuprofen and tells him not to worry about all of this. The physician then motions to the nurse in the room to call in the next patient.

### Question

#### 1. How would you as the mentor intervene in this situation?

- *You probably won't have time to talk with the mentee very long about the management of this patient; therefore, decide on some targeted teaching points to give now, and then talk with the physician at the end of the day when the clinic is over.*
- *For now, emphasize to your mentee that this patient may very well be experiencing D4T neuropathy. Medication can be prescribed for this neuropathic pain, and sooner than later he can try substituting a different NRTI for D4T to see if the symptoms abate.*
- *Also suggest exploring the patient's feelings of depression. Ask questions to identify the extent of the depression (also making sure that the patient has no intent of harming himself at this point). Ask about support networks for the patient, etc.*
- *Model some counseling for the patient so that the mentee can see what an appropriate counseling session for this patient would be.*
- *At the end of the day, talk to the mentee more about the importance of the palliative care approach in HIV clinical management. Talk about the need to adequately address physical symptoms, as well as psychosocial issues across the continuum of HIV care – from the moment a patient is diagnosed with HIV until death.*
- *Provide an in-service lecture for providers in the clinic that includes a discussion of all the different types of interventions that can be provided (both pharmacologic and non-pharmacologic) for common HIV symptoms, e.g., anemia, cough, neuropathy, fatigue, diarrhea, etc.*





## Worksheet 8.6: Pediatrics Case Study – Basic I

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### Case

A 28-year old woman brings her 5-year old niece to clinic. She has taken care of this girl since her sister, her niece's mother, died of a wasting illness 3 years ago. The girl has been chronically ill with recurring pneumonia and diarrhea. She is small for her age and quite thin.

In the clinic, a rapid HIV test is ordered and the result is positive.

### Question

**1. At what stage of AIDS is this child?**

- *This little girl with small stature and failure to thrive is at WHO stage 3 of AIDS, for her moderate malnutrition and recurrent pneumonias.*

### Case (continued)

When the mentee receives the positive HIV test result he looks confused. He starts looking uncomfortably at the aunt and the patient.

### Questions

**2. How would you intervene with this issue of pediatric disclosure?**

- *Ask the mentee if he has ever had to provide HIV results for pediatric patients before? If not, ask the mentee if he feels comfortable providing disclosure counseling.*
- *Ask the mentee if he would like you to model this counseling session for him.*
- *Remind the mentee of important teaching points to include during disclosure counseling:*
  - *Explain benefits of disclosure to the girl's aunt: Allows children to participate in their care and make informed decisions; increases sense of self-control and self-esteem; reduces anxiety; helps them to develop coping strategies, goals, and a sense of hope; supports grieving process; helps them prepare for coming events (illness, painful procedures, discrimination, death); reduces secrecy burden on caregiver.*
  - *Providers should reassure caregivers that their wishes regarding disclosure/information sharing will be respected.*
  - *In general, children tend to follow the lead of their parent/caregivers. If they are strongly opposed to certain issues being discussed directly, children will usually not ask directly about those issues.*
  - *Inform parents how information is shared among care team members and that all information is kept confidential. Inform families that this information sharing is essential to provide the best care for their child and family.*
  - *Immediately after disclosure, children may not have any questions. Many need to process what they have been told. Ideally a clinic visit/counseling session/home visit*

*should be scheduled shortly after the disclosure to assess how the child and family are coping.*

- *Even if children show no adverse response when disclosed to, they should be reassured that the team is there to help them stay healthy and to deal with their illness. Whenever possible, they should be given positive messages that their family and the health care team will be partners in caring for them.*

**3. What tests would you suggest the clinic doctor order?**

- *Before starting antiretroviral drugs (ARVs), she should have a CD4 percentage count if this is possible.*
- *Other preliminary tests would include a stool examination for parasites and a chest x-ray to rule out pulmonary TB.*

**4. What treatment and what advice would you recommend?**

- *She should be started on ARVs.*
- *She should also receive cotrimoxazole prophylaxis.*
- *Any additional underlying infections should be treated appropriately.*



## Worksheet 8.7: Pediatrics Case Study – Basic II

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### Case

A 20-month old girl was born to an HIV seropositive mother. At the time of delivery, both the mother and child were asymptomatic. The mother received prophylactic nevirapine but the baby received none. At birth, the child weighed 2,400 g. Today, she weighs 7 kg.

