ISWP Competency Subcommittee

July 17th, 2018 Meeting Recap

The ISWP Competency Subcommittee met by conference call on Wednesday, July 17th, 2018 from 10:30 a.m. to 11:30 a.m. U. S. Eastern Time. This provides a recap.

Meeting Recording Link: https://iswp.adobeconnect.com/pfot7xjedves/

Next Meeting: Wednesday, August 1st, 2018 at 10:00 am U.S. EST.

Discussion

1. Brief updates from ISWP

- **ISWP Wheelchair Service Provision Basic Test:** The test is now available in 14 languages: Albanian, Arabic, English, French, Lao, Hindi, Mandarin, Khmer, Portuguese, Russian, Romanian, Spanish, Urdu and Vietnamese. 2,648 Basic Test takers as of 30 June, 2018 with 71% pass rate. Working with a team in Bangladesh to translate into Bengali.

- **ISWP Wheelchair Service Provision Intermediate Test:**

- **a. Knowledge Test** 372 test takers with 64% as the pass rate. 38 Spanish test takers with 13% pass rate.

  b. Skills Test: 45 case studies from 32 test takers, of which 13 submitted two each for English. Spanish – no submissions. Of the 32 test takers, 23 are part of the skills test. Elsje suggested that it be presented differently; it is confusing. The mentoring case studies don't form part of the skills test and should be counted separately. **Krithika** to report separately on subsequent Subcommittee calls.

2. Update from Mentoring Phase 4 (Intervention): Alex provided an update upcoming mentoring phase. Of the two new mentors, one was recommended to move forward (Bart Van Der Heyden), and one was not due to his case study feedback. At this point, we have one mentor who participated in previous phases and one new mentor, who passed the case study submissions. ISWP is looking for another mentor or a co-mentor to support the third group. ISWP contacted some individuals who could provide the support; however, none are available.

Mentors have received case studies, however, we anticipate schedules and timelines changing to find the third mentor.

Elsje asked about finding the third mentor at this stage. In earlier email with a list of names, some of the people considered do not have specific WSTP Intermediate level experience or training. In the e-mail, it's indicated they are familiar with WHO WSTP. While they are familiar with some of the content and familiar/expert in some of the other packages, she wanted to emphasize that any prospective mentors must have expert and very good knowledge and be a trainer and have experience in mentoring, as well as knowledge of WSTP-Intermediate, which forms theoretical foundation. If that person does not have the required background or hasn't passed skills test, there must be enough time for them to complete the case studies to ensure they have the knowledge and skills to participate as a mentor.

Alex agreed with Elsje's recommendations, but acknowledged limited time to complete the studies and asked if there was other documentation that would support their training and mentoring skills. Elsje said that's the only way they can see, unless the current mentors know the person and/or the person has been an experienced trainer. She doesn't see any shortcuts. They have raised the possibility of one or more mentors not succeeding, and there needed to be a Plan B.

Dietlind said that in addition to showing skills, that the mentor should go through the exercise of reviewing a case study once so that experienced mentors can provide input, as well as the importance of the new mentor learning about the process and receiving valuable feedback. The mentor gains more insight into the process, especially since it is fundamental to the mentoring program. Sarah agreed with Dietlind's comments. Elsje said the case study serves as an assessment tool, as well as an in-service training.

Suggestions for moving forward – Mary will inform mentees in the third group that they will be moved to a wait list. Previous pilots indicated 5 mentees per group was feasible.

Elsje expressed other concerns about the mentoring process. Looking back on the mentoring process initially, they provided a lot of input. The need from the initial mentors' side was to focus on strengthening the trainer group to mentor participants. ISWP felt the focus should be on service providers, and future programs would have the focus. Phase 4 is still focusing on participants, but continuing to have difficulties finding skilled trainers which is tapping and draining a very small resource. She is concerned we are creating part of the problem. Mary indicated it was consistent from the beginning that we would do an intervention based on the three pilots. She agreed, however, that a mentoring program with an emphasis on trainers makes a lot of sense. She looks to the group for recommendations and guidance on funding sources or something an expanded group or task force could take on.

Elsje added that if we focus efforts on trainers, we can extend reach greatly. Instead, we are focusing on participants in small numbers and are limiting numbers of those who can mentor as well as those who are mentored. It is creating problems now.

Second point: Focus and format of mentoring program – initially developed the first pilot program, raised a list of concerns regarding limitations because of funding and time constraints. In subsequent discussions and revisiting program, we wanted to be sure we could deliver mentoring programs that have the correct output. The whole point is to enhance skills and knowledge of target group. The only way to measure that is to have before and after objective measurement system. Because of the complex nature of WC users at intermediate level, having theoretical knowledge is one thing. What most participants struggle with is applying the theoretical framework, as demonstrated by the low number of people who have taken the skills portion, and no one has passed. This illustrates complexity, especially for non-clinicians.

In mentoring, if we reinforce ways to provide and facilitate clinical reasoning, then there needs to be adequate time for mentee to implement and come back with information so mentors can see progress in development. We have not been able to accommodate that critical part in the mentoring process. It's always the same – case study submission, feedback, then input on theoretical basis on ways to improve observational skills and knowledge, but it's never taken back to the actual practical clinical context. A concern that we have 4 pilots, but none have developed the content and aim to reach the right aim. Second, there isn't an end point so it is not feasible to bring in an assessment instrument. Else wants to discuss structure and format of mentoring and reasons why we aren't moving forward in light of feedback on current format.

