The Clinical Supervisor in Integrated Behavioral Health: Key to Achieving *The Quadruple Aim*

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Executive Summary

Integrated Behavioral Health (IBH) aims to bridge the gap between medical and behavioral health care by bringing behavioral health clinicians (BHCs) into primary care. A clinical supervisor oversees the work of the BHCs and in this way plays a key role in all aspects of integrated, interdisciplinary care. The clinical supervisor is essential to the achievement of The Quadruple Aim, a paradigm of health care system improvement that involves: 1) Improving the health of populations, 2) Enhancing the patient experience, 3) Reducing cost per capita, and 4) Improving the provider experience (Bodenheimer and Sinsky, 2014). The clinical supervisor plays a key role in the achievement of these four aims through the provision of training and clinical oversight of behavioral health clinicians, through collaboration with medical and operational leadership, and by fostering collaboration across disciplines.

The clinical supervisor recruits, hires and trains BHCs and introduces them to the fast pace and complex interdisciplinary work of primary care. With this foundation in place, clinical supervisors promote the first aim: population health. Clinical supervisors teach how to deliver behavioral health care for a population of patients and then how to measure its reach and impact. They focus on the second aim by supporting the BHC in providing patient-centered care from both operational and clinical perspectives. Clinical supervisors also play an essential role in the third aim by promoting clinical pathways and approaches that provide care in a cost effective manner. Finally, the clinical supervisor improves the experiences of the primary care provider and that of the behavioral health clinician so that they can work together effectively.

Clinical supervisors promote efficient and effective practices that help sustain empathic connection. They introduce tools and algorithms for outcome measurement and triage. They lead program development and nurture interdisciplinary relationships. They serve as a buffer against the BHC's chronic exposure to trauma, and they assist in monitoring patient safety. The clinical supervisor's focus on all four aims (cost, quality, patient experience and provider experience) requires that the supervisor possesses a combination of empathy, clinical knowledge, pragmatism, business acumen, adaptability, flexibility, professional maturity, and resilience. A strong clinical supervisor is an essential, but undervalued resource. This article reviews the role and scope of the clinical supervisor in Integrated Behavioral Health settings, demonstrates the importance of the clinical supervisor to the achievement of The Quadruple Aim, and encourages increased attention to and investment in this role.

Introduction

Over the past two decades, Integrated Behavioral Health (IBH) – which brings behavioral health clinicians into the primary care team – has emerged as a key strategy to bridge the gap between medical and behavioral health care. In IBH, clinical supervisors oversee the work of behavioral health clinicians (BHCs), who provide psychological assessment, treatment, linkage and referral. The scope and role of the clinical supervisor is

critical to achievement of The Quadruple Aim, a paradigm for health care system improvement. This framework was expanded from the widely adopted Triple Aim (Berwick, Nolan and Whittington, 2008) which posited that three dimensions were essential for improvement of health care system delivery: (1) Improving the health of populations; 2) Enhancing the patient experience; and 3) Reducing cost per capita. In 2014, Drs. Tom Bodenheimer and Christine Sinsky added a fourth dimension: improving the provider experience (Bodenheimer and Sinsky, 2014). Unacknowledged, behind the scenes, and at times invisible to daily operations, the clinical supervisor is key to the achievement of The Quadruple Aim. Yet, this role is absent from the literature on Integrated Behavioral Health.

Clinical Supervision in Behavioral Health Settings

In traditional behavioral health settings, BHCs participate in "clinical supervision," in which an experienced and licensed therapist trains and/or oversees a junior, typically unlicensed, therapist. Much like an attending physician trains a resident, the supervising BHC has authority to direct the work of the clinician and performs what are essentially teaching, coaching, oversight and quality assurance functions. When supervisees become licensed, the clinical supervisor transitions to the role of mentor and consultant. However, unlike attending physicians and medical residents, or medical residents with interns, this clinical consultation continues throughout one's career to manage subjectivity, to identify blind spots, to ensure sound clinical decision-making, and ultimately to improve the quality of care. Through the discussion of individual cases, the clinical supervisor ensures appropriate assessment, diagnosis, and selection and application of treatment methodologies through patient engagement, assessment, intervention, and the end of treatment. The supervisor provides a framework for ethical practice, including confidentiality and limits to it, informed consent, and the maintenance of boundaries. In a traditional supervisory relationship, the supervisee brings forward their subjective reactions to the client for examination and the scheduled hour is almost sacred in its reliability and regularity. Most importantly, through discussion and reflection, the clinical supervisor helps ensure patient safety throughout.