The mother is bringing the baby in for her third clinic visit. You note that the baby walks but does not talk. She has had several bouts of bacterial skin infection, and once she had pneumonia, which was treated with penicillin. Today, her mother has brought the child in because she doesn't seem as active as other children. She notices that her weight is less than the weight of other girls of the same age. She has no diarrhea or vomiting. Upon examination, the girl has no fever, but has a few small lymph nodes and a few scattered umbilicated papules on her abdomen which her mother says are increasing in number. She also has white patches in her mouth that can be scraped off with a tongue blade. Her mother says she has noticed these off and on for several weeks.

### Questions

- 1. Will a rapid HIV test be a reasonably reliable way to determine if this child is infected with HIV? At what age does maternal antibody generally disappear?**
  - *Now that she is 20 months old, a rapid HIV test will be a reliable indication of her real HIV status. Maternal antibody disappears by 18 months of age. Prior to 18 months of age, an HIV DNA PCR test is the only reliable way to accurately diagnose HIV infection in a child or an infant.*
- 2. How would you determine if this child's growth retardation is due to immunosuppression? Is a simple CD4 count adequate?**
  - *This child is growth retarded. At the age of 18 months, she should weigh more than 8 kg. The history of pneumonia and skin infections is worrisome and might indicate immunosuppression. An HIV test is indicated. Other causes of growth retardation should be considered/investigated, especially issues like food security and neglect. Other underlying infections, such as tuberculosis, candidiasis, and enteric infections, should be considered.*

### Case (continued)

You notice that the infant has been displaying signs and symptoms of possible HIV infection since her first clinic visit a few months ago. These signs include developmental delays, growth retardation, and likely oral thrush and other recurrent infections.

## Questions

**3. How will you use this opportunity to teach your mentee about HIV testing for exposed infants (born to HIV-infected mothers)?**

- *Emphasize the importance of providing HIV testing as soon as possible for exposed infants, especially those with HIV symptoms.*
- *Point out that this infant should have been tested for HIV infection during her first visit to the clinic.*
- *Teach the mentor about high HIV morbidity rates in children under 5 years of age.*

**4. What is the best way to insure that this child has a good chance of survival?**

- *If she is HIV positive, she should have a CD4 count and a determination of the percentage of CD4 cells of the total lymphocyte count. ARVs should be started (WHO Clinical Stage 3 – moderate malnutrition not responding to standard therapy, and persistent candidiasis after 6 weeks of age. The generalized lymph nodes and molluscum lesions are indicators of Stages 1 and 2, respectively). If she is HIV seronegative, then other causes of her growth retardation should be investigated.*
- *One of the most common causes of death in a child is death or illness in the mother. This mother needs to be evaluated with a physical examination and a CD4 count, and she should be started on ARVs, if appropriate. In addition, she definitely should take cotrimoxazole.*



## Worksheet 8.8: Pediatrics Case Study – Advanced I

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### Case

Your mentee asks you to see a 32-month old boy brought to the outpatient pediatric clinic because of weakness and failure to thrive. He is 3 kg below his expected weight for age. The physical examination reveals an afebrile, fussy child who does not like to be touched. Although his abdomen is protuberant, there is no palpable liver. His lungs are clear. He has scaly lesions on his legs. He and his mother have never been tested for HIV. He lives at home in the poorest part of town with his mother, father, two older sisters, and grandmother. Everyone at home is well; his grandmother was sick last year, but took medicine of an unknown type and has recovered. His mother says he does not have diarrhea, but his appetite is poor.

### Question

1. **What working differential diagnosis should your mentee be considering in this child?**
  - *HIV disease is strongly suspected, but TB, malnutrition from lack of food, enteric parasitic infections, or combinations of these etiologies are also possibilities.*

### Case (continued)

The child is admitted to hospital with a diagnosis of protein-energy malnutrition. The white blood count (WBC) and differential are normal. The hemoglobin is 9.5 g/dl. A chest x-ray is normal. Stool studies have been collected and are pending. Your mentee, the doctor caring for the child, suggests that an HIV rapid test be done on the child. The parents are not available to give permission for the test, so the test is postponed until the parents are available. He is given vitamins and a nutritious porridge rich in protein and carbohydrates. After 2 weeks in the hospital, there is no change in the child's condition. He seems to have no appetite, and he continues to be sullen and fussy.

