A PUBLICATION OF THE HCH CLINICIANS' NETWORK

HEALING HANDS

Vol. 10, No. 1 ■ February 2006

The Challenges of Supervision in HCH: Helping Staff Succeed

Supervising staff in today's health care settings is difficult at best. Patients present with complex needs, time and resources are scarce, and managed care requirements exert pressure to do more with less. But supervision in Health Care for the Homeless programs is fraught with a special set of challenges, including the need to oversee staff that work in multidisciplinary teams in unconventional settings, the significant potential for staff to experience secondary or vicarious trauma, and the impact that societal factors not in the clinician's control—such as lack of accessible, affordable housing and health insurance—have on patient's physical and mental well-being. This issue of Healing Hands *examines how supervisors in HCH programs can be effective in their work, how they can address secondary trauma, and how they can work successfully with students and volunteers.*

Kate is a clinical nurse specialist in mental health who began working at Health Care for the Homeless 9 months ago. She counsels clients with serious mental illnesses and facilitates a group at the local domestic violence shelter. She meets with her supervisor David every other Wednesday at 1:00 p.m.

David is a licensed certified social worker and mental health therapist. Two years ago he was promoted to supervise a team comprised of peer counselors, social workers, and Kate. David never supervised people prior to this promotion.

At 1:20 p.m. on Wednesday, Kate rushes into David's office, plops down into a chair, and begins eating her lunch. She apologizes for being late. "One of my clients had his medications stolen last night and I felt I had to see him," Kate explains. "Also, I can only stay for 15 minutes today because I offered to see one of Betty's patients for her." David expresses his displeasure about her lateness for supervision, which is becoming a pattern, and Kate becomes upset.

"I'm trying as hard as I can to get everything done, but sometimes it seems impossible," Kate exclaims. "I think my patients have to come first."

David tells Kate she has seemed rather tired and distracted lately and notes that a client recently complained about her attitude. Kate yells at David and storms out of the room.

In a later session with his own supervisor, David learns some ways to better handle his relationship with Kate. He calls her into his office at the end of the day and acknowledges how difficult her work is and how draining it must be. Feeling affirmed, Kate apologizes for her outburst.

"I suppose I could do a better job of letting you know when I'm feeling overwhelmed and ask for help from you and the other team members," Kate says. "I also think taking time to eat lunch and relaxing a bit would help."

David reminds her of the importance of regular supervision. Kate acknowledges this and agrees to make it a priority. They end their meeting on a conciliatory note.

David's struggles as a new supervisor in HCH, and Kate's as an employee who is overwhelmed with her work, are not uncommon. It is not unusual for clinicians to be promoted to supervisory positions without prior experience or for them to supervise colleagues who are not their professional peers. Clinicians who work with traumatized patients face the risk of secondary trauma and lack of appropriate self-care. To address these and other challenges of supervising in an HCH setting, **Ken Kraybill, MSW,** training specialist with the National Health Care for the Homeless Council, offers a comprehensive training workshop for supervisors (see www.nhchc.org/trainsupervisors.html). Much of the material in this issue of *Healing Hands* is drawn from this work.

DEFINING SUPERVISION There are many definitions of supervision, but they all share two things in common: they acknowledge, as Kraybill says, that "supervision is all about good client care," and that supervision takes place in a relationship that extends over time.[1] **Charles McConnell**, author of *The Effective Health Care Supervisor,* describes the nature of health care supervision as "getting things done through people. The difference between getting things done through people and getting people to do things is as fundamental as the difference between leading and pushing."[2]

Clinical supervision, Kraybill notes, is distinct from other administrative functions performed by supervisors. Evaluating the quality of care provided (through assessment, diagnosis, and treatment) is the primary focus of clinical supervision and is often achieved through case reviews. However, "it is not unusual in HCH for clinical and administrative oversight to be done by one person," Kraybill says. For that reason, when he trains clinicians, he doesn't make a distinction between clinical and administrative supervision. "We talk about effective supervision," he says.

