Supervision: Trends and Tools for Best Practice

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Speaker Disclosure

- Melanie’s travel expenses were paid for by the university
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- Melanie is a former member of the ASHA Board of Directors
- Melanie is a member of the Georgia Board of Examiners for Speech-Language Pathology and Audiology
- Melanie receives royalties from her textbook “Professional Issues in Speech-Language Pathology and Audiology,” (Lubinski, Hudson, 2013, Delmar-Cengage)

Learner Outcomes

Participants will:
- Identify stages of skill acquisition in the development of clinical skills and knowledge.
- Discuss evidence-supported strategies promoting independent practice through critical reflection.
- Describe a supervisory model that incorporates the key elements of the supervisory process.
- List 3 parts of the ASHA Code of Ethics pertaining to clinical supervision.
Myths and General Assumptions

• Experience creates the best supervisors

Myths and General Assumptions

“We do not learn from experience … we learn from reflecting on experience.”

~John Dewey

Experience as a Liability

• Supervisors and Mentors may be far removed from the actual experience of learning new and challenging skills
• May be reluctant to express your own vulnerability-fixated on your image of being an expert
• Tendency to make unfair comparisons between supervisees
• Unrealistic expectations about how learning occurs, leading to frustration and impatience
Myths and General Assumptions

We Are Not Creating Our Clones

• Adjust supervisory style according to the needs of the supervisee
• Reinforce the concept of collaboration
• Provide opportunities to achieve independence
• Incorporate reflective practice to encourage flexibility, growth, and independence

Myths and General Assumptions

• Competent clinicians are effective supervisors
Competencies Are Specifically Defined

- As a distinct area of practice, effective supervision requires a unique set of knowledge and skills.
- Education should focus on specialized skills for the supervisory process.
- Attainment of competence requires specific training.

(ASHA, 2013c; CAPCSD, 2013).

Clinical Supervision: Historical Perspective

- 1985: ASHA Position Statement to establish a clear position on clinical supervision.
- 2005: ASHA revision of certification guidelines for the Clinical Fellowship Experience (no longer a "CFE"; "Mentor" instead of "Supervisor" with more autonomy given to Clinical Fellow).
- 2010: ASHA Policy document regarding ethical issues pertaining to supervision of students.
- American Board of Audiology and most states now have specific supervision requirements for beginning clinicians.
- 2013: ASHA Policy Document on Supervision of Assistants.
- 2013: ASHA Ad Hoc Committee on Supervision.
- 2016: ASHA Ad Hoc Committee on Training in Supervision.
- 2020: ASHA will require training for supervisors of graduate students and clinical fellows.

ASHA Position Statement on Knowledge and Skills in Clinical Supervision (2008)

11 Core areas that should be acquired by supervisor:

1. Preparation for supervisory experience
2. Interpersonal communication and supervisor-supervisee relationship
3. Development of supervisee’s critical thinking and problem-solving skills
4. Development of supervisee’s clinical competence in assessment
5. Development of supervisee’s clinical competence in intervention
6. Supervisory conferences or meetings of clinical teaching teams
7. Evaluating growth of supervisee both as clinician and as professional
8. Diversity
9. Documentation
10. Ethical, regulatory, legal requirements
11. Principles of mentoring
Overview of Essential Knowledge and Skills for Effective Supervision

- Developed by ASHA’s Ad Hoc Committee on Supervision in 2013
- Identified 9 overarching knowledge and skill areas of training for all persons engaged in supervision

Knowledge

- Supervisory process and clinical education;
- Includes knowledge of collaborative models of supervision; adult learning styles; teaching techniques (e.g., reflective practice, questioning techniques); ability to define supervisor/supervisee roles and responsibilities appropriate to setting.

Skills

- Relationship Development
- Communication Skills
- Establishing and Implementing Goals
- Analysis
- Evaluation
- Clinical Decisions
- Performance Decisions
- Research/Evidence-Based Practice
Relationship Development

- Establish and develop trust
- Create environment to foster learning
- Transfer decision-making and social power to supervisee, as appropriate
- Educate supervisee about supervisory process

Communication Skills

- Expectations, goal-setting, requirements of relationship
- Expectations for interpersonal communication
- Appropriate responses to differences in communication styles and evidence of cultural competence
- Recognition and access to appropriate accommodations for supervisees with disabilities
- Engage in difficult conversations, when appropriate
- Access to and use of technology for remote supervision, when appropriate

Establishing and Implementing Goals

- Collaborative development of goals/objectives for supervisee’s clinical and professional growth in critical thinking
- Set personal goals to enhance supervisory skills (e.g., ASHA’s Self-Assessment tool)
- Observe sessions, collect/interpret data, share data with supervisee
- Provide feedback to motivate and improve performance
- Understand levels and use of questions to facilitate clinical learning
- Adjust supervisory style based on level and needs of supervisee
- Review relevant paperwork and documentation
Analysis

• Examine collected data and observation notes to identify patterns of behavior and target areas for improvement;
• Assist supervisee in conducting self-reflections until independence is achieved.