### Question

2. **What error was made on the first clinic visit?**
  - *A rapid HIV test should have been done at the time the child was first seen. Not getting the result in a timely fashion has further delayed making the diagnosis. Now, the parents' absence is making the case more difficult to sort out and the child's condition is stagnant. All efforts must be made to contact the child's parents. If available, a hospital social worker should be involved. Orders should be left with the ward nurses to contact the house staff immediately if one of the child's parents appears.*

## Case (continued)

The mentee finally encounters the child's mother on the pediatric ward. She refuses to grant permission for an HIV test because she says if it is positive it would indicate that she also is infected with HIV. She doesn't want to know. Eventually, the child's father comes and the mentee calls you to talk with the father. You persuade the father to give permission for his son's HIV test. He says that he mostly wants to know if his wife is infected, and that this is the best way to know the truth about her. The rapid HIV test is done on the boy. The result is negative.

## Question

**3. Now what is the most likely diagnosis for the child? How would you direct the mentee to proceed?**

- *In small children, AIDS, TB, and malnutrition can occur separately or in combination. Now that HIV has been ruled out, the diagnosis of TB becomes more likely. The child has access to adequate nutrition in hospital, so it is unlikely that this is simple malnutrition resulting from poor intake. The history of the grandmother at home who took medication is suspicious for TB treatment, which could have exposed the boy to the tuberculin bacilli as an infant.*
- *A trial of TB medications using the standard pediatric regimen should be initiated as soon as possible.*

## Case (continued)

Within 7 days of starting TB treatment, the child begins to eat and gain weight. Fortunately for this young patient, he has two treatable illnesses and improvement in his condition can be forthcoming. After 8 weeks of induction treatment, the child is ready to be discharged on continuation phase TB medications.

## Question

**4. The mentee comes to you with concerns about sending this child home with the parents who did not seem adequately concerned about the child's health at the time of admission. How would you advise the mentee to proceed?**

- *This is a difficult situation. Hopefully, the parents have visited the child enough in the hospital to understand the disease process and the need to continue the TB treatment uninterrupted. TB control nurses/personnel should be utilized to ensure that the child continues to get his medications. Although it may be difficult in resource constrained settings, a social worker should be involved, and home visits would be very helpful. If possible, a meeting attended by the boy's parents, the attending doctor/house staff, the ward charge nurse, and the mentor could be arranged to discuss the case and to outline an agreeable follow-up care plan. A recommendation should be made that the parents and the two sisters at home be evaluated for TB and isoniazid (INH) prophylaxis. Referral to any available social supports in the area might help to gain the parents' confidence and trust. If the family is not able to care for the child adequately, he may need to be placed in a foster home.*



## Worksheet 8.9: Pediatrics Case Study – Advanced II

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### Case

You are working as a clinical mentor in a busy hospital-based HIV center. There are separate pediatric and adult HIV clinics serviced by one ARV pharmacy. Several full-time doctors are assigned to the adult clinic, and one full-time pediatrician assisted occasionally by a member of the house staff is assigned to the pediatric side of the clinic. There are a number of nurses working in both sides of the clinic, most of whom specialize in either adult or pediatric care. You are working to mentor all of the doctors in the clinic.

The pediatrician in the HIV center suddenly goes on medical leave. The hospital administrator is able to send a member of the house staff to work in the pediatric clinic only two half days per week. This is not adequate to keep up with the flow of patients through the clinic; there are several hundred children who get their care at this clinic, many of whom are on ARVs. Although it is not your primary responsibility, you are called upon to help figure out a solution to this situation.

### Question

#### 1. Describe several options on how to proceed at this point.

- *If you have a license to practice in this setting, you could step in and begin to see patients. This helps with the immediate need of the patients, but takes you away from your duties as a mentor. It is a temporary fix, but does show your willingness to help out and demonstrates commitment to patient care.*
- *You could refuse to do anything, forcing the administration to solve the problem; it could easily have happened in your absence, and is likely to happen again after you leave.*
- *You could suggest to whoever is in charge of clinic staffing that one of the doctors on the adult side temporarily be assigned to work in the pediatric clinic. Although this doctor may claim limited experience caring for children, you and the experienced pediatric nurses will be there to help. You could work side by side with the doctor seeing pediatric patients. This allows you to demonstrate history taking, patient examinations, and prescribing practices. It gets the patients seen and cross trains another provider, so they are able to see pediatric patients as well as adults. If the pediatrician is going to be out for a prolonged period, the position of acting pediatrician could be rotated among all of the doctors on the adult side of the clinic.*
- *If the pediatric doctor is going to be on leave for an extended period, you can train nurses to triage pediatric patients when they arrive at the clinic. This way, physicians can concentrate on seeing patients with the most urgent needs. If acceptable in your particular country setting, you can train nurses to see stable follow-up adult HIV patients who have been successful on ART. This can free up time for one of the adult physicians to attend to patients in the pediatric ART clinic.*





## Worksheet 8.10: Prevention of Mother-to-Child Transmission I

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### Case

You are mentoring a group of nurses on the postpartum ward. A 31-year old HIV-infected mother had a healthy baby boy 2 days ago, and is scheduled to be discharged this afternoon. (Both the mother and baby took prevention of mother-to-child [PMTCT] prophylactic regimens).