FORM AND FUNCTIONS OF SUPERVISION In general, supervision includes three main functions (see box).

The Three Functions of Supervision

Administrative – Carry out managerial responsibilities, make decisions; provide organizational structure and access to agency resources to facilitate work getting done; address organizational barriers to effective provision of care.

Educational – Provide information required for doing the work; assess gaps in knowledge and skills; promote continuing education to upgrade knowledge and skills.

Supportive – Provide psychological/interpersonal context to enable staff to mobilize required emotional energy; address emotional barriers to providing effective care; enhance commitment and motivation, decrease stress, promote self-care.

– Ken Kraybill, MSW

The specific manner in which supervision is applied is referred to as a model.[3] Developmental models of supervision have dominated research in this area since the 1980s[1] and are particularly useful in HCH, Kraybill notes. The developmental model of supervision acknowledges that both the supervisor's and supervisee's capabilities grow over time, and the supervisor's role changes as staff become more autonomous. The supervisor teaches new staff, coaches those at an intermediate level, and becomes a consultant to his or her more seasoned employees. "One size doesn't fit all," Kraybill says.

For example, pediatrician **Susan Spalding, MD,** Medical Director for Homeless Outreach Medical Services at Parkland Hospital in Dallas, tailors supervision to the level of each person's experience. "With my nurse practitioner who has 20 years' experience, I make certain she is keeping up with new developments," Dr. Spalding says. Staff that join her program right out of school need closer supervision and are paired with a senior clinician for 6 months.

Different approaches to supervision, as distinct from models of supervision, can be found among the different clinical disciplines that make up a typical HCH multidisciplinary team. In social work, it is common for supervisors to meet with each team member every week or two to review cases and to "make sure their emotional equipment is in tune," says **Dan McDougall-Treacy, MSW,** Director of Homeless Family Services at Valley Cities Counseling & Consultation in Seattle.

In contrast, notes Kraybill, clinical supervision by medical providers may entail a review of chart notes but rarely includes time for reflection. Though each approach has its place, Kraybill urges nurses, mid-levels, and physicians to "take time to sit with your peers to talk out loud about your work and learn from each other."

CHALLENGES FOR HEALTH CARE SUPERVISORS There are a number of challenges inherent to health care supervision that are not unique to HCH. These include being promoted from within the organization, with little if any supervisory experience, and serving dual roles as both a clinician and a supervisor.

"Many who become supervisors are the 'shining stars' as direct providers," Kraybill says. "They fall into or are drafted into supervision, but few get formal training. They learn on the job." Sometimes their formal training may actually work against them.

"A physician's training is technical, scientific, task-oriented, focused, and intense," says **Mark Bulgarelli, DO**, Medical Director at Family Health Centers of San Diego, where he supervises 45 physicians and 20 mid-levels in 13 clinics. "There is not much room for, 'You feel bad; let's talk about that.'"

Frequently, especially in smaller health care settings, supervisors who are promoted from within continue to serve as clinicians. They wear two hats, as both "functional specialists" and "management generalists."[2] This is difficult for the clinician who has to divide his or her time between supervision and direct service and for the staff who lack focused supervision. "I never take off my administrator's hat so trying to keep clinical time separate is difficult," acknowledges **Deborah Formella, CRNP,** a nurse practitioner and Director of Performance Improvement at Baltimore HCH.

CHALLENGES UNIQUE TO HCH The type of care HCH clinicians provide and the environments in which they work pose a set of challenges to supervision that are unique to homeless health care. Among these is the fact that supervisees work in multiple sites, each with its own culture and rules. For example, Kraybill points out, it may be acceptable for staff to hand out condoms in one shelter but not in another. Supervisors have to be aware of these environmental differences.

Secondary Trauma Bearing witness to the intense suffering their clients experience makes HCH clinicians particularly vulnerable to

what is variously called compassion fatigue or secondary or vicarious trauma. "Compassion fatigue is the feeling that your foot is on the gas and the brake at the same time," writes author **Karl LaRowe, MA, LCSW**.[4] These issues and the difficulties they present for supervision are discussed in the article on secondary trauma in this issue.