Evaluation

• Assess performance of supervisee
• Determine if progress is being made toward achieving supervisee’s goals
• Modify current goals or establish new goals if needed

Clinical Decisions

• Respond appropriately to ethical dilemmas
• Apply regulatory guidance in service delivery
• Access payment/reimbursement for services rendered
Performance Decisions

- Guide supervisee in reflective practice techniques to modify own performance
- Assess supervisee performance and provide guidance regarding both effective and ineffective performance
- Identify issues of concern in regard to supervisee performance
- Create and implement plans for improvement that encourage supervisee engagement
- Assess response to plans for improvement and determine next steps, including possibility of failure, remediation, or dismissal

Research-Evidence-Based Practice

- Refer to research and outcomes data and their application in clinical practice
- Encourage supervisee to seek applicable research and outcomes data
- Utilize methods for measuring treatment outcomes

Skill Acquisition and Models of Supervision

- Diagram illustrates the progression from novice to expert in supervision skills.
- Different stages of expertise are defined:
  - Novice: Limited knowledge and experience
  - Beginner: Gaining foundational skills
  - Competent: Proficient in basic competencies
  - Proficient: Advanced skills with varying levels of expertise
  - Expert: Mastery and leadership in the field of supervision
Dreyfus Model of Skills Acquisition

- Five-stage learning process
- Used to assess and support progress in skill development
- Provides definition of acceptable level of assessment of competence
- Supervisee progresses from one stage to the next as level of clinical knowledge and skills increases

Dreyfus Model of Skills Acquisition (1980)

Novice Stage

- Minimal knowledge connected to practice
- No experience in application of maxims
- Predictably inflexible behavior
- Needs close supervision
- Cannot be expected to use discretionary judgment
- Supervisor needs to use more direct style of supervision (modeling)
### Advanced Beginner

- Marginally acceptable performance
- Limited situational perception
- Beginning to treat knowledge in context
- Continue to treat attributes and aspects separately and with equal importance
- Second-year grad student

### Competent

- Able to plan deliberately using analytical assessment to treat problems in context
- Able to view actions in terms of long-term goals
- Able to incorporate deliberate planning to achieve goals
- Able to use standardized and routine procedures in context
- New graduate at Master’s degree level

### Proficient

- Able to see situation as a whole in terms of long-term goals (Holistic understanding)
- Maxims used for guidance
- Able to modify plans in terms of expectations
- Perceives deviations from typical, so able to make better clinical judgments
- Takes responsibility for own decisions based on what is most important in a situation
- Certified for independent practice
Expert

- Makes decisions based on both a set of rules and experience to manipulate rules and achieve end goal
- Has intuitive grasp of situations; relying on analytical approach to problem-solving only in unfamiliar situations
- Able to see end goal and knows just how to achieve it
- Able to go beyond existing standards to achieve end result
- Has had advanced training and clinical experience at proficient level

Models of Supervision

"A process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the situation (tasks, client, setting and other variables)."

(Anderson, 1988)
Anderson’s Definition

• Promotes decreased level of direction on part of supervisor, i.e. less strict control
• Supports flexibility
• Supports self-evaluation
• Supports critical thinking
• Promotes collaboration between supervisor and supervisee

Anderson’s Stages

• Not time-bound; supervisee may be at any given stage depending on circumstances, including knowledge and skills
• Promotes professional growth of supervisor: As supervisee progresses along continuum, supervisor learns to adjust supervisory style according to needs of supervisee

Anderson’s Model
Key Components of a Supervisory Model

• Collaborative Planning
• Observation and Data Collection, and Data Analysis
• Evaluation and Feedback

(Anderson, J., 1988)

Features of an Effective Model

• Based on key elements of supervisory process
• As supervisee grows, supervisor adjusts methods and style to fit skill level and confidence of supervisee
• As knowledge base of supervisee widens, independence increases
• Should support principles of reflective practice leading to self-supervision

The CORE Model of Supervision and Mentoring

• Collaboration
• Observation
• Reflection
• Evaluation

(Hudson, 2010)
Collaboration

Goal is to establish effective and trusting working relationship; Emphasis on joint nature of supervisory process

Collaborative Process

ASHA’s position statement on clinical supervision in speech-language pathology states that it is a collaborative process, with shared responsibility for many of the activities throughout the supervisory process.


Collaboration

- Where supervisor sets the stage for growth in the supervisory process
- Explain policies and procedures; set the “ground rules”
- Establishes performance expectations
- Explains assessment procedures
- Establishment of goals and objectives to promote clinical knowledge, personal improvement, productivity and self-directed learning
Observation

Purpose is to collect data on some aspects of clinical work

Reflection

*WHAT MATTERS MOST IS HOW YOU SEE YOURSELF.*

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Evaluation

- What are the essential features to include?
- How will supervisee performance be measured?
- How often should the supervisee be evaluated?
- Does the supervisee have the option of evaluating the supervisor?
- How will the concerns of both parties be handled?
- Should this be a formal or informal process?

Supervisory Relationship/Setting Expectations
Components of a Successful Supervisory Relationship

• Understanding of different communication styles
• Knowledge of adult learning styles
• Trust
• Self-Disclosure
• Cultural competence
• Boundary management
• Appropriate balance of power
• Knowledge of conflict resolution strategies
• Recognition of the value of both parties in the relationship
• Validation of strengths
• Support and advocacy
• Active listening, Empathizing, Questioning

Setting Expectations

Fredrickson and Moore (2014) cite the importance of clarifying expectations and discussing discrepancies early on as an important strategy.

