# The “New normal” for Clinical Education:

# Tele-supervision

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# Disclosures

- Financial Disclosure
  - Receive a salary for working at a special education cooperative providing speech and language services
  - Work as an independent contractor providing tele-supervision services for Simucase
- Non-Financial Disclosure
  - None

- There are no relevant financial or non-financial relationships influencing the content of this course.

# Learning Outcomes

- Participants will be able to:
  - Explain differences in providing supervision in face-to-face versus "tele" formats.
  - Identify and state ASHA and state of practice guidelines related to tele-supervision
  - Describe possible advantages, barriers, and challenges to providing tele-supervision

# Clinical Education

- Clinical education comprises a large part of the training program for students in allied health professions
- The main purpose is to ensure that programs are graduating students that not only have academic knowledge, but who have also developed clinical reasoning, and clinical skill and competence
- Programs are different in terms of access to clinical education opportunities for their students, typically utilizing both on and off-campus sites, as well as many clinical educators, in order to get the job done
- We know that the supervision of students in clinical practicum sites is crucial for a variety of reasons –- for legal and ethical reasons, for teaching purposes, for mentoring

# Traditional Supervision

- Students have been supervised since the inception of training programs, however, in 1985 ASHA published a position statement on *Clinical Supervision in Speech-Language Pathology and Audiology*
- At that time it was recognized that supervision is a skill that needs to be discussed and developed separately from an SLP or AUD's clinical skills, that clinical supervision is a separate area of practice
- Providing clinical education is a skill that is separate from one's ability to provide service; just because an SLP/AUD is an excellent clinician does not automatically mean that that person can teach those skills to others in an effective manner
- The Position Statement outlined 13 essential tasks of supervision

# Thirteen (13) Essential Tasks of Supervision

- Written globally so that they could be applied to a variety of work settings and levels of clinical competency
- The “skill set” of a clinical supervisor must include working knowledge of serving a particular population in a work setting, as well as knowledge of supervision methodology and processes
- How this is done, the techniques and activities the supervisor utilizes, changes according to the level of experience and skill of the supervisee
- Students change dramatically from the time they enter a graduate program until the time they are ready to enter into their Clinical Fellowship and subsequent certification -- Supervisors need to have skills that meet supervisee’s needs at each juncture along the way

# ASHA's Thirteen (13) Tasks of Supervision

1. Establish and maintain an effective working relationship
2. Assist in developing clinical goals and objectives
3. Assist in developing and refining assessment skills
4. Assist in developing and refining clinical management skills
5. Demonstrate for and participate with the supervisee in the clinical process
6. Assist in observing and analyzing assessment and treatment sessions
7. Assist in the development and maintenance of clinical and supervisory records

# ASHA's Thirteen (13) Tasks of Supervision

8. Interact with the supervisee in planning, executing, and analyzing supervisory conferences
9. Assist in evaluation of clinical performance
10. Assist in developing skills of verbal reporting, writing, and editing
11. Share information regarding ethical, legal, regulatory, and reimbursement aspects of professional practice
12. Model and facilitate professional conduct
13. Demonstrate research skills in the clinical or supervisory process

# Anderson (1988) Model of Supervision

- Most supervision models in SLP are based on the 1988 Anderson model of supervision, which outlines supervision as a process, one that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations, and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)

- The model calls for a gradual shift from didactic, directed supervision to an independent, student-centered supervisory style as the student clinician becomes more and more competent and can engage in self-evaluation and analysis

# Expansion of Supervisory Model (Strong, 2020)

- ASHA (1985b) includes:
  - Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation.
  - Effective clinical teaching also facilitates critical thinking and problem solving in the supervisee
- This expands the Anderson model to more than just skills

# Expansion of Supervisory Model (Strong, 2020)

- Inclusion of other more recent supervision frameworks and models to create a comprehensive approach to supervision
  - Importance of Relationship in Supervision (Dunn et al., 2017)
    - "Core clinical skills such as unconditional positive regard for the supervisee, empathy and perspective taking, and exploration of supervisee's values and cultural background are essential elements of building a strong supervisor-supervisee alliance." (p. 217)
  - Supervision, Questioning, and Feedback Model coming out of the athletic training field (Levy, et. al, 2009)
  - Questioning based on Bloom's Taxonomy (Strong, Bates, Hillenbrand, Jones, Hicks, 2017)
  - Delivering different types of feedback (Stone & Heen, 2014)

# Expansion of Supervisory Model (Strong, 2020)

- Putting it all together to end up with *Reflective Supervision*
  - Incorporates self-examination and reflection, as well as emotional health, and self-care
  - (Gellar and Foley, 2009)