Clinical Supervision in Integrated Behavioral Health Settings

As the structure and model for clinical supervision is absent from the literature on Integrated Behavioral Health, little is known about clinical supervision in primary care settings or the range of resources allocated by community clinics for this role. What follows are my observations from almost a decade of overseeing a team of dedicated clinical supervisors and BHCs mostly in urban safety net clinics.

The allocation of resources to clinical supervision may depend on the model of integration, and there appears to be a wide range of how many resources are allocated to clinical supervision even when models of care delivery are relatively similar. One factor in this variation is the ability of clinics to hire licensed clinicians, which are often in high demand. In community clinics that are dependent on bilingual staff to provide care, unlicensed staff is often hired to work under the direction of a clinical supervisor, who then has the legal responsibility for their work. In fact, unlicensed clinicians typically receive more frequent supervision than licensed clinicians. In a model in which all unlicensed BHCs receive regular weekly individual supervision and all licensed BHCs receive regular bi-weekly supervision, along with group supervision, the allocation of the clinical supervisor's time is significant. When the clinical supervisor's role goes beyond training and oversight to include performance evaluation, crisis consultation, quality assurance, and program development, the need for clinical supervision time is even greater.

A Typical Day in a Community Health Center

One clinical supervisor starts her day by reviewing and co-signing notes from an unlicensed, relatively new BHC who is working under her license. She looks for accuracy in assessment, diagnosis and

formulation of the treatment plan; monitors fidelity to evidence-based practice; evaluates the patient's response to the intervention; and decides whether the documentation achieves the balance of being both concise and comprehensive. The clinical supervisor observes that the BHC included an objective measure and that the ICD-10 code is correct and reimbursable. Finally, she reviews the BHC's schedule on that date, and observes that this BHC fit in two urgent patients into her schedule and also ran a group.

She next meets with an experienced BHC. She discusses how to optimize the BHC's schedule, and reviews three high-risk patients who are due to come in that day or the next. All three patients are being closely monitored for suicidality, with some combinations of impulsivity, substance abuse and/or previous hospitalizations. Crisis stabilization is needed but unavailable for all three and none meet the criteria for an involuntary psychiatric hold. The patients cannot be linked to other behavioral health services outside primary care because of barriers such as transportation, language, lack of coverage, or previous negative experiences with behavioral health care services. The clinical supervisor reviews the details in depth, because the level of severity is far greater than what should be managed in primary care. Together with the BHC, they plan for what the BHC should do if any of the patients don't come to their appointments. They move on to discuss and plan for the new treatment group the BHC is about to begin. The BHC closes by mentioning there are ten other patients with high acuity that they didn't have time to discuss.

Next, the supervisor meets with another BHC and they discuss four patients. The first is a patient with school refusal. The BHC is very experienced in treating adults, but has never worked with parents or children before. They next discuss a patient who is dually diagnosed with a substance abuse disorder and schizophrenia; the BHC cannot locate an appropriate treatment program. The third patient is a patient with two decades of alcohol dependence. The patient is ready for treatment and was accepted into a residential program that requires that he receive a prescription for a benzodiazepine. However, the medical provider is concerned about the safety risk from concomitant alcohol and benzodiazepine use, and will not refill the prescription because the patient failed to keep appointments. The patient has begun to make frequent appearances to the Emergency Department, where he is prescribed benzodiazepines and then returns to the primary care clinic for help with his drinking. The clinical supervisor directs the BHC to convene a conversation between the consulting psychiatrist and the PCP to formulate a plan that will help this patient finally access treatment for his alcohol abuse. The fourth and final patient they discuss is new; he was referred to the BHC because he was just assaulted. Placed on the agenda for next time are the BHC's interest in learning more about working with geriatric patients; how to engage adolescents; and how to speak with a medical provider who schedules patients with situational stressors into the BHC's "urgent" appointment time slot, reducing access for actively suicidal patients. The clinical supervisor goes to meet her next supervisee. It's 11am.

Throughout the day, the clinical supervisor supports, listens, teaches, guides, and directs. In every encounter, the clinical supervisor is working on quality, patient experience, cost, and both the BHC's and/or primary care provider's (PCP) experience – all aspects of The Quadruple Aim. (See Figures 1 and 2).