A Need for Strong Interpersonal Skills To succeed in HCH, staff need to have a unique combination of strong clinical and interpersonal skills, Formella says, and a good supervisor is responsible for nurturing proficiency in both. In particular, staff may need to check some of their preconceived notions at the door. Baltimore HCH uses a harm reduction approach to substance use disorders. "If you believe in abstinence only, it may be difficult to incorporate harm reduction in your practice," Formella says.

Good supervision starts at screening and hiring, clinicians acknowledge. "Many are drawn to this work, but not everyone succeeds," notes **Jennifer Weeber**, Director of Community Programs at Hazard Perry County Community Ministries in Hazard, Kentucky. At Baltimore HCH, each potential employee has at least two interviews with a multidisciplinary panel. "We make our expectations clear at the outset," Formella says. "You are expected to be able to interact with all members of the team." During orientation, all new employees, even those who will not have direct patient contact, spend time with staff in each clinical discipline. Staff who struggle to adjust to the HCH model of care are paired with an experienced clinician, Formella adds.

Interdisciplinary Work The interdisciplinary team approach to health care, a hallmark of the HCH model, may create special problems in supervision. "Supervising in a cross-disciplinary setting is a challenge, especially when the person who is supervising you is not your professional peer," says **Jeff Olivet, MA**, a consultant and trainer for the National Health Care for the Homeless Council and former case manager with the Children's Outreach Team at Albuquerque HCH. "However, there is strength in that cross-disciplinary exchange of ideas and perspectives that you don't see anywhere else."

Further, Olivet says, "an effective supervisor doesn't have to understand all the clinical issues his staff deal with. Instead, it's the supervisor's job to ensure that staff have the support they need to do their job well."

At Hazard Perry County Community Ministries, HCH Project Director **Ruth ("Rosie") Woolum** provides administrative supervision for the staff, which includes lay health outreach workers, an LPN, a phlebotomist, and the clinic manager. Clinical Director **Beverly May, MSN, CFNP**, provides clinical supervision. Having staff share supervision responsibilities works when the "chain of command is clear," Woolum says.

THE SKILLFUL SUPERVISOR When Kraybill lists the roles that supervisors play, one may think that supervisors are really superheroes: They "inspire, teach, support, model, challenge, evaluate, collaborate, and advocate," Kraybill says (see box). Still, Formella believes supervision is not difficult to learn if you start with good interpersonal skills.

The Skillful Supervisor

- Understands the importance of supervision
- Initiates regularly scheduled supervision meetings
- Communicates effectively
- Provides constructive feedback
- Employs progressive discipline steps when needed
- Is aware of and accepts own limitations and strengths
- Has the courage to expose vulnerabilities, make mistakes, and take risks
- Is invested in the development of the supervisee
- Accepts and celebrates diversity, is tolerant and respectful
- Has a sense of humor
- Practices self-care

– Ken Kraybill, MSW

HCH clinicians offer the following recommendations for helping themselves and their staff succeed:

- **Provide rules and tools.** "Provide each employee an orientation to the organization and its mission and to his or her responsibilities, along with the necessary tools to get the job done," says **Alina Perez-Stable, MSW**, Executive Director of Camillus Health Concern in Miami.
- **Honor supervision.** Set standing meetings with supervisees and give them your full attention. "When I meet with senior managers, my focus is on them," says **Laura Gillis, MS, RN**, President and CEO of Baltimore Homeless Services and former Clinical Director at Baltimore HCH. "I shut the door and I don't respond to phone calls or e-mail."
- **Listen, ask questions, and check expectations,** advises McDougall-Treacy. "Sometimes staff become disappointed when a client doesn't follow through. I remind them that sustaining the engagement is the most important thing they can do."
- **Be patient with the individual and impatient about client care.** "You have to have patience while the supervisee grows and evolves," Olivet says. "At the same time, you should be impatient with anyone who provides less than the highest quality of clinical care."
- **Welcome questions.** "My nurse practitioners have to function independently in the field, so I want them to feel comfortable asking questions," says Dr. Spalding. "I always let them know I'm glad that they called."
- **Praise liberally and criticize sparingly**. "I'm liberal with praise and I give my staff a wide berth unless their behavior is clearly unacceptable," Dr. Bulgarelli says. Likewise, Dr. Spalding is unlikely to criticize colleagues whose practice style is different from her own. "Most of what I see are shades of different practice styles, but that's okay," she says. When criticism is necessary, there is a right way to do it (see sidebar).