Setting the Stage: Considerations

• Preferences for types of communication (email, phone, text, etc.), frequency and best times
• Dress code
• “Pet peeves” (cell phone on during sessions)
• Special needs
Group Think

What would you want to discuss during the collaborative stage? What should your supervisee know about you? Is there anything that you would want to know about him/her?

The Take-Away: Key Elements of Supervisory Relationship

- Emphasis on “union” between supervisor and supervisee
- Supervisor and supervisee are in growth process together
- Relationship-building is an important component
- Interactions become the instructional process that enables the supervisee to grow

Cultural Competence and Diversity Considerations
Diversity

- Race
- Ethnicity
- Gender
- Gender Identity/Expression
- Age
- Religion
- National Origin
- Sexual orientation
- Disability

Culturally Competent Supervisors

“Culturally competent supervisors had open discussions regarding differences that exist in cultures and the effect that racial differences have on the relationship between supervisors and supervisees.”

(Coleman, 2000)

Cultural Values and the Supervisory Relationship

Differences in cultural values have an impact on the nature and effectiveness of all aspects of clinical interventions, including supervisee relationships.

(Coleman, 2000)
Establish and Maintain Open Communication

• If the supervisor did not want to discuss culture then supervisees viewed this negatively which then affected the supervisory relationship

(Burkhard et al., 2006)

Establish and Maintain Open Communication

Just raising the topic of culture improved supervisee satisfaction

(Duan and Roehlka, 2001)

Promote Cultural Fluency

Supervisors have a responsibility to train their workers to be culturally fluent through self-awareness by developing and nurturing “responsive, reciprocal and respectful” relationships.

(Staub, 2009)
Remove the Elephant in the Room

- Initiate the conversation
- Implement principles of reflective practice
- Incorporate self-assessment and personal reflection

Personal Reflection Tool


Establishing and Implementing Goals
Goals of Clinical Supervisor

Ensure protection and welfare of the client

Goals of Clinical Supervisor

Provide for professional growth and development of the supervisee

Goals of Clinical Supervisor

Ensure that supervisee is practicing within professional guidelines
Scope of Practice in SLP

- http://www.asha.org/policy/SP2016-00343/

Scope of Practice in Audiology

- https://www.asha.org/policy/sp2018-00353/
Goals of Clinical Supervisor

Teach supervisee to become a competent and independent clinician

Non-Clinical Goals

• Licensure/credentialing/liability
• Navigating the workplace/policies and procedures
• Working with other professionals: Teambuilding
• Managing time and resources effectively
• Dealing with stress and avoiding burnout
• Managing conflict in the workplace
• Cultural competence

Establishing Goals

• A collaborative process
• Supports supervisee’s professional growth in critical thinking, problem-solving, self-awareness, reflective practice
Establishing Goals

- Refer to competencies that will be evaluated
- Select goals from these competencies
- Consider standards for measuring performance
- Discuss time frame for goal attainment
- Plan review dates to see if goals are being addressed

Establishing Goals

- Should be measurable
- Serve as a guide for action
- Serve as a source of motivation
- Should require a “stretch” on the part of the supervisee

Establishing Goals

- Qualitative self-evaluation in rating physician performance
- Areas: professional development, colleague relations, other professional activities, hobbies and personal pursuits that help you with your job
- Self-determined goals are relevant to job performance or professional development
- What could be done by medical director, practice and health system to help you better achieve the goals?

(Flood, Steven C., 1998)
Data Collection

- Supervisor needs to determine what specific data is being collected (ex. supervisee’s communication skills; quality of service delivery based on specific clinical activity, etc.)
- Data collected by supervisee typically centered on client behavior
- Should correspond to established goals related to expected clinical activities and professional growth
Types of Data Collection

- Verbatim recording
- Selective verbatim
- Rating scales
- Tally
- Interaction analysis
- Nonverbal analysis
- Individually designed

(From Casey, Smith and Ulrich, 1988)

Data Analysis

Analysis of data allows supervisee to observe relationship of his/her behavior to that of client

Data Analysis

- Logical
- Meaningful
- Have a specific purpose
Purposeful Analysis of Data

- Identify patterns of behavior
- Target areas for improvement

Assessment, Feedback, Critical Reflection

Purpose of Assessment

- To enhance learning for both parties
- Supervisor should emphasize “growth” and not “judgment” aspect
- Supervisee should know that no “surprises” will be brought up
- Should provide objective assessment and direct feedback
Assessment/Evaluation

The effective supervisor assists the supervisee in describing and measuring his or her own progress and achievement as part of this ongoing process

(ASHA, 2008)

Evaluation Tools

- Performance Profiles
- Self-Evaluation Checklists
- Skill Inventories (CFSI)
- Narratives (journals)

Supervisory Knowledge and Skills

Need to have knowledge of strategies that foster self-evaluation

(ASHA, 2008)
Self-Evaluation

- Encourages reflection-on-action (determines effectiveness of applicable solutions)
- Serves as source of motivation (recognizes role as leader)
- Promotes independence (utilizes feedback when constructing professional goals)

Self-Evaluation Checklist

Five point rating scale (1=unsatisfactory, 2=needs improvement, 3=meets job requirements and expectations, 4=exceeds job requirements and expectations, 5=outstanding)
- Skill and knowledge relating to your position
- Dependability: punctuality, availability
- Patient Relations; communication
- Commitment to the organization: goals and procedures
- Organizational skills, time management, efficiency
- Overall quality you deliver to the workplace
- Productivity
- Teamwork
- Positive attributes you bring to your work
- One or two areas that need improvement

Evaluation and Feedback

Overemphasis on evaluation component of supervisory process may be destructive to the supervisory relationship. (S. Dowling, 2001)
Types of Feedback

• **Appreciation**: designed to validate, motivate, and express thanks.
• **Coaching**: geared toward facilitating improvement in the receiver or identifying a problem in the relationship between the giver and the receiver.
• **Evaluation**: serves to rate or rank the receiver against a set of standards.