- Effective because it enables a supervisory process where teaching of clinical knowledge and skill, self-evaluation/self-reflection, and mental health are combined

- This results in new clinicians who are skilled, self-aware, and engage in self-care, which results in better patient care and relationships

# Current (pre-pandemic) Supervision

- To summarize:
  - We had all probably been using a combination of
    - The good practice we know and use from the Anderson (1988) model
    - The reflective supervision model that combines the more recent information about supervision
- BUT ….. even though we were probably getting pretty confident about our supervision skills, there were still stressors to the system

# Clinical Education Stressors

- We also know that programs have faced ever-increasing difficulty in the ability to provide adequate clinical education opportunities for their students:
  - Placement shortages (pre- and during pandemic)
  - Excessive clinician workload negatively impacting preceptor wiliness and ability to provide quality student education
  - Expectations for interprofessional education and experience
  - Increasingly complex healthcare and school systems

- This has necessitated creative problem-solving in training programs
  - First: Alternative clinical education experiences such as clinical simulation
  - Now: Telehealth and Tele-supervision

# Transition to Telehealth

- Telehealth services, including those provided by allied health professionals, had been increasing as viable options to meet patients' healthcare needs prior to the pandemic
- States had already been including provisions for providing services remotely in laws governing speech-pathology and audiology
- Pandemic (!!!) resulting in the immediate need for alternative and creative ways to serve almost all patients, as well as ways for students in the allied health professions to gain clinical experience

# Transition to Telehealth

- Student inclusion in the world of telehealth necessitates changes in so many things: clinical practicum experiences, policies, procedures, learning standards, and laws.
- New clinical practicum opportunities of course means new supervision issues to solve
- Just as we had realized that great clinicians are not by default great supervisors, we quickly realized that clinical supervision of telehealth sessions or practicum was both similar to and different from face-to-face clinical supervision
- That means we have a new frontier to conquer …. Student participation in telehealth and effective supervision of those experiences

# Pioneers!

- We are lucky to be part of a field that includes creative problem-solvers and innovators! Prior to the pandemic, we already had some pioneers in our field working on providing remote supervision

- Early research suggests tele-supervision can be a viable method for clinical supervision and it can provide graduate students a similar learning experience to being supervised in person
  - Dudding and Justice (2004) – explored videoconferencing as a clinical training tool
  - Dudding (2006) – discussed distance supervision
  - Carlin and colleagues (2012, 2013) – looked at e-supervision as "promising practice" and reported preliminary research findings, explored graduate student perceptions of tele=supervision
  - Dudding (2012) – models of tele-supervision
  - Chipchase et al. 2014) – videoconferencing model

# Can Tele-supervision Support the 13 Tasks of Supervision?

- Due to the advances in service delivery in the field of speech-language pathology, and student participation in remote service-delivery, Laughran and Sackett (2015) proposed a hybrid model of supervision where some of the tasks of supervision could be met via tele-supervision rather than face-to-face
- Back to the 13 tasks and competencies that ASHA lists as necessary for supervision
- Laughran and Sackett note that these skills not only include direct and indirect supervision activities, but also require building a professional relationship and modeling professional behavior
- This leads them to ask the question –- can tele-supervision support that?

# Can Tele-supervision Support the 13 Tasks of Supervision?

- There was not much literature in the field of speech-language pathology about the effectiveness of e-supervision, so the evidence was drawn from literature from all allied health professions.
- The position statement does not specifically denote the method of delivery of supervision, nor how modifications may need to be made to utilize tele-supervision in addition to traditional face-to-face methods of supporting students' emerging clinical skills
- The use of tele-supervision may help to solve the problems of providing quality supervision in underserved areas, as well as increase student access to a diversity of placements and supervisors

# Definition of tele-supervision for Common Understanding

- Telesupervision, or e-supervision, is the systematic use of technology to support clinical supervision. (Laughran & Sackett, 2015)
- Carlin (2012) defines e-supervision as “a method of supervision that uses videoconferencing technology to provide real-time, synchronous, clinical supervision to speech language pathologists (SLPs), clinical fellows, and graduate students” (p. 26).
- Use of information and communication technologies (ICT) to provide distant clinical supervision to students on clinical placements (Chipchase, et al., 2014)

# Meeting Supervision Tasks via E-Supervision
(Laughran & Sackett, 2015)

- "The most commonly reported form of e-supervision involves the use of two-way videoconferencing to observe a treatment session and to interact with the supervisee in a supervisory conference after the treatment session has been completed." (p. 7)

- Interpersonal communication and developing a relationship are integral to the first task of supervision
  - Videoconferencing can alter the nature of communication interactions, which can alter the supervisory relationship and how information is exchanged between supervisor and supervisee
  - Reduction in nonverbal cues via video may necessitate an increase in preparation and planning for the supervisory conference to rely more efficient verbal communication

