Behavioral Health Institute (BHI)
Training, Workforce and Policy Innovation Center
TeleBehavioral Health 301 Training Series

Behavioral Health Telehealth Resource
Website: https://bhinstitute.uw.edu
Email: bhinstitute@uw.edu

Date: June 17, 2022

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment. BHI established initial priority programs which include:

- Improving care for youth and young adults with early psychosis
- Behavioral Health Urgent Care Walk in Clinic
- Behavioral Health Training, Workforce and Policy Innovation Center
- Expanded Digital and Telehealth Services

WEBINAR LOGISTICS

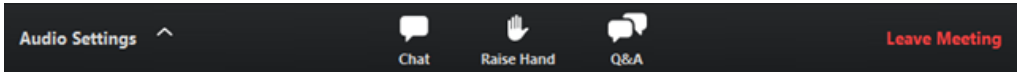
CHAT Box

- We'll share info about logistics
- Let us know if you are having tech issues
- To you: from our training team
- From you: only visible to hosts/panelists
- NOT for content-related questions (see next slide)

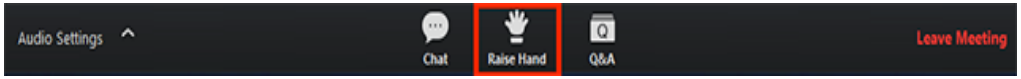
WEBINAR LOGISTICS

Q & A

1. Type question into Q&A Window
2. Raise hand (will be called on/unmuted)
   - Click Raise Hand in the Webinar Controls



   - The host will be notified that you've raised your hand.



   - Click Lower Hand to lower it if needed

Speaker Disclosures

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners have no relevant conflicts of interest to disclose:

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DISCLAIMER

Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

Always consult with legal counsel.

We gratefully acknowledge the support from

Washington State Health Care Authority

NRTRC NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

AHECWW AREA HEALTH EDUCATION CENTER FOR WESTERN WASHINGTON AT WHATCOM COMMUNITY COLLEGE

BUILDING TELEHEALTH CAPACITY for BEHAVIORAL HEALTH

TeleBehavioral Health 301

Telesupervision: Promoting effective and safe practice

ERIKA SHEARER, PHD

PATIENT CARE LINE MANAGER, PRIMARY CARE MENTAL HEALTH INTEGRATION

VA PORTLAND HEALTH CARE SYSTEM; UW SCHOOL OF MEDICINE

JUNE 17, 2022

- Learning Objectives:
  - Discuss the rationale for telesupervision.
  - Describe considerations related to adaptations for the telesupervision modality.
  - Identify strategies to scaffold learning experiences.

APA CoA stance on telesupervision

In non-pandemic times (as defined in the APA CoA SoA):

- For interns, telesupervision may not account for more than half of the minimum required 2 weekly hours of individual supervision (1 hour), and half the minimum required 4 total weekly hours of supervision (2 hours; APA CoA SoA, C-15 I).
- For postdoctoral residents, telesupervision may not account for more than half of the minimum required 2 weekly hours of face-to-face supervision (1 hour; APA CoA SoA, C-15 P).

In pandemic times:

- APA CoA has temporarily expanded the permission to engage in telesupervision in response to the COVID-19 pandemic for all supervision.

The case for telesupervision

- Telemental health produces results comparable to in-person care; it is reasonable to expect that the quality of supervision should not be diminished because of a shift in platform or setting.
- However, it is necessary to have a thoughtful approach to the provision of telesupervision to enable success.
- COVID-19 has made the use of telesupervision essential to maintain provision of training and uphold safety of public health.