(Stone, D. and Heen, S., 2014)

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Receiving Feedback

“For us as clinical educators, it is crucial that we cultivate the skills that will allow the receiver… to make thoughtful decisions about if and how he or she will use the information that is received.”

(McCready, V., Raleigh, L., Schobor-Peterson, D., Wegner, J., 2016)

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Effective Feedback

• Descriptive, not evaluative
• Specific, not general
• Focused on behavior, not individual
• Well-timed
• Shares information, not giving advice
• Considers quantity recipient is able to receive
• Determines degree of agreement from receiver

(Pfeiffer and Jones, 1987)
Effective Feedback

- Should be designed to motivate and enhance performance
- Self-assessment tools are important part of this component

Critical Thinking

The clinical educator must not only teach critical thinking skills but also nurture the disposition toward critical thinking.

(Gavett & Peapers, 2007)

Critical Thinking

"Educational and professional success require developing one's thinking skills and nurturing one's consistent internal motivation to use those skills"

(Facione, 2000, p. 81).
Critical Thinking

"Most clinical educators recognize the significance of, and implications for implementing teaching methods which foster critical thinking. However, many clinical educators demonstrate uncertainty about which methods to employ and how to implement such methods."

(Procaccini, S., Carlino, N., Joseph, D., 2016)

Reflective Practice

Reflective practice enables us to spend time exploring why we acted as we did, what was happening in a group, etc. In doing so, we develop sets of questions and ideas about our activities and practice.

(Schon, 1996)

Reflective Practice

• Supervisor will assist the supervisee in conducting self-reflections until independence is achieved;
• Supervisor will guide the supervisee in using reflective practice techniques to modify his/her own performance.

(ASHA, 2013)
Levels of Reflectivity

- Technical Rationality
- Practical Action
- Critical Reflection

(Application of Critical Reflection, adapted from Pultorak, 1993)

1. What were the strengths of the session?
2. What, if anything, would you change about the session?
3. Which conditions were important to the desired outcome(s)?
4. What, if any, unanticipated outcomes resulted from the session?
5. Was this session successful?

Development of a Repertoire

Repertoire is a key aspect of reflection-on-action approach. Practitioners build up collections of images, ideas, examples and actions they can draw upon.

(Schon, D., 1996)
Portfolio Contents

• Observations/Evaluations
• Video or audio
• Letters
• Continuing Education
• Goals and Outcomes

Journals

A useful tool for clinical teaching of reflective practice

(Vega-Barachowitz and Brown, J., 2000)

Journals

• Your most important textbook for self-directed learning
• Your selections will accumulate into a body of knowledge that will give you real power in your field of interest
• It will be your record of what you do, what you decide to change, and what you learn when you put your plan into action
• It will be where you study the process that you followed as you worked…and where you studied yourself as a performer. Such studies will lead you to changes that will greatly improve your productivity

(Gibbons, M., 2008)
Difficult Conversations

• The fact that conflict exists is not necessarily a negative thing. As long as it is resolved effectively, it can lead to personal and professional growth.

Planning the Conversation

• Invite the other person to solve the problem with you
• State the problem briefly as you see it
• Select the time and location for the conversation
**Keep in Mind**

- Goal is not to provide litany on all the ways the individual failed to meet expectations
- Requires that the message be delivered in a way that others can hear
- Content, timing, tone of voice are all important
- Goal is not to triumph over the individual but to work together to find mutually satisfying solutions

**Basics of Effective Communication**

- Active listening
- Ask purposeful questions
- Respond appropriately to questions when asked
- Consider both verbal and non-verbal aspects of each of these

**Having the Conversation**

- You have to start it off
- Set the context
- Be specific
- Be nonjudgmental
- Provide feedback about the impact of the behavior
- Be brief, stop before the listener shuts down
Having the Conversation

- Try to understand his/her point of view
- Suspend judgment about other’s intentions
- Don’t look for ammunition to prove you are right

Having the Conversation

- Ask clarifying questions; don’t try to fill in the blanks
- “It would help me to understand the situation if you would tell me what your intentions were.”

Having the Conversation

- Restate in your own words what you think you have heard and ask if this is accurate
Don’t Forget………

• You have had time to collect your thoughts and prepare emotionally; the listener has not.