# Meeting Supervision Tasks via E-Supervision
(Laughran & Sackett, 2015)

- Interpersonal communication and developing a relationship (Task 1)
  - Less spontaneity and more task-oriented communication
  - Impact: the quality of supervision is the same as face-to-face, but conversation and relationship-building may be impacted
  - Support for a hybrid model from the fields of counseling and psychology
- The development of independent thinking, clinical problem-solving, and flexibility may be facilitated sooner through tele-supervision (Task 1)
  - Students report an increase in feeling independent, in developing professional relationships, and in independent critical thinking
  - Evidence that tele-supervision allows students to progress through Anderson's stages from evaluation-feedback, to transitional, to self-supervision

# Meeting Supervision Tasks via E-Supervision
(Laughran & Sackett, 2015)

- Developing and refining goal development, assessment and management skills (Tasks 2-4)
  - It has been reported that this can be done via either method, and that both in-person and tele are effective
  - When demonstration is necessary, in-person is preferred
  - Students appreciate dedicated individual time and the immediacy of telesupervision meetings with supervisors
  - Supervisory input into management skills –- developing rationales, sequence for client progression, documentation – often has to be handled through email in a telesupervision platform, and there has been very limited research on the effectiveness of this

# Meeting Supervision Tasks via E-Supervision
(Laughran & Sackett, 2015)

- Demonstrating and participating in the clinical process (Task 5)
  - The nature of distance supervision limits this, and it usually takes place before or after a treatment session.
  - The onus is on the supervisor to provide specific, multisensory instruction
  - In regard to communication and counseling with families, some report not preferring tele-conferencing for this purpose
  - Task 5 includes “demonstrate or use jointly specific materials and equipment of the profession,” which can be difficult via tele-supervision
  - Students may require explicit training in telecommunication technology and application of it, as well as practice with it before client contact

# Meeting Supervision Tasks via E-Supervision
(Laughran & Sackett, 2015)

- With regard to the supervisor's ability to observe and analyze the supervisee during diagnostic and therapeutic sessions (Task 6), both supervisors and students have reported difficulty surrounding support for data collection. Students would like real-time examples and demonstrations, and supervisors have difficulty seeing data sheets and how students are rating client responses.

- Supervisory Task 7 is teaching the supervisee to develop processes for collecting and maintaining records – this can be accomplished well via either modality, with specific attention needing to be paid to confidentiality issues when remote

# Meeting Supervision Tasks via E-Supervision
(Laughran & Sackett, 2015)

- Tasks 8-12 are centered on the supervisor and supervisee, and do not require the presence of the client, and therefore can be completed well via either modality –- in person or tele
  - Supervisory conferences
  - Evaluation of clinical performance
  - Development of verbal and written communication and reporting
  - Gaining information about professional issues (ethics, legal, regulatory, reimbursement)
  - Modeling professional conduct

- Email allows for a "paper trail" in terms of provision of information and edits to work submitted
- Training in confidentiality and ethics related to electronic communication will be necessary!

# Meeting Supervision Tasks via E-Supervision
(Laughran & Sackett, 2015)

- Knowldege and Skill with Research and evidence-based practice (Task 13) can be facilitated in both face-to-face and tele-supervision settings
  - Competencies include reading, formulating, investigating, supporting, refuting, and reporting results of clinical and supervisory research.
  - Both the student and supervisor need access to current research.
  - Supervisors must remain current on evidence and new methods and resources within their supervisory skill set.

# The Winner?

- Laughran and Sackett (2015) recommend:
  - A hybrid model of supervision
  - It would include both face-to-face and e-supervision, and would allow for the most effective clinical supervision by adhering to ASHA's 13 tasks of supervision and competencies within the tasks.
  - In a COVID-free world, this could work very well for many programs: establishing relationships with students and higher levels of hands-on interactions as necessary, while implementing cost and time-saving tele-supervision meetings where appropriate
  - Unfortunately, we are NOT in a COVID-free world yet…

# CFCC/ASHA and Tele-supervision

- COVID-19 has created an unprecedented situation that is affecting the ability for clinical services to be provided on site and in person with clients and patients as required by the 2020 Audiology and Speech-Language Pathology (SLP) Certification Standards. This situation extends to the ability for graduate student clinicians and Clinical Fellows (CF) to be physically present with clients/patients, and for clinical educators and CF mentors to provide on-site and in-person supervision.

- To assist all stakeholders, the CFCC has made a variety of accommodations that allow hours/experience to be counted for ASHA certification in ways which were previously not allowed. The CFCC's timeframe for these accommodations is from March 16, 2020 – December 31, 2021. Given how this situation continues to evolve, the CFCC will consider future extensions as needed.