Research on telesupervision

Most research suggests no differences from in person supervision:

- Supervisee perceptions of supervision effectiveness (Bender & Dykeman, 2016)
- Supervisory working alliance (Conn, Roberts & Powell, 2009; Jordan & Shearer, 2019)
- Supervisee self-efficacy (Reese et al., 2009)
- Supervisee satisfaction (Woo, Bang, Lee & Berguis, 2020)
- Alliance (Woo, Bang, Lee & Berguis, 2020)
- Supervisee competency (Woo, Bang, Lee & Berguis, 2020)

Some identified disadvantages to telesupervision:

- Increased anxiety/frustration related to technology (Sorlie, Gammon, Bergvik, & Sexton, 1999)

A rapid shift to telesupervision

Prior to the COVID-19 pandemic, telesupervision was not common practice within the VA health care setting.

VA mental health providers had to embrace telehealth technologies to enable face-to-face care, training, and supervision during the pandemic.

Some training programs previously engaged in telesupervision and had an established blueprint for facilitating effective, competency-based telesupervision; whereas many programs needed to rapidly pivot to this new modality of supervision.

Transition to Telehealth Questionnaire

- Internship and Fellowship Training Directors of APA-accredited VA Psychology Training programs were provided with anonymous web-based questionnaires to disseminate to their psychology supervisors and trainees.
- The questionnaires included the Supervisory Working Alliance Inventory (SWAI; respective versions for the supervisor- and trainee-oriented questionnaires) as well as demographic items, and specific questions regarding supervisor access, methods and frequency of oversight, and perceived benefits and barriers related to telesupervision.
- This project received VA national designation as non-research.

The participants

- A total of 249 psychology supervisors and 134 psychology trainees completed respective questionnaires.

VARIABLES	TOTAL (N = 382)	TRAINEE (N = 134)	SUPERVISOR (N = 249)
Gender			
Female, no. (%)	294 (71.2)	104 (80.0)	190 (72.8)
Race/Ethnicity			
White, no. (%)	331 (80.1)	107 (78.7)	224 (82.4%)
Disability status			
No, no. (%)	370 (89.6)	118 (86.8)	252 (93.7)
Location of training setting			
Urban areas	303 (74.6)	92 (68.1)	211 (77.9)
Location of patient served			
Both rural and urban areas	322 (78.0)	101 (74.3)	221 (81.3)
Prior telesupervision			
No, no. (%)	346 (83.8)	103 (75.7)	243 (89.3)
Engaged in telesupervision			
Yes, no. (%)	385 (93.2)	135 (99.3)	250 (92.6)

Differences in perceptions of working alliance

SWAI-T (Trainee version)

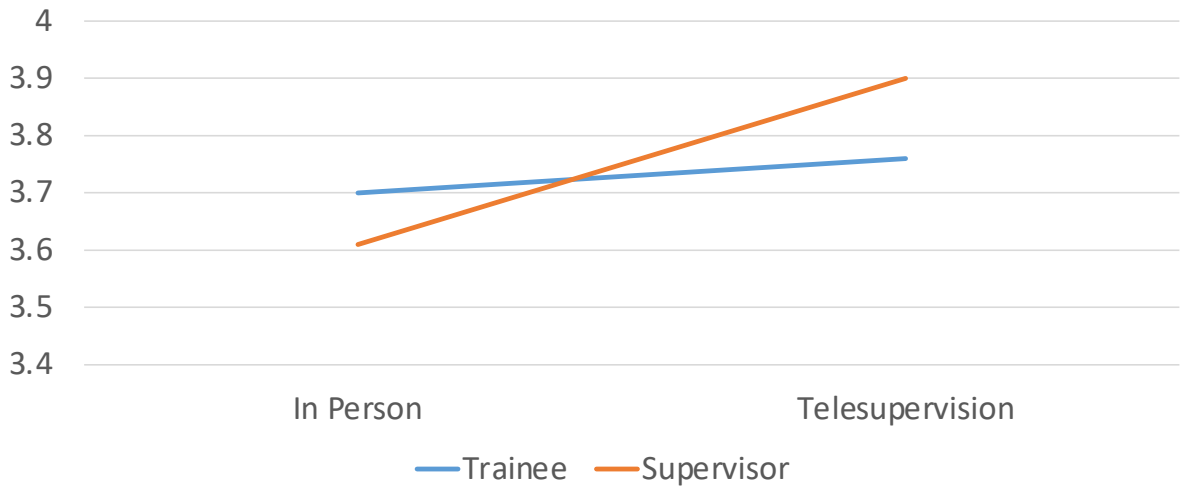
	M	*t*	*p*	*d*
Client Focus		-2.7	<.01	-.3
IP	6.3			
Tele	6.2			
Rapport		1.3	NS	.1
IP	6.4			
Tele	6.5			