Figure 1: The Clinical Supervisor's Impact on The Quadruple Aim

Improving the Health of Populations	Reducing Cost Per Capita	Enhancing the Patient Experience	Improving the Provider Experience
● Evidence-Based Practices ● Metrics ● Treatment to Target ● Behavioral Health Screening	● Schedule Optimization ● Behavioral Health Triage ● Maximizing Billing ● Workforce Development ● Shared Visits	● Reduced Wait Time ● Same Day Access ● Patient Engagement ● Cycle of Caring	● Collaboration ● Consultation ● Warm Handoffs ● Promotion of Care Team ● Burnout Prevention ● Preventing Vicarious Trauma

Figure 2: How The Clinical Supervisor Impacts The Quadruple Aim

Methods	
● Advocating ● Coaching ● Encouraging ● Evaluating Performance ● Modeling Flexibility ● Monitoring	● Problem-Solving ● Promoting ● Recruiting ● Supporting ● Training ● Translating between Disciplines

The Role Of The Clinical Supervisor In Achievement Of The Quadruple Aim

Clinical Supervisors Help BHCs Adapt To Primary Care Behavioral Health

In IBH settings the clinical supervisor has additional responsibilities that go beyond what's expected in supervision of those practicing in traditional behavioral health settings. The clinical supervisor recruits, hires and prepares BHCs for their role in primary care. While graduate level behavioral health training has pivoted to include brief treatment modalities, few training programs prepare BHCs for the fast pace and complex interdisciplinary work of primary care, and even where they do, few trainees have the opportunity to develop mastery during their studies. The clinical supervisor recruits and hires BHCs who are flexible and who have the personal attributes and the clinical range to develop the clinical competencies needed in the complex primary care environment. Candidates must be open to adapting approaches and clinical modalities to meet not only the volume and pace but also the clinical diversity seen in primary care. The clinical supervisor "speaks" both behavioral health and primary care, and therefore, when interviewing and hiring, can discern a good fit: a combination of clinical competence and flexibility, and openness to learning how to work in primary care.

Once hired, the clinical supervisor oversees on-the-job training. In clinics hiring unlicensed BHCs, the clinical supervisor may be training newer BHCs in the core skills such as patient engagement, assessment, differential diagnosis, and treatment. Training new, unlicensed BHCs requires close, weekly supervision; review and co-signature of clinical documentation; and ongoing consultation as questions – especially safety concerns – inevitably arise. Training one unlicensed BHC can require a minimum of several hours a week of teaching and oversight for many months (or more, depending on the level of risk of the patient population).

Even licensed clinicians need assistance adapting to primary care, and have to make adjustments to their established ways of practicing. The clinical supervisor helps experienced BHCs modify brief treatment modalities to use them in primary care, which requires challenging therapist "sacred cows". First, clinic operations require flexible scheduling such as "overbooking" and/or accommodating "walk-ins" and "warm handoffs" or interruptions or introductions or emergencies. Thus, the BHC accustomed to the sacred "50-minute hour" has to make an adjustment. Second, the frequency, duration of visits and number of visits in an "episode of care" may be reduced. For example, a therapist working in a traditional setting may see seven patients at most in a day for visits that are 50 minutes in length, whereas a BHC in primary care may see anywhere from 7 – 12 patients, and the length of visits typically ranges from 15 to 45 minutes, every other week. And BHCs must have the skill and flexibility to lengthen and shorten a visit on the spot, as competing demands require.

The clinical supervisor also helps clinicians adjust to differences in the nature of the supervisorial relationship itself. In IBH settings, behavioral health clinicians document in a shared medical record that is accessible to members of the care team. This is a big adjustment for clinicians who are not accustomed to a shared record. And, the clinical supervisor helps the clinician adapt to the different nature of the supervisorial relationship itself. Traditionally, the clinical supervisor focuses on the patient and the supervisee. In Integrated Behavioral Health, the emphasis in clinical supervision is on the client, the systems and the population – and the supervisee.

The First Aim: Improving the Health of Populations

Clinical Supervisors Facilitate Adjustment To Population Health

Of the four pillars of The Quadruple Aim, Population Health requires the greatest adaptation on the part of the BHC accustomed to carrying a caseload of patients. Rather than asking "How is *my* patient doing?" the clinical supervisor teaches the BHC to look at the entire population of patients who call that clinic *their* medical home and ask, "What percentage of *our* patients are depressed, getting treatment and improving?" Thus, the clinical supervisor teaches population health concepts by first teaching about Integrated Behavioral Health, then about the particular model being implemented, and then clinical and operational standards and procedures. For example, BHCs will need to first learn about visit lengths, number of patients seen, periodicity, target populations, and expectations about an episode of treatment. Next, the BHC learns to adapt brief modalities (Motivational Interviewing, Cognitive Behavioral Therapy, Solution Focused Therapy, Dialectical Behavior Therapy and Problem Solving Therapy) to the setting and patient population. As these skills and methods are being mastered, the clinical supervisor monitors adherence and efficacy.