During the morning, you notice that the nurse taking care of the patient is barely speaking to her. Later, you notice the nurse being extremely rude and unprofessional with the mother when she asks for some water to drink.

You take the nurse aside and tell her that there are several important counseling messages that she should be teaching the patient before she leaves. You ask the nurse why she is behaving in such a hostile manner with the patient.

The nurse answers that this mother should have never become pregnant. “Look at how she put her poor infant in possible danger because of her foolishness. HIV-positive women should never be allowed to have children.”

### Questions

#### 1. How would you intervene at this juncture?

- *As a mentor, one of your tasks is to help model professional attitudes and behaviors. Have a conversation with the nurse in a separate room. Emphasize patients' rights.*
- *Discuss issues of stigma and discrimination. Try to provide the context for the daily challenges of stigma and discrimination that some patients have to face. Sometimes having the health care worker think about the situation of how they would feel if they were in these patients' shoes or had a close relative with HIV. How would they or their loved ones want to be treated?*
- *Also talk about the duty of health care workers to treat all patients equitably and justly.*
- *Consider providing an in-service training on stigma and discrimination; it can be helpful if a PLHIV comes to talk to the staff at the clinic about these issues.*

#### 2. In terms of postpartum counseling, what are some important messages that you would like to address with the mother?

- *Ensuring that the patient has appointment to follow-up with ART clinic.*
- *Suggesting family planning counseling.*
- *Educating the patient about services in the community that may be of service.*
- *Linking up patients to community support groups.*
- *Suggesting infant feeding counseling.*
- *Suggesting partner referral and HIV testing of young children at home (if have not already done so).*
- *Suggesting safe sex practices and other prevention with positives messages.*

**3. What should the mentee be teaching the patient regarding feeding her newborn?**

- *Counsel the mother on breast feeding:*
  - *The pros of breastfeeding (nutritious, inexpensive, available, protects against other infections).*
  - *The cons of breast feeding (risk of HIV transmission to baby until weaning, recommendation of rapid weaning at 4–6 months).*
  - *The need for adequate weaning foods.*
- *Counsel the mother on replacement feeding:*
  - *The pros of replacement feeding (complete absence of breast feeding eliminates the risk of HIV transmission postpartum).*
  - *The cons of replacement feeding (expensive, time consuming, requires clean water supply, fuel).*



## Worksheet 8.11: Prevention of Mother-to-Child Transmission II

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### Case

You are mentoring nurses in the maternity ward. Rose, a 29-year old woman in her third pregnancy, delivered a healthy, 3.5 kg baby girl an hour after she arrived at the maternity ward. After the birth, she told the staff she had a positive HIV-test result (done at the clinic), but did not take the tablet given to her before rushing to the maternity because she did not want her family to know about her HIV infection.

### Questions

#### 1. What treatment does Rose require now?

- *Treating Rose so as to reduce the risk of intrapartum HIV transmission is no longer an option.*
- *Rose will need a follow-up visit to assess her immunologic status and to determine if she needs any HIV-related treatment for her own health.*
- *She needs counseling on disclosure issues.*
- *She also needs counseling on family planning.*

#### 2. What treatment does her baby require?

- *The infant has not had any nevirapine (NVP) exposure, as Rose did not take it at least 2 hours prior to delivery.*
- *The infant requires single dose NVP (2 mg/kg) and AZT (4 mg/kg) for 4 weeks (course of AZT varies depending on national protocol).*
- *Emphasize to mentees that even when mothers forget to take their PMTCT prophylaxis, to not forget that the baby still has a window to take their own prophylaxis.*

### Case (continued)

Rose is reluctant to disclose her HIV positive status to her husband because she fears his reaction. The local HIV physician at the clinic commented in a multidisciplinary meeting that “the husband should be told of her HIV status to protect him. The husband needs to get tested even if it is against her wishes.”