SWAI (Supervisor Version)

	M	*t*	*p*	*d*
Client Focus		-4.7	<.0001	-.4
IP	6.1			
Tele	5.9			
Identification		-2.0	<.05	-.2
IP	6.0			
Tele	5.9			
Rapport		1.1	NS	.1
IP	6.2			
Tele	6.2			

(SWAI; Efstation, Patton, & Kardash, 1990)

Differences in frequency of supervision

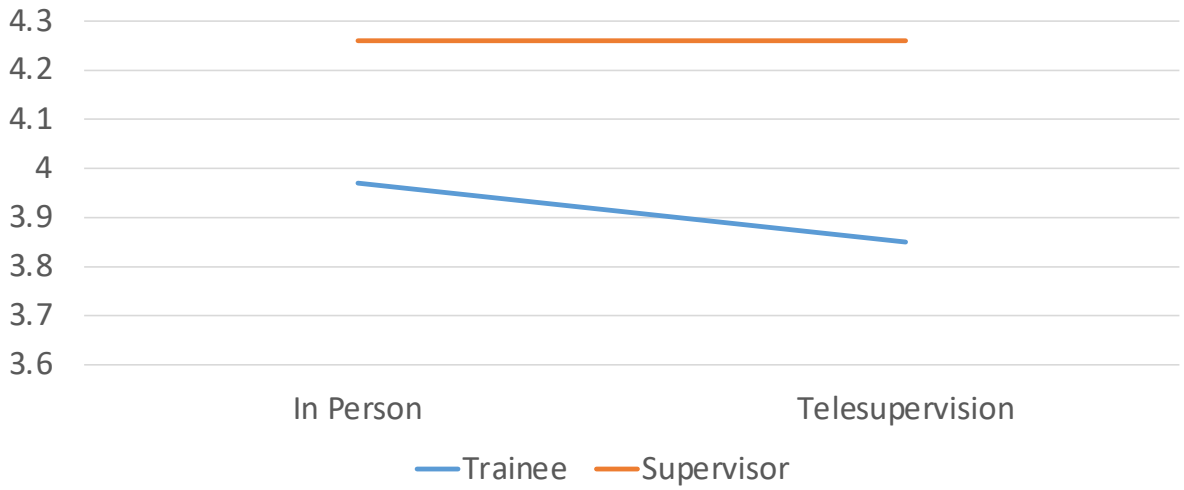


- Significant interaction effect: $F(1,330) = 7.6$, $p < .01$, $\eta^2 = .02$.

Differences in amount of oversight

- Significant interaction effect: $F(2, 289) = 3.36$, $p < .05$, $\eta^2 = .02$; Wilks' $\lambda = .98$.

Differences in frequency of evaluative feedback



- Significant interaction effect: $F(1,324) = 6.4$, $p < .05$, $\eta^2 = .02$.

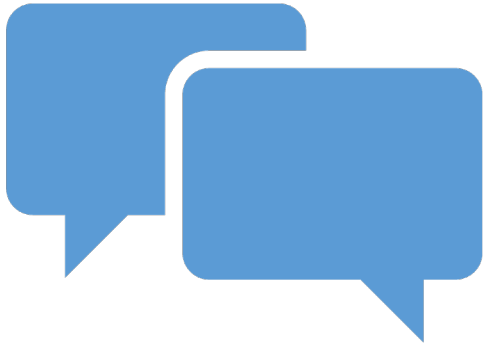
Take home Points

Access to supervision and oversight of clinical work should and can be maintained within the telesupervision modality.