Metrics and Tracking

Clinical supervisors may be the first ones to introduce the BHC to the concepts of universal screening and "treating to target." They demonstrate the tools used to screen patients needing further assessment and to monitor progress in symptom reduction. They also help BHCs establish tracking and monitoring systems that ensure that patients receive a complete episode of care, despite the fact that weekly visits are impossible to schedule. Caring for this high volume of patients, with new patients being assessed and starting treatment every day, requires excellent organizational skills and systems to facilitate memory of specific details about a high volume of patients. If a BHC sees three new and four follow-up patients a day, and sees follow-up patients every two weeks, for an average of three follow-up visits, the BHC would be tracking 140 patients with complex symptoms each month. The supervisor, therefore, helps the BHC monitor this high volume of patients, many of whom may be experiencing severe symptoms. Thus, both the BHC and the clinical supervisor need especially good tracking systems, especially BHCs are monitoring many high-risk patients.

Triage

Caring for an entire population requires constant triage in order to determine how one patient's severity compares with that of another. While a BHC is visiting with one patient, another patient may require immediate assessment. Significant symptoms of a moderate depression will wait while the suicidal patient is treated first. The clinical supervisor helps develop clear triage guidelines and helps both the BHCs and Primary Care Providers (PCPs) utilize the triage criteria effectively. There is often a direct trade-off between PCP and BHC time: If the PCP provides some assessment to determine level of acuity and how a patient should be triaged, that slows them down. Conversely, having the BHC determine the level of need slows down access to care. Just as with medical visits, there is an important trade-off between same day visits and access to follow-up appointments. The correct approach to triage depends on the model, clinic culture,

population, and ratio of PCPs to BHCs. Finding the ideal approach reduces role strain and understaffing in both specialties increases it. The clinical supervisor can play a key role in finding and establishing the appropriate system for meeting the clinic's goals.

Safety and Safety Planning

Through hiring, training, performance improvement, and oversight, the clinical supervisor is responsible for the quality of care provided by the behavioral health staff. They review where quality improvement is necessary. During the process of consultation, the clinical supervisor may provide direction or even become directly involved in high-risk situations that require safety planning and monitoring. During safety planning, the clinical supervisor helps BHCs weigh competing alternatives in safety planning or conflicting ethical mandates. In the case of unlicensed BHCs, the clinical supervisor holds the clinical risk when supporting these BHCs in the management of suicidal and/or homicidal patients. When acute symptoms resolve, the supervisors continue to hold the responsibility for ongoing care. They ultimately are responsible for the management of the high-risk patients amongst the entire patient population of their supervisees.

The Second Aim: Enhancing the Patient Experience

Clinical supervision also focuses on the second aim: patient experience. The clinical supervisor's key role is to support the BHC in providing patient-centered care from both operational and clinical perspectives. Operationally, the supervisor promotes good access and appropriate triage. Clinically, the supervisor supports the BHC in all aspects of a "cycle of caring"– which cycles through empathic connection, active involvement, and conscious termination (Skovholt, 2001). One of the most challenging skills for BHCs practicing in primary care is juggling the high numbers of patients needing care. This requires continuous re-engagement with new patients who have complex, challenging or even overwhelming circumstances. Skovholt states that losing the capacity to care poses a great danger to patients because it results in provider ineffectiveness and incompetence. Caring is the essential quality that must be maintained. Awareness of this cycle enables the BHC to empathically re-engage over and over again. The clinical supervisor stays attuned to the BHC's ability to engage in the cycle and promotes the clinician's resilience.

The clinical supervisor helps BHCs develop and maintain approaches that support positive patient experiences for all patients. The clinical supervisor assists the BHC in working across cultures by maintaining curiosity, checking for bias, modeling empathy and cultural humility. The BHC may also be a bridge to PCPs and a patient advocate: "Let's talk to your medical provider about that." The supervisor helps maintain a strength-based orientation in the context of the medical model, which typically focuses on symptoms or problems. They help ensure that the patient has both "voice" and "choice" in the treatment. By ensuring that BHCs are attuned, humble, and compassionate, the clinical supervisor helps BHCs keep the patient experience central. This aim is perhaps the one most congruent with the BHCs own training, and may be easiest for the BHC to uphold. But the challenge for the BHC is to not just to track and monitor one patient's experience, but also the whole population.