#### 3. How would you as a mentor intervene in this situation?

- *You might start the discussion by asking if anyone knows the country's laws regarding disclosure without permission. Members of the group who are familiar with the laws might then confirm that it is against the law to disclose private medical information without permission from the patient.*
- *The mentors might then address the issue of disclosure to the husband with the patient. Team members (nurses, counselors, social workers, or psychologists) can be asked to give examples as to how to open the discussion with the patient and introduce the concerns of the team while also reaffirming that her information will be kept confidential*

*until she is ready to disclose. The team might also be asked how to support the patient during the process of disclosure when she is ready to have her husband accompany her to the appointment.*

- *The first rule of medical ethics is, “Do no harm [primum non nocere].” Thus, the team might also discuss the risks and benefits of disclosure for the patient in this setting. In many cultures, there is real concern that with disclosure of HIV status, the husband will throw the wife out of the house with her children, thus leaving her further stigmatized as well as homeless. With disclosure, there is also a risk that the husband might resort to physical abuse. It is important that you as a mentor guide the team in supporting her to disclose when she’s ready to do so and in a safe way, to avoid being harmed. For example, the patient can ask the husband to come to the clinic where she can disclose the information to him in the safe environment there.*



## Worksheet 8.12: STI Case Study – Basic I

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### Case

A 38-year-old woman returns to clinic because of the recurrence of painful sores on the labia minor and painful intercourse. She had similar lesions last year, but this year there are more sores and the pain is worse. In addition, she has experienced a whitish vaginal discharge which aggravates the sores. The woman washes dishes and cleans in a restaurant. Recently, she could not work because of her discomfort and tiredness.

The clinic on this particular day has a long line of patients waiting to be seen.

The mentee that you are with prescribes a vaginal yeast cream for the patient and tells her to come back to the clinic in 2 weeks for follow up.

### Question

**1. How would you intervene in this particular scenario?**

- *Talk with the mentee and emphasize that, at the very least, a visual genital exam should be performed to assess the sores that the patient reported. Remind the mentee that genital ulcerative disease in HIV patients can be severe in presentation and the patient has already noted that she is experiencing pain with the lesions.*
- *Offer to help the mentee with conducting the exam and finishing up the paperwork for the visit.*

### Case (continued)

Upon inspection, there are about one dozen lesions, which appear as discrete 2–4 mm ulcers on a reddish base. There has been no weight loss or other general findings.

### Questions

**2. What type of genital ulcers does she likely have?**

- *HSV exacerbated by vaginitis – likely vaginal candidiasis.*

**3. What WHO stage of HIV is she at?**

- *Stage 2 (based on her symptom presentation) – it would be helpful to check the CD4 count of this patient if it has not been checked in a long time.*

**4. What treatment will you prescribe?**

- *Acyclovir 200 mg 5x/day for 7 to 10 days. If vaginal KOH prep is positive for hyphae, treat for vaginal candidiasis with fluconazole 150 mg 1 time dose or 7 day 'azole vaginal cream.*

## Case (continued)

Throughout the pelvic exam, you noticed that people kept knocking on the door and poking their heads into the exam room. You are upset by the lack of privacy for this patient.

## Question

### 5. How would you intervene in this situation?

- *Talk to the clinic staff about privacy issues.*
- *Help set protocols for ensuring privacy in the clinic.*
- *Suggest that staff and waiting patients should not enter an exam room when the door is closed without first knocking and someone giving them permission to enter.*
- *Other issues that can be addressed include the physical layout of the clinic, such as setting up screens, sheets, or other barriers between patient exam tables and the door, to provide a certain degree of visual privacy.*



## Worksheet 8.13: STI Case Study – Basic II

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### Case

You are working with a physician mentor at one of the larger HIV clinics in the city. Today there are only two providers at the clinic. Normally there are four providers, but the other two are out due to illness.

A 21-year-old HIV infected man comes to the clinic because he noted a sore on the shaft of his penis 3 days ago. This sore does not hurt. He tried to wash the sore several times, but it does not improve. He reports that he had sexual intercourse with a new partner 2 weeks ago. The physician prescribes acyclovir therapy without doing a comprehensive exam. The only part of the physical that is done consists of your mentee looking briefly in the patient's mouth from across the desk. You are alarmed because the physician may miss important diagnostic clues or other conditions by omitting a physical exam.

### Question

**1. How would you intervene as the mentor in this situation?**

- *Acknowledge how challenging it must be to see so many patients on a daily basis, especially given the circumstances of having a higher patient case load than usual.*
- *Emphasize the critical importance of doing genital exams on patients who are symptomatic.*
- *Ask the mentee why he has not done a physical exam on the patient.*

### Case (continued)

The mentee answers that he refuses to do genital exams on the patient because there are no gloves in the room or sinks with running water.