The telesupervision modality may have put a magnifying glass on aspects of in-person supervision that were not going well.

Good supervision = good supervision.

Fostering Access and Communication



Setting expectations related to communication and access

Identifying who trainees should access

Supervisor Coverage (in order)	Phone Number
Rotation_1 Primary Supervisor: _____	Office: _____ // Cell: _____
Rotation_1 Secondary Supervisor: _____	Office: _____ // Cell: _____
Rotation_2 Primary Supervisor: _____	Office: _____ // Cell: _____
Rotation_2 Back-up Supervisor: _____	Office: _____ // Cell: _____

***If trainee cannot reach the primary or back-up supervisor for their rotation, they can contact either _____ (Phone #: _____) or _____(Phone #:_____)**

Just as in the case of in-person supervision, trainees must have appropriate levels of access to telesupervisors.

Coverage plan should be detailed and overtly discussed, as trainee may not be as able to physically seek out a supervisor.

Coverage plan is ideally multi-layered, with contact methods for each supervisor identified.

Identification of layered coverage is a good idea for easy access to proper oversight for both in-person and telesupervsion

- Regularly occurring supervision
- On-the-spot supervision for emergent concerns
- Unscheduled (ad hoc) supervision for non-emergent concerns

Identifying *how* to access

Regularly occurring supervision

- Regularly occurring supervision should be scheduled and prepared for in the same manner as in-person supervision.
- Engaging in telesupervision will increase the video teleconferencing skillset, making telehealth patient-care skills more proficient.
- Evidence suggests that the video-based modality has some benefits regarding increased disclosure and greater emphasis on verbal aspects of communication, which facilitate improved communication and supervision processes (Gibson et al., 2011; Gammon, Sorlie, Bergvik, and Hoifodt, 1998; Reese et al., 2009)

On-the-spot and ad hoc supervision

Must have same level of access to supervision for emergent and non-emergent needs.

A supervisor should be available with capability to join a session in a timely manner.

Supervisors must know how to take these actions instead of trying to problem-solve technology in the moment.

Some examples of ways to be readily available include:

having an instant messaging option open and visible	having cell phone on with screen up and in view to see alerts	encouraging use of words such as "URGENT" or "EMERGENCY" so supervisor is prompted to attend to message.

Identifying *when* to access supervision

The availability needs must be clearly discussed.		
Supervisors must be informed of exactly when trainees have scheduled patients.	Trainees must be informed of supervisor availability as well as back up supervision plan.	Expectations with regard to the frequency and method of check in must be explicated.

Maintaining Appropriate Oversite of Virtual Trainees

Amount of oversight is based on trainee competency

- The ranges in intensity of oversight may span from within the treatment room to readily available:
  - Within Treatment Room: video teleconferencing and telephone sessions are conducted jointly, with supervisor and trainee both being present in the provision of virtual care.
  - Readily Available: supervisor is accessible to join video teleconferencing and/or phone sessions; supervisor is available by instant messaging, phone call, and/or text as needed.

Assessing and adjusting the intensity of oversight

Prior to telesupervision/telehealth experience:

- Baseline competency assessment to understand the developmental need of the trainee.

At the onset of the telesupervision/telehealth experience:

- Supervisors may need to adjust intensity/type of oversight according to demonstrated competencies of trainee.
- Scaffolding can include trainees doing a practice telehealth session with the supervisor to become comfortable with the technology.

Throughout telesupervision/telehealth experience:

- Supervisors continue to monitor competency development of trainee and adjust intensity/type of oversight accordingly.
- Be willing to step-back to a higher level of oversight with increased frequency of feedback as needed.

Maintaining direct observation

- Direct observation of work needs to be maintained in a manner that is consistent with accreditation standards and the ongoing learning needs of the trainee.
- Supervisors can engage in direct and/or live observation by:
  - Dialing into video sessions (e.g., co-facilitating individual and group sessions or joining as an observer in sessions as needed)
  - Three-way phone calls with patient-trainee-supervisor
  - Recording the sessions to be later reviewed by the supervisor.

