CLINICAL EDUCATION AND SUPERVISION: FACILITATING THE FOUNDATIONS OF INDEPENDENCE

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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 “CFY”; “Mentor” instead of “Supervisor” with more autonomy placed on Clinical Fellow)
- 2007: ASHA Policy document regarding CF Mentoring
- 2008: ASHA Technical report and document addressing knowledge and skills for clinical supervision
- 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
- 2013: CAPCSD White Paper on Supervision
- 2016: ASHA Ad Hoc Committee on Training in Supervision
- 2020: ASHA will require training for supervisors of graduate students and clinical fellows
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
SELF-ASSESSMENT OF COMPETENCIES IN SUPERVISION (2016)
SUPERVISORY PROCESS AND SKILL ACQUISITION
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)
10 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)
• 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
KEY ELEMENTS OF THE SUPERVISORY PROCESS
Anderson’s Continuum of Supervision

Stages: Evaluation-Feedback, Transitional, Self-Supervision

Styles: Direct/Active, Collaborative, Consultative

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 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
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 (HUDSON, 2010)
Goal is to establish effective and trusting working relationship; Emphasis on joint nature of supervisory process.
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
Fredrickson and Moore (2014) cite the importance of clarifying expectations and discussing discrepancies early on as an important strategy.
24 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?
ESTABLISHING AND IMPLEMENTING GOALS
27  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

Teach supervisee to become a competent and independent clinician.
GOALS OF CLINICAL SUPERVISOR

Ensure that supervisee is practicing within professional guidelines
31 SCOPE OF PRACTICE IN SLP

- http://www.asha.org/policy/SP2016-00343/
SCOPE OF PRACTICE IN AUDIOLOGY

- https://www.asha.org/policy/sp2018-00353/
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

- 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

- A collaborative process
- Supports supervisee’s professional growth in critical thinking, problem-solving, self-awareness, reflective practice
OBSERVATION
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
Analysis of data allows supervisee to observe relationship of his/her behavior to that of client.
PURPOSEFUL ANALYSIS OF DATA

- Identify patterns of behavior
- Target areas for improvement
What matters most is how you see yourself.
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)
The clinical educator must not only teach critical thinking skills but also nurture the disposition toward critical thinking.

(Gavett & Peapers, 2007)
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

(Pultorak, E.G., 1993)
What were the strengths of the session?

What, if anything, would you change about the session?

Which conditions were important to the desired outcome(s)?

What, if any, unanticipated outcomes resulted from the session?

Was this session successful?
JOURNALS

- A useful tool for clinical teaching of reflective practice

(Vega-Barachowitz and Brown, J., 2000)
PURPOSE OF EVALUATION

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
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?
SELF-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)
• Performance Profiles

• Self-Evaluation Checklists

• Skill Inventories (CFSI)

• Narratives (journals)
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)
“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., Schober-Peterson, D., Wegner, J., 2016)
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
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
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.
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.”
• Restate in your own words what you think you have heard and ask if this is accurate
The biggest communication problem is we do not listen to understand.

We listen to reply.
• You have had time to collect your thoughts and prepare emotionally; the listener has not.
• 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)
GENERATIONAL, LINGUISTIC AND CULTURAL ISSUES
“It is important for clinical educators to be aware of their cultural identity, gather knowledge about other cultures, and develop positive attitudes about different cultures. Clinical educators should use their supervisory meetings to initiate discussions related to cultural influences and differences to ensure supervisee success.”

(Subranamian, 2020)
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)
Just raising the topic of culture improved supervisee satisfaction

(Duan and Roehlke, 2001)
REMOV E THE ELEPHANT IN THE ROOM

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

• http://www.asha.org/uploadedFiles/Cultural-Competence-Checklist-Personal-Reflection.pdf
ETHICAL ISSUES IN SUPERVISION

There is no right way to do a wrong thing.
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.
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
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.

- [Rules, Regulations and Procedures | Louisiana Board of Examiners for Speech-Language Pathology and Audiology (lbespa.org)](http://lbespa.org)
- [Information for teachers (teachlouisiana.net)](http://teachlouisiana.net)
ETHICAL ISSUES IN SUPERVISION

- Documentation Lapses
- Employer (Supervisor) Demands
- Dual Relationships
- Use and Supervision of Support Personnel (Paras)
- Supervision of Students and Clinical Fellows
- Client Abandonment
- Reimbursement for Services
- Impaired Practitioners
- Affirmative Disclosures
Vicarious Liability

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

WHERE WOULD WE BE WITHOUT THE RIGHT DOCUMENTATION?