- **Be flexible but know your limitations.** "Sometimes staff experience life-changing situations, such as illness or separation," notes Perez-Stable. "If they need some short-term flexibility, we figure it out." Still, Gillis advises, "You can be sympathetic and supportive, but you can't be someone's therapist." Refer staff to your Employee Assistance Program (EAP) to deal with personal issues that impact their performance.
- **Advocate for your staff.** "As the only clinician in my organization who is also an administrator, I think it's my job to help the agency understand that we're only as good as the provider going into the exam room," says Dr. Bulgarelli. "If my providers are seeing 30 patients a day, they need to refill their tank on a regular basis."
- **Take care of yourself.** Ask for and get supervisory coursework, Gillis recommends. Meet regularly with your own supervisor to discuss supervision issues. Remember, as Kraybill says, "there is no such thing as perfect supervision."
- **Don't forget to have fun.** At Hazard Perry County Community Ministries, supervisors supported staff who planned a Patient Appreciation Day to honor musicians, artists, and bakers among their clientele. "Both staff and patients had fun, and the staff felt good about their job and the organization," Weeber says.

BEING AN EFFECTIVE SUPERVISEE Successful supervision is "a partnership where each participant brings his or her gifts to the table and each has a responsibility to participate in the process," Perez-Stable says. The first rule of being an effective supervisee is to make sure you have a supervisor, McDougall-Treacy notes. "Assert your desire to meet regularly, because there is too much potential for isolation in this work." Adds Kraybill, "Ask directly for what you need to do your work well, and inquire regularly about ways to improve your job performance." Be prepared and on time for supervision meetings and "learn from your experience," Kraybill says. "It will help you become an effective supervisor some day."

SEEING INTO THE FUTURE In his supervision workshop, Kraybill encourages supervisors to borrow liberally from the techniques of motivational interviewing to help employees reflect on and build their own motivation for doing this work (see the October 2003 issue of *Healing Hands* at www.nhchc.org for a more detailed discussion of motivational interviewing). "Use reflective listening, respect ambivalence, and promote self-efficacy in your staff," Kraybill says. "At its best, supervision helps people grow in this job or move on to another one," he adds. "It helps them see into the future."

Effective Criticism Helps Employees Grow

"Providing constructive feedback that can be heard, accepted, and acted on is an essential supervisory skill," Ken Kraybill says, but it is often a source of discomfort for supervisors and staff. The purpose of constructive feedback is to help the employee do his or her job better and, as such, it should always focus on the *problem* and not on the *person,* Charles McConnell writes.[2] Effective criticism should be timely, private, and rational and must include a guide for how to correct the problematic behavior.

"When dealing with performance problems, emphasize the employee's strengths and develop a plan together to work on areas that need improvement," Dan McDougall-Treacy says. For their annual evaluations, Ruth Woolum asks her staff to write down their strengths and weaknesses, and they discuss them together. "Maybe their weakness reflects a system problem," Woolum says. "It's my job to get them what they need to be effective."

At Baltimore HCH, supervisors use a process of progressive discipline that includes a verbal warning, followed by a first and second written warning, and possible termination of employment. "Providing discipline is clear cut when someone is stealing money, but it's more complex if they are late with paperwork or pushing boundaries by lending clients money or accepting gifts from them," Kraybill notes. At any point in the disciplinary process, employees can be referred to an EAP program or put on leave, and the Human Resources office and agency director should always be involved in decisions to terminate employment.