Alex added that regarding the format of current phase, it was changed to implement feedback received in pilots. Mentees reflect on what they have learned through the mentoring program. Also, after receiving case study feedback at the beginning of program, mentees will work through changes in the case study, make corrections and include feedback from colleagues to present what they have done differently with the case at end of program.

The goal attainment scale was a way to individualize the program. The aim was that trainees would focus on a particular area in their case study where they did poorly and would try to develop skills in that particular domain. We watered down the document a lot based on stakeholders' feedback. Now mentee and mentor would only come up with one professional development goal as mentee proceeds through program. If we find the tool is not useful, we would not use in subsequent phases.

Elsje would like to review the tool based on the changes. Elsje explained the changes come down to reflection on a personal scale. Not implemented yet is structured, guided supervision as the mentee goes back into service, does assessment, or implements other options. Also, there is no objective measure that a person may feel more confident in what he/she is doing, is clinically accurate, or if the person now making other mistakes.

Regarding the case study, they get detailed feedback on what the errors were – which is essentially what they are presenting when they present the case study again. Emphasizes should be on clinical reasoning, not repeating what's been learned. Current program doesn't give any objective measure of improvement in person's skills and knowledge.

ISWP asks that mentee submit another case study in three months after the mentorship has ended to demonstrate implementation of knowledge.

Elsje said we are preparing people in being successful on passing the test. There are too many different combinations of options, and you don't get to improve clinical reasoning skills by submitting one more case study. A mentee should submit as many as possible with constant feedback from a mentor. I know that from years of training – you can't give one session of training and expect the person to become skilled service providers by themselves. It doesn't work like that in the clinical field.

Mary acknowledged it would be hard to see a large gain, but we could try an alternative approach in the future. We don't have to use again if it doesn't work.

Elsje said the goal attainment scale is fine if used in appropriate context. Her point is that the mentors are responsible for making sure there are appropriate programs. Because our mentoring program doesn't follow through with opportunity to provide participants to go back, practice, or complete case studies on which they can get ongoing, structured feedback, she doesn't think they are succeeding. She questions the value of what we are doing. Still don't have evidence that we made any difference because we are leaving out critical components of a program.

Mary asked for recommendations for something else that can be implemented within the time and scope of the project. Suggested revisiting letter at end of Pilot 1, which mentors believe can be implemented.

Dietlind – asked whether there is room to change the activities around this within the upcoming mentoring phase. Can we improve on the current activities planned to make it more effective and have a bigger impact? Currently, there is one case study which gets verbal feedback, then written feedback, and then submitted again at conclusion. Elsje feels we can save time there and allow participants do an assessment on a user or review past case studies in between to check other aspects of understanding.

Within the next week, **Alex** will review current activities and timeline and present alternative plan for Subcommittee's input. Dietlind suggested determining how to restructure to use the hours better to accomplish the group's goals. Elsje said, for example, look at current suggestion that participants submit a case study, get written feedback, get in-person discussion with a mentor, and they do a presentation of the case study. That's giving way too much input and the same kind of input in different ways when it can be done in a more condensed way. We should decide on one way to do it that would free 2-3 hours per mentee which can be used more constructively – give homework, submit photographs and slides of other cases or other activities. At this stage, we can't change the number of hours committed by mentors or mentees, but we could change the content.

Mary recapped we propose a syllabus documenting each activity with designated weeks and hours, keeping hours same. We would rearrange some activities to include some suggestions made today. We could then look at the current plan and a revised plan side by side to compare and comment. Using that feedback, they will develop a proposed final syllabus.

Alex said in mentee focus groups, the mentees suggested receiving multiple iterations of feedback on the same case. Also in survey feedback, mentees wanted to show how they changed the service delivery for a particular client for the case study that they failed. The process was designed to incorporate this feedback. Sarah wondered if we could recognize the feedback, reflect that we have heard and considered, but give them more learning opportunities. Maybe it's more about the feeling of giving them more opportunities for learning. Maybe somehow, we can communicate it from both sides and say we have heard their feedback, but also want to bring more value to their experience from the field. From her experience, they will get more value from the revised approach.

Elsje had additional suggestions regarding the mentoring program in reviewing hours and activities. A lot of time is devoted to goal attainment scale and plan. Right now, it's more important to get the program right. She suggested Alex do the goal attainment scale and free the mentors' time to provide active mentoring activities, contact time, and feedback with mentees. Alex confirmed the only expectation between mentor and mentee is to know where they are now and one goal they would like to achieve at the end of the program. The rest would be completed by ISWP.

An orientation for the new mentors took place on Tuesday, July 17.

Participants *(check mark indicates participation on call)*

- ✓ Sue Fry, Motivation Africa
- ✓ Sarah Frost, Motivation UK
- ✓ Dietlind Gretschel, Rehab Lab (chair)
- Patience Mutiti, Motivation Africa
- ✓ Charles Kanyi, Motivation Africa
- Haleluya Moshi, KCMC
- Maureen Story, Sunny Hill Health Centre for Children
- Megan Giljam, Shonaquip
- Catherine Ellens, Sunny Hill Health Centre for Children
- Sharon Sutherland, Consultant
- ✓ Elsje Scheffler, DARE Consult
- Nekram Upadhyay, Indian Spinal Injuries Centre
- ✓ Alex Miles, University of Pittsburgh (co-chair)
- ✓ Mary Goldberg, University of Pittsburgh
- Jon Pearlman, University of Pittsburgh
- ✓ Nancy Augustine, University of Pittsburgh
- ✓ Krithika Kandavel, University of Pittsburgh

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Reviewed by: Alex Miles