Wrapping It Up

• Determine what each of you needs to consider the problem solved
  Example: I want you to make a commitment to attend the clinic meeting every week.
• Determine whether the other person is able and willing to do this; if not, work with her/him to come up with an alternative
• It is not a compromise when you both give in on what you really want, but a new, creative approach that will genuinely work for both of you
After the Conversation

• Wait to let new agreements manifest
• Check in with other person to see how it is going
• If solution has been inadequate, meet to re-tool the plan

Self-Reflection

• Was I specific about the concerns? Did I provide examples?
• Did I avoid shaming, blaming, judging, using inflammatory language?
• Did I listen to the other person with an open mind?
• Were the timing and setting conducive to the conversation?
• Did my nonverbal communication and tone of voice match my words?
• Did I take responsibility for both my intentions and my impact?
• Did I check assumptions about the other person?
• Did I try to find mutually satisfactory solutions, or was I trying to be right or to win?

(Sanderson, 2005)

Ethical Issues and Regulatory Responsibility

THERE IS NO RIGHT WAY TO DO A WRONG THING.
Why Have a Professional Code of Ethics?

- Improve self-worth and satisfaction in profession
- Credibility lies in technical competence and public trust
- Ethics is good business

GOT ETHICS?

Why Have a Professional Code of Ethics?

- Professional guidance (backbone)
- Provide consensus
- Give support to responsible professionals
- Official statement to promote public good
- Promote public trust

GOT ETHICS?

"Your integrity is on the line. Want me to say you're in a meeting?"
Ethical Standards

- Guide professional behavior related to practices, procedures and circumstances
- Established by professional organizations at national, state or regional levels, accrediting agencies or employers
- Are not religious or scientific in nature
- Organized by Preamble (vision statement), Principles (goals to be maintained), Rules of Conduct (Dos and Don’ts of each principle)

ASHA Code of Ethics

ASHA’s Code of Ethics contains the rules or standards agreed upon by our membership that govern our conduct and activities. A code of ethics is a shared statement of the values specific to a particular group. The importance of adherence to the Code by ASHA members lies in the preservation of the highest standards of integrity and ethical principles, and it is vital to the responsible discharge of obligations by members of our profession working in all settings.

Is Adherence Optional?

- The Code of Ethics is not simply inspirational in nature; it is essential to ensuring the welfare of those served and protecting the integrity and reputation of the professions. As a consequence, ASHA members and certificate holders are required to abide by the code’s principles and rules, and the Association enforces that mandate by sanctioning those found in violation. Depending on the egregiousness of the misconduct, the sanctions that the Board of Ethics can impose range from a confidential reprimand for lesser violations to revocation of ASHA membership and certification for a period of years, up to life, for violations of a serious nature
ASHA Code of Ethics

- Applies to all ASHA members, certified or not
- Applicants for membership or certification
- CF seeking to fulfill standards for certification
- Suggests minimally acceptable conduct
- Organized into a preamble and four principles of ethics which are further defined by rules of ethics
- May assist members in self-guided ethical decision making

ASHA Code of Ethics

- Fundamentals of ethical conduct described by Principles of Ethics and Rules of Ethics
- Four Principles form underlying basis
- Rules are specific statements of minimally acceptable as well as unacceptable professional conduct

Four Principles of COE

- Principle I: Responsibility to persons served professionally and to research participants, both human and animal
- Principle II: Responsibility for one’s professional competence
- Principle III: Responsibility to the Public
- Principle IV: Responsibility for professional relationships
ASHA Code of Ethics-2016

- Updated preamble
- Modified jurisdiction over complaints
- New terminology section
- Increased ethical responsibilities for members in supervisory, mentoring, administrator or owner roles


States’ Codes of Ethics

- Codes of ethics or professional conduct are principles designed to help professionals conduct business honestly and with integrity. They are generally aspirational in nature.
- If a state does not reference a specific code, know what constitutes grounds for discipline.
- Please be advised that statutes and regulations may change at any time, so check periodically for updates.

Common Ethical Complaints

- Documentation Lapses
- Employer Demands
- Use and Supervision of Support Personnel
- Clinical Fellowship Mentoring/Student Supervision
- Client Abandonment
- Reimbursement for Services
- Business Competition
- Impaired Practitioners
- Affirmative Disclosures
Vicarious Liability

- The supervisor is ultimately responsible, both legally and ethically for the actions of the supervisee.

Documentation Lapses

- False Claims Act: knowingly submitting false claims for rehabilitation therapy services that were unreasonable, unnecessary and unskilled.
- Supervisor requests that they "sign off" on documentation for patients they did not evaluate or treat;
- Supervisor may request altering or supplementing patient or treatment paperwork (5.9% in recent survey);
- Supervisor may automatically place patients in highest therapy reimbursement level, rather than using individual evaluations to determine appropriate level of care;
- Pressure therapists and patients to complete the planned minutes of therapy even when patients were sick or declined to participate.

Ethical Concerns

- False Claims Act: knowingly submitting false claims for rehabilitation therapy services that were unreasonable, unnecessary and unskilled.
- Supervisor requests that they "sign off" on documentation for patients they did not evaluate or treat;
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- Pressure therapists and patients to complete the planned minutes of therapy even when patients were sick or declined to participate.
ASHA Code of Ethics

- **Principle of Ethics I; Rule Q:** Individuals shall maintain timely records and accurately record and bill for services provided and products dispensed and shall not misrepresent services provided, products dispensed, or research and scholarly activities conducted.

- **Principle of Ethics III; Rule D:** Individuals shall not defraud through intent, ignorance, or negligence or engage in any scheme to defraud in connection with obtaining payment, reimbursement, or grants and contracts for services provided, research conducted, or products dispensed.