In California, behavioral health care delivery covered by public insurance is bifurcated. Patients with mild-to-moderate symptoms have coverage through county health plans, and those with severe symptoms with higher levels of impairment such as severe and persistent mental illness receive care through the behavioral health care delivery system. People, however, do not fit neatly nor continuously into just one category, but rather may move back and forth between them. The BHC cares for patients who are often caught between the two systems of care. The role of the clinical supervisor is to help BHCs and PCPs collaborate effectively in order to help patients access care. The BHCs advocate, monitor, and support patients who need to access the right level of care. Most importantly, for several reasons, they often continue to provide care for patients who require a higher level of care than what can be provided in primary care. Patients may not want to transfer care because they feel comfortable in their medical home, because they have had a bad experience with county services, because of the stigma of care at the county or because they've come to trust the BHC.

While the current structure of behavioral health care for those with public insurance does not acknowledge the

patient experience, the BHC does. Whether they are helping patients who come close to needing emergency care and psychiatric hospitalization, on the one hand, or whether they are monitoring patients who they are trying to refer to a higher level of care (or anywhere in between), the BHC cares for patients that need more care than primary care is designed for. In counties where access to specialty behavioral health is limited, the BHC can be monitoring many patients with active suicidality or other risk factors simultaneously. The clinical supervisor provides strategies for continued monitoring and assessment and encourages transfer of care when possible, ever mindful of the patient experience.

The Third Aim: Reducing Cost per Capita

Clinical Efficiency and Efficacy

Clinical supervisors play a key role in maximizing revenue and reducing costs. They do this through influence and input at both the clinical and operational levels. Excellent clinical skills inform the efficiency of care without detracting from quality. Clinical supervisors help BHCs to develop the skills to triage and assess quickly. They also teach the BHC how to make brief sessions effective and therapeutic by teaching about agenda setting, topic selection, empathic re-direction, and by focusing on discrete action steps. They also help BHCs engage patients in effective management of their chronic and/or complex conditions, including co-morbidities, in order to reduce the need for more expensive care. An example of this is the extensive monitoring the BHC provides to prevent patients from seeking care from Emergency Departments.

Clinical supervisors facilitate the implementation of group treatment because it is effective, reduces isolation and improves access, and also because it reduces the per capita cost of care. Not only does group treatment allow for more than one patient to receive care and therefore generate revenue simultaneously, but it also provides an efficient way to deliver non-billable services, thus reducing the number of non-revenue generating IBH appointments. The clinical supervisor teaches clinicians how to run groups if they don't have prior training, helps implement them at their clinics, and then supports the clinicians in managing the clinical and operational challenges that inevitably arise.

In addition to increasing revenue through maximizing the number of patients seen, or through group treatment, clinical supervisors also facilitate the conversion of non-licensed clinicians to licensed clinicians. Through tutelage and assistance, clinical supervisors overseeing non-licensed BHCs influence the overall licensure exam pass rate among BHCs at a given clinic. The conversion of unlicensed BHCs to licensed ones has multiple fiscal benefits. The licensed BHCs generate revenue, require less oversight, and are able to see more patients. Finally, an attuned clinical supervisor can increase the retention of BHCs and thereby reduce expenditures related to staff turnover.

The Intersection of Clinical and Operational Factors

Supervisors help BHCs maintain a systems perspective in all aspect of their work, including helping the BHCs understand their role in cost effective care by identifying their role in keeping schedules full, replacing no-shows, reducing wait time, optimizing appointment length, billing appropriately, running groups, and targeting specific sub-populations for intervention. Clinical supervisors help develop the systems and algorithms that can identify and address targeted populations to meet their needs in a more cost effective manner. For example, patients who are "high utilizers" because of their underlying psychiatric needs will benefit from more intensive attention from BHCs, often lowering medical utilization.

In order to maximize schedules, the clinical supervisor introduces the BHC to "tetrising" the schedule, shortening or lengthening appointments so that more appointments can fit in. The BHC needs guidance and encouragement to view the schedule as a guide, rather than an accurate prediction. The clinical supervisor brings the operational perspective to the BHC, and conversely, learns about operational issues to bring to leadership. For example, when no-show rates are related to not being able to cancel appointments by phone,

or if the automated reminders are not reaching patients with IBH appointments, operational solutions are required.

The Fourth Aim: Improving the Provider Experience

The Behavioral Health Clinician's Experience

BHCs need support and assistance in making a full adaptation to primary care behavioral health and to The Quadruple Aim. The clinical supervisor almost singlehandedly makes this adaptation possible. Even after that adaptation, the clinical supervisor has an almost singular impact on the experience of the BHCs. Clinical supervisors must be "bicultural" and able to translate and even interpret behavioral health concerns to PCPs and healthcare system issues to BHCs. The medical model is challenging for BHCs. The medical model identifies problems or symptoms that suggest a diagnosis and its corresponding treatment. In contrast, BHCs have been trained to build upon patients' strengths and their innate resilience to their presenting concerns. The clinical supervisor helps the BHC bridge the paradigms by providing empathic, strength-based strategies that are relevant. The clinical supervisor also provides essential emotional support to help refuel the BHC in assisting patients in need. This support may come in the form of encouragement, validation, and/or recognition. They encourage the BHC to engage in more self-care activities, to strengthen their work-life balance, or to engage in continuing education to increase effectiveness.