### Question

**2. How would you respond to the problem of a lack of supplies in the clinic?**

- *This is a common scenario in many clinics around the world. It is important to think creatively to come up with effective solutions.*
- *If there is no water, explore using liquid sanitizers for hand-washing needs or arranging for water to be carried into exam rooms in large basins periodically throughout the day.*
- *Talk to hospital administration about securing gloves for the HIV clinic, emphasizing the need for proper infection control measures throughout the facility.*
- *Tell the mentee when there are no gloves in the clinic, he can at least do visual inspections by having the patient point to lesions/ ulcerations without the mentee having to touch the area. At the very least this can help to narrow down a diagnosis.*



**I-TECH**



**INTERNATIONAL  
TRAINING &  
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CENTER ON HIV**

## **Session 9: Program Orientation**

### **Facilitator Guide**

#### **Basics of Clinical Mentoring**



## Session 9: Program Orientation

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**Time:** 1/2 day\*

### Learning Objective

By the end of this session, participants will be able to:

- Explain the background and details of the country program in which they will be working in order to provide appropriate and applicable clinical mentoring

### Session Overview

Step	Time	Method	Title	Resources
1	1/2 day*	Activity	Program Orientation to (no slides)	Orientation Tools (as identified)

*\*The format and content of this session will vary based on the setting and context in which clinical mentoring will take place, and the particular needs of the clinical mentor group that is being trained/oriented. This Facilitator Guide, therefore, provides general guidelines and suggestions for content to include in the program orientation session rather than a detailed, step-by-step approach as is provided in other sessions.*



### Orientation Tools\*

- Sample Orientation Schedule for New Mentors
- Clinical Mentoring in the Field: Important Policies and Procedures

*\*These tools are not included in the Participant Handbook as they need to be adapted by the facilitator before being given to participants.*

## Trainer instructions

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### Overview

Session 9 is intended to be a half-day session (the second half of the last day of training) that orients participants to the specific program and setting in which they will be working. The following information is provided as an illustrative overview of the type of content to include in this mentor orientation, as well as suggestions for how to structure this time in the training. Facilitators should read through the following information and prepare an appropriate program orientation for the specific trainees of the workshop.

### Orienting Mentors

It is important to set up an orientation program for new mentors to familiarize them with the specific program and setting in which they will be working, as well as the policies and procedures of your organization. Some mentoring programs have brief orientation periods, (2 days) and others have longer orientation periods (1-2 weeks).

#### Important components of an orientation:

- Introduction to your organization and its structure.
- Brief introduction to the history of HIV treatment programs in your setting.
- Overview of the structure of health care services in your setting (for mentors from other countries).
- Information on logistics (e.g., transport, reimbursement, accommodation).
- Policies and procedures (see below for a generic document detailing policies and procedures to be followed).

**Resources for mentors:** Provide mentors with as many resources as possible to help them prepare for their mentoring assignments. The following are key documents to include:

- National clinical care and treatment guidelines (on such topics as tuberculosis, antiretroviral drugs, prevention of mother-to-child transmission of HIV).
- Copies of previous mentoring site reports, which will help mentors better understand the context of the facility to which they have been assigned.
- A CD-ROM of all the training curricula that have been used for HIV training of health care workers within the country thus far.
- A list of suggested tasks for mentors to provide an idea of what their role entails (see below for a list of suggested clinical mentoring activities).
- Documents in the “Tools and Resources for Clinical Mentors” section of the *I-TECH Clinical Mentoring Toolkit*; orient mentors to the resources found here.
- I-TECH’s “trigger case scenario” films, found at [www.go2itech.org](http://www.go2itech.org) in the Clinical Training Materials database.
- DVD from the previous version of the *I-TECH Clinical Mentoring Toolkit* (version 1.1).

## Organizing This Session

It is important to note that a complete orientation will require longer than one afternoon. The time set aside in this training may focus on one area of orientation and should be supplemented with additional orientation sessions. Use your discretion as a facilitator to assess the participant's needs, and address an appropriate portion of the mentor orientation during this time.

The sample orientation schedule provided below is for a long-term placement that includes a 1-week orientation for the mentor before they go to the clinical site, as well as suggestions for weeks 2 and 3 once the mentor is onsite. An optimal long-term placement orientation includes an in-country orientation with an observation and teaching period. Note that orientation programs for expatriate mentors will be slightly different from programs for local mentors. If you have a short-term mentor, you can determine which elements of this outline are essential, and provide written materials to the mentor. Conference calls can be used to discuss the materials with the mentor and to answer questions.