- **Principle of Ethics IV; Rule E:** Individuals shall not engage in dishonesty, negligence, fraud, deceit, or misrepresentation.

Employer Demands

- Supervisors may demand increase in caseloads, tighter time limits, higher production quotas, and rejection of a professional’s independent judgment.
- Supervisors may pressure to provide services for which service provider had inadequate training/experience (7.4% in recent survey)
- Supervisors may assign duties that are outside of the scope of practice.
- Other?

Ethical Concerns
ASHA Code of Ethics

- Principle of Ethics II, Rule A: Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience.

SLP Scope of Practice (2016)

- http://www.asha.org/policy/SP2016-00343/

Audiology Scope of Practice

Use and Supervision of Support Personnel

• Because of differing state requirements and various job titles, the Ethics Office receives numerous ethical inquiries about roles and responsibilities of support personnel.
• The Board of Ethics does not have jurisdiction over an assistant practicing alone. The board’s jurisdiction is limited to a member, certified member, or applicant (ASHA, 2008).
• In general, however, there is no ethical use of assistants in any setting without adequate direction and supervision by an ASHA certified professional (ASHA, 2004).
• While ASHA endorses the use of trained and supervised support personnel, ASHA does not require the use of support personnel. SLPs should not be expected to use support personnel, particularly if they feel that quality of service may be compromised. ASHA expects SLPs to use support personnel in accordance with the ASHA Code of Ethics and may impose sanctions on SLPs if assistants are used inappropriately.

http://www.asha.org/policy/SP2013-00337/#sec1.10

Ethics and Supervision of Assistants

• Appropriate training and supervision of SLPA is to be provided by SLPs who hold ASHA’s Certificate of Clinical Competence (CCC) in Speech-Language Pathology.
• An SLP should not supervise or be listed as a supervisor for more than two full-time (FTE) SLPA in any setting or combination thereof.
• Activities may be assigned only at the discretion of the supervising SLP and should be constrained by the Scope of Practice for SLPA.
• The best interest and protection of the consumer should be paramount at all times.
• The purpose of the SLPA should not be to increase or reduce the caseload size for SLPs, but rather to assist SLPs in managing their existing caseloads. SLPA should not have full responsibilities for a caseload or function autonomously. (ASHA, 2013)

SLP Assistants
Audiology Assistants

- The roles and tasks of audiology assistants are assigned only by supervising audiologists.
- Supervising audiologists provide appropriate training that is competency-based and specific to job performance.
- Supervision is comprehensive, periodic, and documented.
- The supervising audiologist maintains the legal and ethical responsibilities for all assigned audiology activities provided by support personnel.
- Services delegated to the assistant are those that are permitted by state law, and the assistant is appropriately registered/licensed if the state so requires.

Affiliation with ASHA

- ASHA has established an Associates Affiliation program for support personnel in speech-language pathology and audiology, open to individuals who:
  - are currently employed in support positions providing audiology or speech-language pathology assistant services and
  - work under the supervision of an ASHA-certified audiologist (CCC-A) or speech-language pathologist (CCC-SLP).
  - Applicants are required to obtain the signature of their ASHA-certified supervisor(s) in order to become ASHA Associates.

Ethics and Supervision of Students

- ASHA-certified individuals who supervise students should possess or seek training in supervisory practice and provide supervision only in practice areas for which they possess the appropriate knowledge and skills.
- The supervisor must oversee the clinical activities and make or approve all clinical decisions to ensure that the welfare of the client is protected.
- The supervisor should inform the client or the client's family about the supervisory relationship and the qualifications of the student supervisee.

http://www.asha.org/Practice/ethics/Supervision-of-Student-Clinicians/
ASHA Code of Ethics

- **Principle of Ethics II, Rule E**: Individuals in administrative or supervisory roles shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member's certification status, competence, education, training, and experience.

Mentoring Clinical Fellows

- **Possible Ethical Issues**:
  - arbitrary termination of the CF mentor-supervisory relationship
  - termination of the CF mentor-supervisory relationship such that client abandonment occurs
  - failure to establish outcomes and performance levels or failure to do so in a timely fashion
  - failure to complete and sign the CF report or failure to do so in a timely fashion
  - withholding paperwork for the benefit of the employer and to the detriment of the Clinical Fellow
  - failure to provide the required amount of supervision
  - mentoring/supervisory responsibility for an excessive number of Clinical Fellows

  - assignment of excessive nonclinical duties to the detriment of the Clinical Fellows' clinical experience
  - recruitment of Clinical Fellows to function as independent practitioners without appropriate supervision
  - failure to report a Clinical Fellow's noncompliance with the Code or applicable law
  - failure to fulfill the responsibilities of CF mentoring/supervision as agreed
  - acceptance of compensation for the CF mentorship or supervision from the Clinical Fellow being mentored or supervised, except reasonable reimbursement for direct expenses, which does not include paying the mentor/supervisor's ASHA certification dues/fees or certification application dues/fees
  - delegation of tasks for which the Clinical Fellow is inadequately prepared
Client Abandonment

ASHA Code of Ethics

• **Principle of Ethics I; Rule T.** Individuals shall provide reasonable notice and information about alternatives for obtaining care in the event that they can no longer provide professional services.