Vicarious Trauma

Emotional support is particularly needed in settings where the incidence of trauma is high. In the safety net, patients have few resources and bring their experience of trauma to their PCPs – either through chronic diseases (Felitti et al., 1998), somatic symptoms, psychological symptoms or through direct disclosures of recent or historic traumatic events. The PCPs "hand-off" the psychological trauma to the BHCs who hear the details and experience the patient's full affect session after session. The BHC often listens to the traumas experienced by the patient – the rape or assault by a family member, *coyote*, neighbor or stranger. Often these traumas are plural rather than singular. Over time, BHCs are exposed to significant levels of trauma.

This chronic exposure may result in vicarious trauma symptoms for the BHC: flashbacks, intrusive thoughts, nightmares, depression, numbing, dissociation or avoidance. Judith Herman states, "no one can face trauma alone." She goes on to say: "If a therapist finds herself isolated in her professional practice, she should discontinue working with traumatized patients until she has secured an adequate support system."[1] In this context, the clinical supervisor's role in preventing vicarious trauma is paramount. Clinical supervisors create a safe space to discuss the supervisee's emotions related to patient trauma and serve as a buffer against vicarious trauma. They help support the BHC's resilience by listening empathically, encouraging self-care, providing perspective, and focusing on patient strengths. They encourage the BHCs to stay connected to their own strengths and support systems. The structure and regularity of clinical supervision – a forum to vent, problem-solve or receive emotional support – is essential to making the work sustainable.

The Primary Care Provider's Experience

The Quadruple Aim posits that primary care is burning out PCPs, thus threatening affordable, high quality, health care delivery. PCP satisfaction improves when BHCs are available to address the behavioral health needs of their patients, which, when unaddressed, create significant stressors for PCPs. When PCPs can identify behavioral health conditions and then hand off or refer to a team member, they can focus on addressing the medical condition. They avoid opening an emotional Pandora's Box, and thereby feel that they have responded to an important need. PCPs also learn essential skills either through collaboration or through more direct training provided by BHCs. Helping a patient manage their own symptoms – panic, anxiety,

trauma, and mood – becomes a shared responsibility. The clinical supervisor not only improves the skill level of the BHC but also models how to bring this expertise forward to the PCPs. However, Integrated Behavioral Health can be both a stressor and a salvation for PCPs. For the PCPs, working with the BHCs can be another stressor – one more task to remember or manage. The clinical supervisor can serve as a bridge by advocating for simple systems that strengthen rather than erode collaboration.

The PCPs are not the only ones stretched thin. With the integration of behavioral health into primary care, the medical model impacts behavioral health care. The pressures experienced by PCPs are now being extended to BHCs who, like PCPs, are at increased risk of burnout (E. Horevitz, Personal Communication, 2016). BHCs can be stretched by the demand for high volumes as well. IBH programs are well advised to not replicate the factors that lead to burnout in PCPs. At the same time, PCPs would be well advised to learn from the experience of BHCs about the importance of clinical supervision. One can imagine the benefit that PCPs would gain from a regularly scheduled meeting to receive empathic support, training, and guidance, during which one could engage with a mentor to receive guidance, to reflect and to problem-solve. One bi-weekly hour focused on the provider's experience would go a long way in providing essential emotional support to PCPs.

The Clinical Supervisor Promotes Collaboration between PCP and BHC

When PCPs and BHCs collaborate in positive and productive ways, their respective experiences improve. Treatment planning for both disciplines improves with input from the other. Interdisciplinary work also contributes to the experience of providing "whole person care." Given that primary care is the de facto provider for the majority of behavioral health conditions and lifestyle factors figure prominently in chronic disease management, PCPs have significant experience with behavioral health and are appreciative of the ability to refer to BHCs. When patients are shared, collaboration results in better care, decreases isolation and increases the PCP's sense of efficacy. Yet, in an under-resourced environment, the interdisciplinary work can be stressful and can result in an erosion of empathy between medical providers and behavioral health clinicians. In the safety net, expectations on both BHCs and PCPs are high, and primary care is difficult for each, though for different reasons. The BHC may see 7 patients impacted by poverty, trauma or other psychosocial stressors or psychiatric conditions, whereas the PCP may see 18 patients with complex co-morbidities. In the moment, the BHC may or may not see the intensity of the work of the PCP - the long hours, the call, the patient complexity or the life and death responsibility. The PCP may or may not see the invisible hours of monitoring high-risk patients, working with families, or trying to link patients to scarce community resources. From this vantage point, conflict is over-determined. The clinical supervisor can help each PCPs and BHCs maintain their empathy for the other.