Scaffolding to Enable Training in Competencies

- Goal is to facilitate development of profession-wide competencies in a virtual environment, not changing expected competencies or lowering standards.
- Supervisors may need to overtly translate how to successfully meet expectations and develop needed competencies within the virtual setting.
- For example;
  - A trainee who is having difficulty with the competency related to Consultation and Interprofessional/Interdisciplinary Skills, may benefit from assistance in identifying ways in which trainee can effectively develop and exhibit this competency in a virtual manner.
  - Competency related to Ethical and Legal Standards could be met via appropriate telehealth documentation, observation of appropriate informed consent process, and demonstration of knowledge related to ethical

Upholding the provision of feedback

As with in-person supervision, telesupervisors need to be intentional and consistent in providing timely and meaningful feedback to trainees.

Feedback mechanisms for trainees and telesupervisors need to be explicated (e.g., email, instant messaging, etc.).

Training programs should provide electronic means and associated prompts to assist supervisors in maintaining appropriate documentation of supervision sessions, completion of relevant training forms, supervisory contracts, and other record management in accordance with training program requirements.

Supervision Session Checklist Tool (Adapted from Falender & Shafranske, 2015)

Please review the following checklist at the end of the supervision session and collaboratively share the information with your supervisor.

Did supervision cover the following elements?

- ____Addressed my goals for both learning and immediate needs for supervision session
- ____Addressed diversity/multicultural identities of patient(s), supervisee, or supervisor or interaction, including inclusion of diversity variables in clinical conceptualization and treatment planning of interventions
- ____Engaged in experiential supervision (e.g., active problem solving, role-play, modeling)
- ____Addressed my feelings, reactivity towards patient, and/or supervisor relationship.
- ____Monitored patient progress (including use of measurement-based care and any adjustments in treatment planning)
- Any areas or items to be addressed at next supervision session?

Supporting Supervisees and Staff

Providing necessary support to supervisors

1. Provide dedicated time to adjust to telesupervision and incorporate access and oversight recommendations.

2. Ensure appropriate access to technology and time to develop comfort in the use of the technology.

3. Encourage continuing to operate in a manner that is consistent with facility privileging and professional licenses.

4. May benefit from increased contact with the Training Director and colleagues for both provision of support, increasing consultation, and maintaining timely communication of feedback with trainee and training program.

5. Consider ideal supervisor characteristics when selecting supervisors.

Providing necessary support to trainees

- The same processes at the start of a rotation apply for both formats of supervision.
- Trainees may benefit from intentional practice to gain comfort and feedback for telehealth:
  - being able to practice a telehealth session with their supervisor
  - observing the supervisor engaging in telehealth sessions
  - co-facilitating individual or group telehealth sessions
  - feedback from supervisor (e.g., background setting, camera angle, presence via video to include facial expressions, tone, and hand gestures)
- Within the provision of telehealth and telesupervision, the trainee also must know:
  - emergency procedures specific to telehealth
  - expectations for communication with the supervisor (frequency, timeliness) for emergent and non-emergent issues
  - how to record sessions/engage in live observation
  - best ways to gain access to supervision between scheduled sessions

Implementation of telesupervision:

- Does not mean that quality of supervision is lowered
- Does not alter expectations of trainee, supervisor, or training program at large

Successful implementation includes:

- Thoughtful adaptation of traditional supervision methods to continue to assist in developing needed competencies and completing training requirements, while maintaining patient safety and quality care.

Good supervision = good supervision

QUESTIONS & DISCUSSION

Thank you for your time!