Client Abandonment

• ASHA members must, at all times, maintain their focus on the welfare of the client, even when, as clinicians, they decide to end their relationships with employers or patients. Given the current shortage of CSD professionals, however, departures may leave clients without appropriate care. Adequate notice is necessary to prevent treatment disruptions, but even when given adequate notice, employers may be tempted to pressure or threaten departing clinicians to stay or give unreasonable amounts of notice. The Board of Ethics “Issues in Ethics” statement on client abandonment (ASHA, 2010b) offers specific guidance to remain ethical while in transition. Prior to departing, a professional must make effective efforts to provide for the patient’s continuing care. The more seamless the transition for the patient, the better.
Reimbursement for Services

• Ethical issues typically related to intent, fraud, and misrepresentation.

http://www.asha.org/Practice/ethics/Representation-of-Services/

Ethical Issues

• Misrepresenting information to obtain reimbursement or funding, regardless of the motivation of the provider.
• Providing service when there is no reasonable expectation of significant communication or swallowing benefit for the person served.
• Scheduling services more frequently or for longer than is reasonably necessary.
• Requiring staff to provide more hours of care than can be justified.
• Providing professional courtesies or complimentary care for referrals or otherwise discounting care not based on documented need.
Business Competition

Services must be designed to serve the public by providing accurate information in all aspects of the professions, from advertising to prognosis.

http://www.asha.org/Practice/ethics/Competition-in-Professional-Practice/

Impaired Practitioners

"These drug tests, they're absolutely confidential right? I don't want any rumors spread about me."
Impaired Practitioners

- Recognizing and dealing with impaired practitioners, professionals, and assistants is ugly but important. Impairments range from untreated or undiagnosed mental health issues to substance abuse of all types. The issues may be as much legal as they are ethical. National mental health statistics and surveys of ASHA members indicate that there may be a number of professionals who are challenged by mental illness, substance abuse, or both. Impaired professionals pose a liability to clients and colleagues that increases with time and opportunity, so addressing their impairment is imperative.

- Because the circumstances surrounding an impaired professional are complex, this type of ethical dilemma should not be taken on by one person. The supervisor, director, owner, lawyer, employee assistance program counselor, ethics officer, and/or compliance officer should be consulted to draw up a plan that encompasses all needed aspects to manage both the impaired professional as well as his or her caseload and/or students.

ASHA Code of Ethics

- Principle of Ethics IV; Rule I. Individuals shall not knowingly allow anyone under their supervision to engage in any practice that violates the Code of Ethics.

ASHA Code of Ethics

- Principle of Ethics I; Rule S. Individuals who have knowledge that a colleague is unable to provide professional services with reasonable skill and safety shall report this information to the appropriate authority, internally if a mechanism exists and, otherwise, externally.
Self-Disclosure

• University programs and licensure boards increasingly require applicants to reveal past criminal or professional discipline history, and applicants for ASHA certification, reinstatement, and recertification must do the same. This requirement generates many inquiries from applicants regarding what or how much to reveal.

Self-Disclosure

• Most licensure boards share professional discipline records of reciprocal members or applicants with the Ethics Office. Some state licensure boards also require licensees who are disciplined by a state board to self-report this professional discipline to ASHA’s Ethics Office within a month of receiving it. This requirement has led to several Board of Ethics-initiated ethics complaints against ASHA members. For instance, if a member’s license was revoked by the state licensing board as a result of the member being convicted of a felony by a court, the Board of Ethics would likely initiate a complaint against that member and possibly sanction the member with revocation of ASHA certification and membership for many years.

ASHA Code of Ethics

• Principle of Ethics IV; Rule S. Individuals who have been convicted; been found guilty; or entered a plea of guilty or nolo contendere to (1) any misdemeanor involving dishonesty, physical harm—or the threat of physical harm—to the person or property of another, or (2) any felony, shall self-report by notifying ASHA Standards and Ethics (see Terminology for mailing address) in writing within 30 days of the conviction, plea, or finding of guilt. Individuals shall also provide a certified copy of the conviction, plea, nolo contendere record, or docket entry to ASHA Standards and Ethics within 30 days of self-reporting.
The Ethical Supervisor

- Holds paramount the welfare of those served professionally (clients, research subjects, animals)
- Seeks advanced knowledge in the practice of effective supervision
- Delegates tasks appropriately
- Establishes supervisory relationships that are collegial in nature
- Practices non-discrimination
- Is aware of situations creating a dual relationship
- Promotes supervisee’s ethical knowledge and behavior
- Differentiates between theoretical differences and ethical dilemmas; discusses and practice solving potential ethical dilemmas
- Is available to the supervisee
- Maintains accurate and thorough documentation

Medicare

- Clinical educators must comply with Medicare guidelines related to coverage of student and clinical fellowship services. ASHA has compiled information about these regulations in the following sources:
  - https://www.asha.org/practice/reimbursement/medicare/student_participation/
  - https://www.asha.org/practice/reimbursement/medicare/student_participation_slp/

Medicaid

- Audiology and speech-language pathology are recognized as covered services under the Medicaid program. The federal government establishes broad guidelines, and each state then administers its own program. Review and approval is conducted by the federal Centers for Medicare & Medicaid Services (CMS).
- Medicaid coverage of services provided “under the direction of” a qualified professional varies by state.
  - https://www.asha.org/practice/reimbursement/medicaid/
HIPAA and FERPA

- [https://www.hhs.gov/hipaa/index.html](https://www.hhs.gov/hipaa/index.html)
- Facilities may provide training
- Supervisors ensure that students and CFs are aware of policies and procedures

Tele-supervision

- The use of tele-supervision as an alternative to in-person supervision may depend on the policies, regulations, and/or laws of various stakeholders such as universities, clinical settings, ASHA, state licensure boards, and state and federal laws and regulations.

