ATTC
Advancing the Integration of Substance Use Disorder Services and Health Care

Workforce Development through Clinical Supervision: A Promising Approach for Facilitating the Adoption and Implementation of Evidence-Based Practices for SUDs in Health Care Settings
(Workforce Development Work Group)

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Outline for Concurrent Session at the ATTC Network Forum November 5, 2014

I. Efficacy of Clinical Supervision (Review of the evidence-base)

Message: CS has a positive impact on both staff and client outcomes

a. Impact on Staff Outcomes
   i. Knowledge & Skills acquisition
   ii. Clinician self-efficacy
   iii. Patient-provider relationship/therapeutic alliance
   iv. Job performance
   v. Work attitudes/job satisfaction
   vi. Other benefits?

b. Impact on Clients (much less research on this topic)

II. Overview of Clinical Supervision (definitions and roles)

Message: CS is essential for staff/organizational capacity to provide SUD services

a. Broadly speaking it's a process of mentoring and coaching

b. Goals/objectives of Clinical Supervision include:
   i. Professional development
   ii. Quality assurance
   iii. Consensus building around programmatic goals

III. Models/Approaches to Clinical Supervision in Health Care Settings

Message: Clinical Supervision for SUD treatment in Health Care Settings should follow the same principles that are employed in specialty care

a. What is the responsibility of PCPs regarding SUD treatment services

Service provision for individuals with SUDs requires the application of general counseling theories and treatment methods that should be applied by professionals when working with individuals with alcohol and/or drug problems regardless of the particular treatment setting.

b. What services should be provided to individuals with SUDs

Activities and competencies of a SUD counselor, as well as any other primary care staff (e.g., physicians, nurses, MAs) that would support this process, should be based on the following practice dimensions that have been outlined in TAP 21 and thus the focus of Clinical Supervision:

i. Clinical evaluation, including screening, assessment and diagnosis of Substance Use Disorders (SUDs) and Co-Occurring Disorders (COD)
ii. Treatment planning for SUDS and COD, including initial, ongoing, continuity of care, discharge, and planning for relapse prevention
iii. Referral
iv. Service Coordination and case management for SUDS and COD
v. Counseling, therapy, trauma-informed care, and psycho-education with individuals, families and groups in the areas of SUDs and COD
vi. Client, family and community education
vii. Documentation
viii. Professional and ethical responsibilities

c. Fundamentals of Clinical Supervision

i. What should Clinical Supervision emphasize/prioritize

CS should be provided for the purpose of building staff competencies that will enable staff of all disciplines to effectively apply the above outlined counseling and treatment methods. This should include a focus on the adoption & implementation of evidence-based and promising practices for the treatment of SUDs.

ii. Essential elements of clinical supervision (TAP 21A/TIP 52)

d. Who requires clinical supervision for SUD service delivery

While the primary target of clinical supervision will be behavioral health staff employed within these settings, medical staff (e.g., physicians, nurses, Medical Assistants) supporting this process will also require the knowledge necessary and the oversight to ensure effective implementation. How this is accomplished will depend on the model of integration.

IV. Models/Approaches to Implementing Clinical Supervision

a. Numerous models for integrating SUD services/professionals
i. Are addiction services co-located (i.e. a licensed SUD clinic is embedded within the primary care setting as an independent treatment unit)
ii. Are addiction services co-located as part of a licensed mental health clinic and provided by mental health professionals with COD expertise
iii. Are addiction services provided by staff specialists (CACs) and in what way are these specialists integrated into the multidisciplinary team
iv. Collaborative models of Integrated SUD Treatment

b. Strategic approaches to the implementation of CS for SUD services
    i. Amending existing supervision structure to incorporate a focus on SUD
    ii. Formation of multidisciplinary teams with designated patient caseloads
    iii. Morning “huddles” to facilitate routine information sharing and case review
    iv. EMR as a facilitator of integration, and a tool for clinical supervision
    v. Other strategic approaches?

V. Challenges to Implementing CS in Health Care Settings

Message: Models for the effective implementation of CS for SUDs in Health Care Settings are not yet well established, in part due to the structural approaches to integration

a. Limited research on effective models of clinical supervision in health care settings

b. Staffing structure may inhibit integrated service provision
    i. Certain models/approaches are less conducive to the integration of SUD services
    ii. Supervision is often provided by professionals that do not possess certification or have experience with SUD treatment (i.e. mental health or medical professionals)
        1. What is the supervisors understanding of Recovery and relapse
        2. To what extent is the supervisor trained in the treatment of SUDs
        3. Is there “buy-in” regarding the importance of addressing SUDs and the responsibility of providing such services in primary care settings
        4. Does the supervisor promote staff development for SUD treatment; this includes a proactive training agenda for the inter-professional team

c. Program Structure may not adequately support the integration of SUD services
    i. How are addiction services funded/reimbursed? Are there perceived barriers or disincentives that impede the delivery of SUD treatment services?
    ii. Who is responsible for administering SUD services/treatment? This is especially problematic in settings that have not integrated addiction/behavioral staff.
    iii. Lack of understanding of what is required in the way of SUD Tx. Despite legislation calling for MH/SA parity “required” SUD services are not explicitly outlined.
    iv. Lack of accountability to provide SUD services. In what way are primary care settings held accountable for providing SUD services? Again, despite legislation calling for parity, early evidence suggests that SUD services are sparse.

d. Challenges related to Treatment Provision
    i. Stress level/overworked medical staff
    ii. Large client caseloads and more limited patient contact
    iii. Complexity of patient co-morbidities (MH, SA, CJ, physical health, etc.)
    iv. Case management and more comprehensive approaches are necessary to effectively treat individuals with SUDs (employment, housing, criminal justice, etc.)

VI. Measuring Fidelity and Effectiveness of Clinical Supervision

Message: Outline the importance of fidelity as it applies to clinical supervision

a. Why Fidelity Matters - CS plays a critical role within service organizations to ensure process implementation and quality of service. Adherence of counselors and therapists to such processes and components are necessary to comply with standards and to promote a clear delineation of roles and responsibilities. Fidelity is the process in which adherence to a set of practices are conducted and implemented as expected.

b. Models of Fidelity for Clinical Supervision
    i. Indicators of Fidelity
        1. Understanding of Theory
        2. Competencies on implemented practice
    ii. Ways of Measuring Fidelity
        1. Key domains of measurement
        2. Goal setting, problem solving, action planning, ongoing support/monitoring
    iii. Purpose of Measurement
        1. Establishing vs. measuring fidelity
    iv. Challenges of Measuring Fidelity

VII. SBIRT model as a recommended and practical approach to the integration of SUD in PCS.

In primary care settings where patient caseloads are high, staff resources and expertise are limited, and service provision is complicated, Clinical Supervision for SUDs and COD can focus on building staff competencies that will support the adoption and implementation of SBIRT as a method of identifying, engaging, and facilitating linkage to care for patients presenting with SUDS and COD. This is a targeted approach to integrated care most practical for PC settings.

1) **The critical role of Screening (S) for SUDs and COD**
   Must be proactive in identifying SUD and COD among patients as FQHCs and other primary care settings are the likely entry point for these individuals
2) **Capacity to provide Brief Interventions (BI)**
   Motivational Interviewing is a skill essential to patient engagement
3) **Technology Assisted Care can facilitate SBI in primary care settings –**
   A growing body of work supports the use of technology-based interventions to facilitate screening and brief intervention in primary care settings. These interventions are resource efficient and may also be cost-effective.
4) **Referral to Treatment (RT) is essential for ensuring a care continuum**
   Primary care settings simply can not provide sufficient services