UNEMPLOYED?
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;
- 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.
• **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.
“Getting here on time every morning, and never have a day off sick, just isn’t good enough Moulding! How are you ever going to get through all the stuff I keep piling on top of you if you don’t work through your lunch-break as well?”
ETHICAL CONCERNS

- 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?
• **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/
• https://www.asha.org/policy/SP2018-00353/
• **Principle IV, Rule H:** Individuals shall not engage in sexual activities with individuals (other than a spouse or other individual with whom a prior consensual relationship exists) over whom they exercise professional authority or power, including persons receiving services, assistants, students, or research participants.
USE AND SUPERVISION OF SUPPORT PERSONNEL
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.

- *Assistants Code of Conduct (2020)* – effective June 1, 2020
SLP ASSISTANTS

- Appropriate training and supervision of SLPAs 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) SLPAs 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 SLPAs.

- 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. SLPAs should not have full responsibilities for a caseload or function autonomously. (ASHA, 2013)

- Rules, Regulations and Procedures | Louisiana Board of Examiners for Speech-Language Pathology and Audiology (lbespa.org)
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.
SUPERVISION OF STUDENTS AND CLINICAL FELLOWS
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/
• 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.
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.
A 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.

Bilingual SLPs must be able to independently provide comprehensive diagnostic and treatment services for speech, language, cognitive, voice, and swallowing disorders using the client's/patient's language and preferred mode of communication.

https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935225&section=Key_Issues
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.
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
MENTORING CLINICAL FELLOWS

Possible Ethical Issues:

- 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
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1. Hold the CCC-A or CCC-SLP,

2. Have 9 months of full-time clinical experience after earning the CCC-A or CCC-SLP, and

3. Have completed 2 hours of professional development in the area of supervision.

In addition:

Mentors may not be related to their CFs, nor receive direct compensation from their CFs for their mentoring.
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/)
HIPAA AND FERPA

- https://www.hhs.gov/hipaa/index.html

- Facilities may provide training
- Supervisors ensure that students and CFs are aware of policies and procedures
• 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.

• COVID-19: Tracking of State Laws and Regulations for Telpractice and Licensure Policy (asha.org)
COVID-19 CONSIDERATIONS

- The CFCC has provided an allowance for Clinical Fellows to accumulate CF experience weeks/hours through telepractice from March 16, 2020 – December 31, 2021.

- Telesupervision may be used for direct, on-site, and in-person observations of Clinical Fellows by the CF mentor(s) for the segment(s) of the CF experience that occurs between March 16, 2020 – December 31, 2021. As a reminder, a minimum of six hours of direct observations are required per segment (one-third of the CF experience) and up to six hours may be completed in one day.

- The Clinical Fellow, the supervisor/CF mentor, and the client/patient/student must all be located in the United States, and the Clinical Fellow, the supervisor, and the CF mentor must be appropriately credentialed to provide services both in the state they reside and in the state(s) that they provide services.
SOCIAL MEDIA

• Breaching Confidentiality
• Misrepresentation in promotion of services and products; listing of credentials
• Defamation
CLIENT ABANDONMENT

I Quit!!
• **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.
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.
• Many SLPs are concerned about client abandonment if they refuse to provide services without appropriate PPE. ASHA’s Issues and Ethics Statement on Client Abandonment states that some disruptions of clinician-client relationships are involuntary. As such, “clinical relationships may also be interrupted if an organization decides to close a program or when natural disasters occur. It is expected that even in these types of situations, practitioners would hold paramount the welfare of the clients they serve; however, no clinician is ever ethically required to work without pay or to place themselves in physical danger in order to offer client care,” (ASHA, 2019).
REIMBURSEMENT FOR SERVICES
REIMBURSEMENT FOR SERVICES

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

http://www.asha.org/PRACTICE/ethics/Representation-of-Services/
• 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/
• 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/](https://www.asha.org/practice/reimbursement/medicaid/)
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.
IMPAIRED PRACTITIONERS

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

Most licensure boards share professional discipline records of reciprocal members or applicants with the ASHA 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.
• **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
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
• 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
• 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
• 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
• ASHA’s Practice Portal offers one-stop access to resources to guide evidence-based decision-making on clinical and professional issues.

https://www.asha.org/practice-portal/
IN SUMMARY:

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