**Focus areas:** Potential areas of orientation to focus on during this time could include the following.

- Starting a mentoring assignment (establishing objectives, baseline assessment)
- Overview of medical system/structure
- National treatment guidelines and protocols
- Reporting requirements
- Logistical Issues

**Activities:** Refer to the following list of sample facilitation options of different methods to use during training. Prepare the content to be covered in this session and present it using one or more of the methods listed. The following are some examples of how activities could be structured in this session.

### *Option 1: Small group discussion*

- Divide participants into four groups.
- Ask groups to discuss and reflect on the setting-specific information presented.
- Allow adequate time for groups to complete their small group work.
- Bring groups back together as a large group.
- Ask groups to take turns presenting what they discussed in their small groups.

### *Option 2: Individual work*

- Refer participants to the case studies in the previous session.
- Ask participants to adapt the case study to their specific setting using the national guidelines.
- Ask participants to work on the cases individually.
- Allow participants adequate time to complete the cases.
- Break participants into small groups or come back together as a large group.
- Ask participants to discuss the cases and answers they came up with as a group.

### *Option 3: Large group discussion*

- Ask participants to brainstorm potential challenges and solutions to these challenges for their setting.
- Record the group's answers on flip chart paper, and ask participants to record their answers on their worksheets.





## Sample Orientation for New Mentor

### Week 1

Time	Day 1	Day 2	Day 3	Day 4	Day 5
9:00	Welcome and overview of orientation	Toolkit overview  Review of materials available for use in field	Clinical Team overview  Overview of clinical considerations and competencies  Medical malpractice  Clinical Team role  Maintaining boundaries in the field (how do you assert your predetermined role)	Country-specific orientation  Safety in the field  Communicating in the field  Accessing research and information in the field  Medical and dental	Clinical systems overview Patient flow  Clinical hierarchy  Setting up a clinic for  ARV roll-out  Review of all charting forms used in the clinic setting
10:00	Organization's philosophy  Mission  Operating principles	(Continued from above)	(Continued from above)  Pre-ART implementation site assessments  Post-ART implementation site assessments	(Continued from above)  Management structure in region  Public health infrastructure	Assessing clinic needs post-ARV roll-out

cont.	Consultant agreement  Structure of organization		Systems level checklist	Decentralized clinic system  Site map of major hospitals/ clinics within region where mentor will be working	
11:00	Financial orientation  Financial structure of organization  Reimbursement  Travel arrangements  Site-specific financial considerations	Monitoring & evaluation (M&E)  Current M&E efforts overview  Summary of organization's field results, particularly as they apply to the country	(Continued from above)  Mental health: Dealing with your own emotional health abroad	Statistics to specific country  Basic epi data of HIV and AIDS in country  Review country guidelines	Final Q&A with domestic team
12:00	Lunch with program manager	Lunch	Lunch with clinical support team	Lunch	Lunch
13:00	Overview of mentorship  Purpose and mission  Contract/agreement for terms of mentorship	Practicing medicine in a resource-limited setting  Ethical considerations  Research considerations  Identifying leaders in the field	Optional site visit	(Continued from above)  Cultural issues working in- country  Political issues and history of country  Region issues	Free time

15:00	Effective training overview  Training of trainers model  How to be an effective trainer	(Continued from above)		(Continued from above)  Health care system overview  Clinical variation to specific country	
16:00	Debrief with program manager	Debrief with program manager		Free time Q&A	

**\*\*Sample Orientation for Mentor: Weeks 2 and 3, if in a Setting Different Than the Host Organization**

General guidelines for orientation content during weeks 2 and 3 are below.

- Overview of in-country organization (if applicable).
- Overview of materials available onsite to mentor.
- Overview of key players in the region.
- Official introductions by host organization to essential persons at site or in region (i.e., CDC country director, etc.).
- Tour of the area and facility.
- Observational period in the clinic environment. If mentor is assigned to more than one facility, include observation time at those locations (i.e., one urban observation and one rural observation if mentor will be in both settings).
- Introductions/identification/participation to trainings in the area included.
- Team teaching with local staff.