# CFCC/ASHA and Tele-supervision

- COVID-19 Guidance from the CFCC (2.3.21): Allowances regarding telepractice with telesupervision
  - Students may engage in service delivery through telepractice with telesupervision with allowances through 12.31.21 in order to obtain supervised direct contact hours. It is up to the discretion of the graduate program to determine how many hours can be earned through telepractice.
  - Multiple students may participate in the same session. Each student who is actively participating in the session will earn the full hour toward the completion of their clinical practicum.
  - Clinical educators may supervise more than one telepractice session concurrently, as long as they are available 100% of the time to each session and must provide a minimum of 25% direct supervision of the total contact time with each client
  - "available" is defined as *line of sight*, which means having all concurrent telepractice sessions in view 100% of the time
  - Clinical educators must meet all supervisory requirements as outlined in the 2020 Certification Standards

# State Regulation and Tele-supervision

- If a program uses telesupervision and telepractice, the program should be aware of applicable state licensure and/or certification restrictions related to tele options.

- Several states do not permit the use of telepractice; however, given the current environment and need for health care services, many of those states are considering/enacted emergency legislation to permit for telepractice.

# State Regulation and Tele-supervision: Illinois

- The Governor issued an executive order related to the use of telemedicine (2020-09) by licensed health professionals. The order provides a definition of telehealth, addresses insurance coverage and lists the covered health care professionals. Speech-language pathologists and audiologists are included in the list. All speech-language pathologists and audiologists who wish to practice telehealth in Illinois must be licensed, registered, certified or authorized to practice in the state

- Guidance issued on March 9th further allows audiologists and speech-language pathologists to supervise students remotely using video or audio technology

# State Regulation and Tele-supervision: Illinois

- Executive Order 2020-9 permits an out-of-state health care provider not licensed in Illinois to continue to provide health care services to an Illinois patient via telehealth where there is a previously established provider/patient relationship. The Department deems such a provider to be "authorized to practice in the State of Illinois" pursuant to Section 5 of the Executive Order without further need to obtain licensure in Illinois

# State Regulation and Tele-supervision: Illinois

- The Illinois Part C Early Intervention (EI) Teletherapy service delivery model has been created and the final steps are being finished. The Illinois Telehealth workgroup members developed Guidance (policy/procedure) and Training for the implementation and practice of the first-ever Illinois EI Teletherapy. The Bureau has cleared all Illinois Department of Healthcare and Family Services requisites to put this into motion.

# State Regulation and Tele-supervision: Illinois

- Currently, there are no guidance for unlicensed speech-language pathologists and audiologists to provide services in the state.

# Necessity is the Mother of Invention

- As a profession, we stepped up to the plate in unprecedented times!
- Clinical service providers quickly adapted to providing telehealth or alternative services.
- This applies to all settings:  healthcare, schools, private practice, early intervention, university clinics
- University training programs adapted and found ways for students to obtain appropriately-supervised clinical experience.
- Students have been able to obtain hours and clinical competencies, progress through programs, graduate, become certified, and join us as new professionals!

# Has it all been smooth sailing and stress-free?

- Absolutely NOT!

- Barriers encountered?
  - Legal issues
  - Technology and equipment
  - Knowledge and skill (both supervisor and supervisee)
  - Stress and anxiety – out of most of our zone of comfort!
  - Organization and scheduling
  - Interactional differences b/w in-person and tele
  - Still “holes” in clinical experience

# Does the chaos come with benefit?

- Abolutely YES!
- We have been able to do it! Services have been provided, students have graduated, we have all stretched our abilities.
- We have moved into innovative clinical practice, innovative clinical education, and innovative clinical supervision waters much faster than we ever would have in a status-quo world.
- Hopefully once the “emergency waivers” are no longer in effect, we will be able to make real change to our laws and reimbursement policies so that we can continue to serve our clients/students/patients in ways that are appropriate to each of them.

# Does the chaos come with benefit?

- We have trained new clinicians with skills they need for their future practice!
- We have opened doors to provide services to the underserved.
- We know what to add to our academic and clinical curricula so that students will be prepared for both face-to-face and telehealth services and supervision.
- We know that what we were doing was good, and that it can be applied to new service delivery models.

# The Take-Aways?

- As a profession we can take what we know from “before” and combine it with “what we know now” and emerge on the other side better from it.

- To revisit my title and come full circle:  Hopefully the “new normal” for Clinical Education is the most appropriate mix of traditional supervision and tele-supervision on a case by case basis.

# Thank you!

- Thank you for your interest in tele-supervision and for taking the time to attend my virtual session.
- If you have any comments or questions that I did not address, please contact me!
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