Ultimately, supervision is about quality patient care. "It's easier for supervisors to provide corrective feedback and guidance when they keep this in mind," Kraybill says.

Secondary Trauma Hurts Clinicians, Patients

Some HCH supervisors call it compassion fatigue; others call it secondary traumatic stress or vicarious traumatization. But they all agree it is a serious problem for their staff and one they must address openly and often. "Simply put," say authors **Karen Saakvitne** and **Laurie Anne Pearlman** in their workbook *Transforming the Pain,* "when we open our hearts to hear someone's story of devastation or betrayal, our cherished beliefs are challenged and we are changed."[5]

HCH providers are vulnerable to secondary trauma because they "willingly enter into another's suffering to offer hope and healing," Ken Kraybill says. Ironically, the same traits that attract individuals to the helping professions also may render them vulnerable to stress, burnout, and depression, according to author Karl LaRowe. A caregiver's ability to empathize with clients is both his or her greatest gift and greatest challenge, he writes.[4] Other individual traits that make clinicians subject to secondary trauma include unrealistic expectations of oneself as a professional, a personal history of trauma, and current stressful personal life circumstances.[5]

Within HCH, the nature of the clients and of the environment also cause stress. Clients frequently miss appointments; they are demanding, manipulative, and extremely needy; they are hostile, angry, and sad; they live chaotic

lives; and they suffer and die, Kraybill points out. Caring also becomes burdensome because of the frustrations of trying to provide help in the face of multiple barriers to care, including inadequate resources and structural supports for homeless people such as housing, health care, and incomes. "Empathic pain together with disappointingly slow progress can translate into vicarious traumatization." [5]

SIGNS OF SECONDARY TRAUMA HCH supervisors say it is fairly easy to recognize when their staff are suffering. "You'll notice a change in behavior," says Laura Gillis. "They become short with each other and with patients. They call in sick and they get sick. They don't follow through on their assignments."

Individuals suffering from secondary trauma may become overly involved with clients and cross patient-professional boundaries. "Many staff who work in HCH have had personal experiences of trauma and loss and they want to give back, but sometimes they give too much," says Ruth Woolum. Staff who cross boundaries may lend clients money, check on them outside of work hours, or, in extreme cases, take a client home with them.

Perhaps the most insidious impact of secondary trauma over time, say Saakvitne and Pearlman, is "its assault on our hope and idealism," which are essential gifts that caregivers bring to their work. "We have an obligation to our clients—as well as to ourselves, our colleagues, and our loves ones—not to be damaged by the work we do," they write.

SUCCESSFUL STRATEGIES The following strategies can help clinicians, supervisors, and organizations become more knowledgeable about secondary trauma and better prepared to address it.

Strategies for Clinicians The "treatment of choice" for addressing stress and avoiding burnout is to practice healthy self-care. "It is foolhardy to think we can be providers of care to others without being the recipients of proper nurture and sustenance ourselves," Kraybill says. In his supervision workshops, he teaches clinicians that healthy self-care

- Is an intentional way of living by which our values, attitudes, and actions are integrated into our day-to-day routines;
- Is about being a worthy steward of the self—body, mind, and spirit—with which we've been entrusted; and
- Is as much about "letting go" as it is about taking action. It has to do with taking time to be a human *being* as well as a human *doing*.

Specific self-care strategies may be as simple as taking a moment to stretch and breathe deeply. Other activities cited as helpful include discussing cases with colleagues, spending time with family or friends, socializing, exercising, participating in hobbies, listening to music, spending time in nature, and attending workshops or conferences.[5] (See the December 1999 issue of *Healing Hands* for more self-care strategies.)

Strategies for Supervisors Everyone working with traumatized clients needs supervision, and this supervision should include an understanding of trauma and awareness of its impact on the helper.[5] Supervisors provide a forum for staff to get reaffirmed and set boundaries, Gillis says. "Don't act like trauma is not happening," she advises. "Talk about it in supervision and in staff meetings."