Difficulties with collaboration can also result from stylistic differences between the medical and behavioral health disciplines. PCPs may speak in bullet points and BHCs may speak in paragraph. They use words like "explore" and "curious." In this context, the clinical supervisor helps the BHC "cut to the chase." PCPs diagnose a problem in order to treat it. BHCs identify the strength in order to promote it. The clinical supervisor is a translator who understands the BHCs' training, understands and appreciates the BHC's adaptations, large and small, to primary care and to population health. They interpret and may even buffer the actions and behaviors of PCPs. Where there is role strain, conflict or confusion, the supervisor advocates for PCPs to BHCs, and to BHCs on behalf of PCPs. This is important yet often invisible work.

Clinical supervisors support BHCs who feel the direct impact of lack of organizational alignment: the patient prescribed a benzodiazepine or SSRI without a behavioral health assessment and intervention; the patient with chronic nightmares not evaluated for PTSD; or the patient with acute pain struggling to adjust, would all benefit from both behavioral health assessment and intervention as early as possible in their treatment. BHCs may be asked to provide more treatment while they are being asked to shorten their visit lengths. They may be asked to take warm handoffs while they are managing actively suicidal patients. Or, they may be asked to reduce the number of patients they see while the number of referrals from providers is down due to PCP vacations or vacancies. The clinical supervisor attends to themes that emerge and works to identify the root cause.

To further improve the collaboration between PCP and BHC, the clinical supervisor promotes the establishment of clear definitions about role and scope. On the one hand, some PCPs have unreasonable expectations of BHCs to solve overwhelming challenges such as unemployment or homelessness. An example of this is a referral documented in the medical record for the true but challenging reason that the patient "needs a job." Needs on this scale are better left to community partnerships. On the other hand, PCPs may at times inadvertently minimize the breadth and depth of the behavioral health skill set by intimating that it is a subset of their own knowledge base. PCPs may say that they could do the work of the BHC but they "just don't have the time," even though they lack training in psychopathology or evidence-based psychotherapies (E. Morrison, presentation to the Community Health Center Network, 2013). Of course, PCPs may consistently utilize skills that are shared by the disciplines, such as engagement, empathy and communication skills, and be able to provide psychoeducation effectively. An increasing number of PCPs have skill in Motivational Interviewing. Yet, it is unlikely that the PCP has also been trained in psychopathology, and possesses skills in the treatment modalities of Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and Problem Solving Therapy, *and* can apply this knowledge quickly and differentially. This is the unique behavioral health skill set that leads to the improvement in clinical outcomes even among the most vulnerable populations. Both of these misunderstandings – overestimating what the BHC can do to resolve patients' social and economic issues or minimizing the breadth of their specific skill set gained after years of training – detract from the BHC's experience. The clinical supervisor plays a key role in resolving these misunderstandings.

The Clinical Supervisor: Unsung Hero of The Quadruple Aim

The Supervisor's Experience

The emotional challenge of the role of the clinical supervisor is enormous. First, the clinical supervisor often feels like the "middle man." Whereas in traditional settings, the clinical supervisor always protects the confidentiality of the supervisee, in primary care the clinical supervisor has broader allegiances. Confidentiality causes role strain for the supervisor. In the course of their partnership, the BHC shares private concerns with the clinical supervisor, and these may be relevant to the agency as a whole. For example, a clinical supervisor knows a BHC is thinking of looking for other work, but a prospective departure is relevant to other staffing or budgetary decisions. Or, the supervisor knows about difficulty between a PCP and a BHC, but the BHC is not ready to take any action. Like any supervisor, the clinical supervisor is often in the position to communicate agency-wide leadership decisions including those that could be unpopular with the BHCs. Performance evaluation creates another potential source of tension between the need to create a safe and trusting relationship with the BHCs while also holding them accountable. While this tension exists in traditional supervision when the supervisor works for an agency, the tensions are increased in primary care where the focus is not only on the individual patient but also on The Quadruple Aim.