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

Additional Information & Resources

After today's session:

Slides & resources will be posted after the session

https://bhinstitute.uw.edu/

Please complete the evaluation survey:

- LINK will be shared in the chat box & also emailed
- Helps the presenters plan future sessions
- Required for Certificate of Completion and CEUs

After today's session:

- Complete evaluation
- Certificate of Completion - no cost.
  - May be able to use Certificate of Completion to meet CE requirements.
- CME credit – nominal cost.
- NASW CEU – no cost

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Accreditation with Commendation: The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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NASW
National Association of Social Workers
WASHINGTON CHAPTER

This workshop has been approved for 1 CEU by the Washington Chapter, National Association of Social Workers (NASW) for Licensed Social Workers, Licensed Marriage & Family Therapists & Licensed Mental Health Counselors.

AHECWW
AREA HEALTH EDUCATION CENTER

Our Provider number is #1975-433.

TELEBEHAVIORAL HEALTH 101

Online Self-Study

https://NRTRC.catalog.instructure.com/programs/telebehavioral-health-101-series

- Introduction to TeleBehavioral Health and Policy Overview
  *Meets telehealth training requirement as established by Washington SB6061.
- Getting started: Facts & Myths, and Security & Privacy
- Digital Health Do's & Don't's, Workflows, and Safety planning
- Billing and Reimbursement for TeleBehavioral Health
- Clinical Engagement over Telehealth
- Clinical Supervision in Telehealth

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TELEBEHAVIORAL HEALTH 201

- Telehealth Policy – the changing federal and state landscape
- Preparing Patients & Technology for Telehealth
- Doing Groups over Telehealth
- Mobile Health (mHealth) for Serious Mental Illness
- Provider Self-Care & Wellness in the Era of Telehealth and Covid
- Behavioral Health Apps
- Children & TeleBehavioral Health
- Applying Telehealth SUD Treatment in Community-based Settings
- Cultural Competence & Humility in TeleBehavioral Health
- Applying Telehealth to Measurement-based Care
- Suicide Risk Assessment over Telehealth
- Couples & Family Therapy over Telehealth

Online Self-Study at

Telebehavioral Health 201 Series - NRTRC (instructure.com)

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TELEBEHAVIORAL HEALTH 301

Jan 21, 2022:	Bree Collaborative Telehealth Guide & Hybrid Models
Feb 18, 2022:	Crisis Management & Risk Assessment
Mar 18, 2022:	Safety & Consent Planning
Apr 15, 2022:	Substance Use Disorder Treatment over Telehealth
May 20, 2022:	TeleBehavioral Health & Groups: lessons from Dialectical Behavioral Therapy
Jun 17, 2022:	TeleSupervision
Jul 15, 2022:	Whole Health & Telehealth
Aug 19, 2022:	Children & Adolescents
Sep 16, 2022:	Trauma-Informed Care
Oct 21, 2022:	Remote Teams & Tele-Teaming
Nov 18, 2022:	TeleMental Health and Professional Liability
Dec 16, 2022:	Reimagining practice: integration of AI, digital therapeutics and automation in behavioral health

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Additional Free Resources for Washington State Behavioral Health Providers

EDUCATIONAL SERIES:

- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO
- UW TelePain series

PROVIDER CONSULTATION LINES

- UW Pain & Opioid Provider Consultation Hotline
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line

UW Medicine
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Washington State Health Care Authority

Seattle Children's
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Moms' Access Project ECHO: CME Series
UW's Perinatal Substance Use, Mental Health and Infant Mental Health Case Conference Series

PROVIDERS, JOIN OUR NEXT COHORT!

Series learning objectives:

- Examine the role of parental mental health and substance use on the socioemotional development of infants
- Describe the parent child dyadic interaction and identify indicators of concern
- Describe the identification and treatment of common perinatal mental health and substance use disorders and the effects on the fetus and infant
- Practice working across perinatal mental health, perinatal substance use, and infant mental health systems
- Discuss the role of stigma, racism and SDOH in the care of perinatal dyads affected by perinatal mental health and substance use disorders

When? First Wednesdays from 12-130pm; Oct 2022 through July 2023

Who can join? Open to providers that care for perinatal patients (mental health, obstetric/childbirth, & substance use disorder)

Register here https://redcap.link/mapecho4 and email us if you have any questions at mcmh@uw.edu.