Supervision of Students and Clinical Fellows
Student Privacy

• The education records of student clinicians are also protected under FERPA; the student clinician has the right to access his or her own education records, seek to have those records amended, control the disclosure of personally identifiable information from the records, and file a complaint with the school or department if he or she feels that these rights have been violated.

Student Privacy

• Universities generally may not disclose personal identifiable information from the student clinician’s educational records without the student’s written consent. One exception is when the information is of legitimate educational interest. A clinical practicum site might be allowed access to a student clinician’s personal identifiable information and must protect the confidentiality of this information, along with any other educational records generated during the practicum experience (e.g., performance evaluations and grades).

Performance Assessment

• It is critical that the clinical educator and the student clinician be jointly involved in the evaluation process (Anderson, 1988; McCrea & Brasseur, 2003).

• Expectations for performance and evaluation tools need to be clarified at the beginning of the supervisory experience (Brasseur, 1989)
Performance Assessment

- Establish clear educational plans and objective goals.
- Set expectations with the student.
- Rate each expected behavior independently.
- Consider specific data to support performance judgments.
- Use full performance rating levels to accurately indicate strengths and areas for improvement.
- Separate oneself from the evaluation—recognize that someone can be different but still perform effectively.
- Conduct in-house reliability training to ensure that all clinical educators use rating systems in a similar manner.

Students With Disabilities

- The rights of students with disabilities are protected by the Americans With Disabilities Act (ADA; 1990) and Section 504 of the Rehabilitation Act of 1973. The ADA and Section 504 of the Rehabilitation Act of 1973 define individuals with disabilities as:
  - persons with a physical or mental impairment that substantially limits one or more major life activities including caring for oneself, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning.
  - persons who have a history or record of such an impairment; or
  - persons who are perceived by others as having such an impairment.

Bi-Lingual Student Clinicians

- When the clinical educator does not also share the language, a unique set of knowledge and skills is needed to understand, monitor, and evaluate the work of the bilingual student clinician:
  - Shared cultural/linguistic relationship between student and client is not an attempt to be exclusionary
  - Bilingual student clinician is not automatically qualified to serve as a bilingual service provider. Adequate linguistic skills and appropriate training required to provide services to the individual with LEP.
  - Roles of bilingual service provider, interpreter, transliterator, and translator are unique, each serving a different function, requiring a different set of knowledge and skills.
Non-Standard American Dialect or Accented Speech

- Students can effectively provide services as long as they have:
  - the expected level of knowledge in normal and disordered communication;
  - the expected level of diagnostic and clinical case management skills, and when necessary; and
  - the ability to model the target (e.g., phoneme, grammatical feature, or other aspect of speech and language) that characterizes the particular problem of the client/patient (ASHA, 1998)—modeling can be provided in a variety of ways, given current technology (e.g., computer applications, software, audio and video recordings)

Mentoring Clinical Fellows

- The main purpose of the Clinical Fellowship is to improve the clinical effectiveness of the clinical fellow. The mentoring SLP must provide performance feedback to the clinical fellow throughout the CF. Feedback and goal-setting require two-way communication whereby both the mentoring SLP and the clinical fellow share important information about the clinical fellow’s performance of clinical activities. A specific time should be set aside for each performance feedback session at the end of each of the three segments of the CF. This session should be used to identify performance strengths and weaknesses and, through discussion and goal-setting, to assist the clinical fellow in developing the required skills.

Mentor Qualifications

- Holds a current CCC-SLP
- ASHA certification is maintained throughout the entire CF experience
- Not related in any manner to the clinical fellow
2020 Standards

- Clinical supervisors will have to have a minimum of nine (9) months of practice experience post-certification before serving as a supervisor.
- Two hours of professional development in the area of supervision post-certification before serving as a clinical supervisor or CF mentor.

Mentoring Clinical Fellows

- [http://www.asha.org/certification/CFSupervisors/](http://www.asha.org/certification/CFSupervisors/)
- [http://www.asha.org/advocacy/state/](http://www.asha.org/advocacy/state/)

Effectiveness and Accountability

- Chart and maintain successful course for new clinician
- Promote self-evaluation leading to self-supervision
- Promote critical thinking skills and reflective practice
- Give proper consideration to their influence
- Demonstrate compassionate guidance
- Instill confidence, empowerment

(Hudson, 2010)
Self-Assessment of Competencies in Supervision (2016)

- Developed by ASHA Ad Hoc Committee on Supervision Training (AHCST), 2016
- A self-rating tool designed to develop training goals to improve clinical abilities as clinical educator, preceptor, mentor, or supervisor
Discussion and Wrap-Up

Resources and References

- Johnson, A., “Mentoring throughout the journey from junior to senior clinician,” from presentation at ASHA, November 19, 2008, Chicago.
Resources and References