In San Diego, Dr. Mark Bulgarelli knows that "our patients take a lot of emotional and physical energy." He counsels his staff on crisis management and de-escalation techniques. "We have to be careful as clinicians that we don't carry our experiences with the previous patient into the next exam room," Dr. Bulgarelli says. At Health Care Center for the Homeless in Orlando, providers who are having problems with a particular patient may request help from one of their colleagues to get a fresh perspective.

Many HCH programs schedule staff retreats or potluck dinners where staff can share stories and strategies and recharge their energy. Taking time to grieve by holding a memorial service for patients who have died is also helpful, notes Deborah Formella. In Orlando, the agency posts client success stories where staff can read them and be "reminded about the good work they do," says **Pia Valvassori, PhD, ARNP**, Assistant Medical Director.

Strategies for Organizations Secondary trauma leads to poor clinical work, absenteeism, and high-staff turnover. Thus, addressing it is cost-effective and need not be expensive, Saakvitne and Pearlman contend. Holding weekly meetings, providing staff with reasonable work expectations, and helping them learn to balance conflicting demands on their time are achievable tasks for most organizations, they believe.

Working Successfully with Volunteers

Many HCH grantees use clinical volunteers to expand and enhance their service capacity, at less expense than hiring additional staff would require. Nearly two-thirds (62 percent) of respondents to a 2004 survey from the National Health Care for the Homeless Council reported using volunteers in their HCH programs to offer extended clinic hours and special services and to serve more clients than would be possible with paid staff alone.[6] Their most frequent source of volunteers was students from professional training programs and primary care physicians.

However, the use of volunteers is not without its drawbacks, respondents noted. They cited as their greatest concerns adequacy of liability coverage, continuity of care, reliability in attendance, screening of applicants (for credentials, background checks, liability coverage), and recruitment. Other issues identified as challenging were assuring adherence to clinic policies and procedures, retention, cultural competency/sensitivity to homeless patients, and supervision.

"CONVINCE ME" HCH clinicians who supervise volunteers and students in their programs have confronted many of these con-

cerns with varying success. Dr. Susan Spalding of Homeless Outreach Medical Services in Dallas is very forthcoming about her experiences with and expectations of the people who volunteer in her program. "You really have to convince me you want to work in homeless health care; otherwise I can refer you to other homeless agencies or other health care agencies that need volunteers," Dr. Spalding says.

Often, she says, volunteers don't show up on a regular basis or they only want to do something exciting. She requires volunteers to make a weekly or monthly commitment and looks for those interested in a health care career, giving priority to students and residents. When this works, however, it works well. "I have one volunteer who has been with me every Thursday night for 3 years," Dr. Spalding says. "She fills out lab slips and weighs patients and helps make the clinic go faster."

"OPENING A CAN OF WORMS" At the Homeless Health Care Center in Orlando, Pia Valvassori supervises students who are doing a clinical rotation in the family nurse practitioner program at the University of Central Florida. She finds that her students "are not aware of the importance of addressing a patient's comprehensive needs." Most troubling to the students, she notes, is when they order a battery of tests and uncover a host of illnesses, including hepatitis C, HIV, and TB. "It's like opening a can of worms, and they don't know what to address first," she notes. She works closely with students in their first few weeks.

AUDITING CHARTS Providers who volunteer in the HCH program at Hazard Perry County Community Ministries work with Clinical Director Beverly May until she is comfortable with the care they provide. "Their charts are audited as part of our regular quality assurance process and we address any concerns with the provider," says Jennifer Weeber, Director of Community Programs. Weeber says she has never had a problem with a volunteer provider. "Perhaps our process would change if we did, but until then, it seems to be working."

SOURCES & RESOURCES

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The HCH Clinicians' Network is operated by the National Health Care for the Homeless Council. For membership information, call 615/226-2292.

This publication was developed with support from the Health Resources and Services Administration. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.