Most importantly, the clinical supervisor, more than any other individual, is directly impacted by the incidence of trauma experienced by the patient population agency-wide. While the BHC hears about trauma among their own patients, that number is multiplied for the clinical supervisor, who hears about the traumas among the patients seen by all their supervisees. If a supervisor supervises 5 BHCs, and each week they each discuss 1 patient's traumatic event and its emotional aftermath, and they touch upon the raw emotions evoked in themselves, the supervisor hears about and experiences the impact of 100 traumas a month, not only on the patient but on the BHCs themselves. In most safety net settings, one trauma per supervisee a week underestimates the incidence of trauma. Placing this aspect of the work in the context of The Quadruple Aim, the role of clinical supervisor is even more challenging. Attention to all four aims requires a unique combination of empathy, clinical knowledge, pragmatism, business acumen, flexibility, professional maturity, and resilience. The clinical supervisor experiences the BHC's emotional overwhelm or fatigue, and therefore is vulnerable to burnout because of the sheer quantity and severity of the patients cared for by their supervisees. A key question becomes how to make the work of the clinical supervisor sustainable.

Supporting the Clinical Supervisor

Primary care settings integrating BHCs into the care team can support the clinical supervisor, and by extension, The Quadruple Aim, in several ways. The first step is to limit the number of clinical supervisees in order to limit the supervisor's exposure to vicarious trauma. Second, involving the clinical supervisor in the alignment of expectations regarding the role and scope of the BHC will improve both PCP and BHC experience. Third, investing in the time to develop agency-wide agreements about target populations, interruptions, warm handoffs, and urgent visits; onboarding all new staff in alignment with these agreements; and then ensuring the implementation of these agreements would strengthen relationships and increase coordination and efficiency. These changes would allow for increased attention toward clinical matters that in tern would help clinical supervisors develop and experience mastery in their work.

Engaging BHCs to teach brief behavioral skills that PCPs can use with their patients would create a uniform language and improve collaboration between PCPs and IBH. Brief teaching on Motivational Interviewing would help PCPs prepare patients for behavior change. Solution-Focused strategies would build on small islands of successes. Mindfulness training would help PCPs manage broad range of clinical symptoms. BHCs can also teach how to communicate their empathy. While empathy is a feeling that many health care providers experience, communicating empathy is a skill many behavioral health clinicians hone in graduate training.

Like PCPs and BHCs, clinical supervisors need opportunities for renewal. These could include program development, planning, and even teaching clinical supervision. They have a unique perspective on interdisciplinary collaboration in primary care and should be tapped not only for contributing to performance improvement efforts throughout the primary care enterprise but for leadership opportunities as well.

Conclusion

Truly integrated care can't meet The Quadruple Aim without the contribution of the breadth and depth of clinical supervisors. They must be able to work in primary care settings; have knowledge of systems, organizations and operations; and understand psychopathology and evidence-based practices. The clinical supervisor must possess not only broad and deep clinical skill, but also emotional intelligence and interpersonal skill. They are at once an ally, coach, boss, mentor, and teacher. Given the fast-paced primary care environment, the diversity of clinical presentations, and the varied personalities and expectations of PCPs, the clinical supervisor models resilience and empathy. A strong clinical supervisor is an essential, but undervalued resource.

Given the centrality of the clinical supervisor to The Quadruple Aim, further attention to the development of competencies and strategies to develop them are needed. Furthermore, the role of clinical supervisor will likely increase in importance to The Quadruple Aim as primary care moves away from the fee-for-service model and towards alternative payment strategies. As the care team expands to include not only BHCs but also panel managers, medical assistants, community outreach workers, health educators, and case managers, the need for different levels of clinical supervision will also expand. Each role on the care team will benefit from behavioral health training and clinical consultation and/or oversight by a clinical supervisor. The Quadruple Aim posits that PCPs need care themselves to continue providing care. And so does the clinical supervisor whose role is worthy of recognition, investment and elevation.

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References

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs, 27*(3), 759-769.

Doherty, W.J., McDaniel, SH., & Baird, M.A. (1996, October). Five Levels of Primary Care/Behavioral Healthcare Collaboration, *Behavioral Healthcare Tomorrow*, 25-28.

Bodenheimer, T., & Sinsky, C. (2014, November/December). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Annals of Family Medicine*, *12*(6), 573-576.

Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). Evolving Models of Behavioral Health Integration in Primary Care. *Millbank Memorial Fund*.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine, 14*(4), 245-258.

Herman-Lewis, J. (1992). *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror*. New York: Basic Books.

Robinson, P. J., & Reiter, J. T. (2007). *Behavioral consultation and primary care: A guide to integrating services*. New York: Springer.

Skovholt, T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. Boston, MA: Allyn and Bacon.

Facher, N. The Importance of Clinical Supervision to The Quadruple Aim, November 2016.

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[1] Herman, Judith. Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror. Basic Books, 1992, p. 153.