## **Clinical Mentoring in the Field: Important Policies and Procedures**

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*[Host organization: This document is a handout on policies and procedures that can be provided to mentors. You should adapt this document as needed, and may wish to supplement it with other specific documents related to your organization's policies and procedures. Note that this document is targeted towards expatriate clinical mentors, and may need significant adaptation for your mentoring group. Other topic areas that you might want to address include: Air transportation/travel, business cards, business expenses, compensation, clinical mentoring agreement, emergency medical evacuation, ground transportation, insurance, invoicing, laptop computer, lodging, meals, passport, per diem expenses, political evacuation, post-exposure prophylaxis, scope of work, security and preventive measures, and visas.]*

This document provides a basic orientation to the policies and procedures that will apply to your clinical mentoring activities. Organized alphabetically, this overview is intended to assist you in preparing for your upcoming assignment. Please review the document carefully and retain it for future reference.

### **Decorum**

As a clinical mentor, you will be representing the institution through which you have been hired, your home institution, and your country. It is important to consider your actions carefully and remember that you are “on-duty” during your entire stay in a country – not just while working. Before leaving, research the culturally appropriate decorum for the country you will be working in. The US State Department hosts a site outlining country-specific behavior at: [http://travel.state.gov/travel/cis\\_pa\\_tw/cis/cis\\_1765.html#u](http://travel.state.gov/travel/cis_pa_tw/cis/cis_1765.html#u). In general, dress conservatively, speak and act in a quiet and humble manner, and avoid situations in which your country's embassy may need to intervene on your behalf.

### **Emergency Situations**

In any emergency situation, contact your host agency, the institution you are representing, and your country's embassy as soon as possible.

In case of lost/stolen cash, credit cards and/or travelers checks, contact your financial organization as soon as possible. Each will provide you with the proper protocol for obtaining replacements. Contact your host agency and the institution you are representing immediately and alert them to what you will need to safely continue your work and/or safely reach home.

### **Informed Consent**

You may find it useful to take pictures of your clinical activities to use when training other trainers. However, it is necessary to obtain informed consent from all persons depicted in your images. Be especially cautious to collect this consent from persons whose private health conditions will be disclosed. Although rights of privacy apply to all patients, those patients and families dealing with HIV require special caution due to the stigma associated with the disease, and the potential for unintended consequences from unexpected publicity of a patient's HIV status. Clinical mentors should never create any media, including written documents, photographs, videotapes, etc., which will disclose private medical information about patients, without first collecting informed consent from the individual (or the individual's parent or guardian in the case of minors).

## Tipping

Few clear rules for tipping are consistently applicable across the world. Generally, a 10% tip is acceptable at most restaurants and hotels. Wealthy locals and all foreigners are expected to leave some sort of gratuity for any services rendered. In all cases, whenever in doubt, try to follow local customs. Also, keep in mind that your actions reflect upon others representing your organization as well as your country's interests abroad. You will often run into individuals who will "expedite" a service for you. This may occur at the airport, a government office, a train station, or a hotel. Most often, these "expeditors" will expect to be paid for their services in the form of a small gratuity.

## Travel Documents

Keep a copy of the front page of your passport, country visa, and immunization records separate from the originals, especially for in-country travel.

## SECURITY/SAFETY CONCERNS

- **Terrorism:** Travelers to certain areas face a risk, usually small, of being caught up in terrorist attack resulting from political tensions. People traveling abroad should be aware of the potential dangers and be sensible in their precautions. Read up on consular reports, be aware of local sensibilities, monitor the media, and be alert. It is important, however, to remember that the risk of being involved in a terrorist attack is very small, like most other risks of travel.
- **Crime:** Crime such as hotel theft, pick-pocketing, muggings, and credit card and ATM fraud is common to urban area worldwide. Depending upon the country, the state of crime may dictate your actions – such as traveling alone, venturing out at certain times of the day, and wearing jewelry. Care should be taken when entrusting one's credit card (or number) to any vendor, as identity theft is common. Travelers should monitor their credit card accounts closely during and after travels. The consular information sheets put out by the US Department of State are an excellent resource for better understanding the current state of crime in a given country.
- **Driving:** Perhaps even more of a hazard than terrorism or crime is the threat of traffic accidents. Should you elect to operate a vehicle, please exercise extreme caution given the relatively high speed of drivers on major roads, poor lighting and paving in rural areas, presence of pedestrians and slow moving vehicles, and frequent aggressive driving behavior.
- **Disease Outbreaks:** In certain countries and/or areas, there is concern about infectious diseases. You are responsible for securing appropriate vaccinations prior to travel, and for taking necessary precautions with such measures as careful food handling, cautious water/beverage intake, and use of mosquito repellants.