# An Exploration of Supervision Delivered via Clinical Video Telehealth (CVT)

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A growing literature base supports the use of telemental health (TMH) as an effective platform for psychological interventions; however, the literature examining the use of telesupervision is limited. Mirroring TMH, telesupervision is potentially advantageous and may offer benefits above and beyond in-person supervision to include increased accessibility of training, reduced cost for travel and improved flexibility of scheduling, and increased access for peer consultation. These benefits may contribute to greater diversity of training and supervision experiences for trainees as well. In this evidence-based practice project, former psychology trainees ($N = 12$) at 1 Veterans Affairs Health Care System (VA) site were invited to complete an anonymous online questionnaire regarding their supervision experiences utilizing both quantitative and qualitative items to explore trainee perceptions of telesupervision implementation, satisfaction, and efficacy. Both the qualitative and quantitative data suggest equivalence between the telesupervision and in-person supervision experiences with regard to rapport with supervisors and focus on clinical goals and tasks. The qualitative data provide additional insight into the trainee perspective on the benefits related to engaging in telesupervision, challenges related to engaging in telesupervision, and components of successful telesupervision. Telesupervision has the potential to contribute to the sustainability of rural health training programs, to increase access to needed mental health care in geographical areas of mental health shortage, and to allow trainees to receive supervision from supervisors who are culturally competent and expert in providing care to diverse patient populations. This article offers suggestions for optimal practice of telesupervision and discusses implications for training programs going forward.

*Public Significance Statement*
Telesupervision is a viable alternative to in-person supervision and offers benefits that could potentially enhance training opportunities, including increased accessibility of training, reduced cost for travel and improved flexibility of scheduling, and increased access for peer consultation. These benefits could contribute to greater diversity of training and supervision experiences for trainees as well as further enhance provision of training within rural settings. This article offers suggestions for optimal practice of telesupervision and discusses implications for training programs going forward.

*Keywords:* supervision, telehealth, Veterans Affairs, training

The Veterans Affairs Health Care System (VA) is the largest provider of telehealth services in the country, with over 2.1 million VA telehealth visits to Veteran patients, of which 45% are rural Veterans (VHA Office of Rural Health, 2016). Telehealth is broadly defined as the provision of physical and mental health care through the use of telecommunication technologies—telepsychology or telemental health (TMH) is a subset of telehealth. The

American Psychological Association (APA; 2013) defines telepsychology as "the provision of psychological services using telecommunication technologies" (p. 3). Examples of telecommunication technologies include, but are not limited to, telephone, mobile apps, interactive videoconferencing, e-mail, chat, text, and web-based interventions. Depending on the technology used, information transmitted between patients and providers may be occurring

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synchronously (occurring in real time) or asynchronously (occurring at different time points) and may include text, graphics, video, sounds, or other data. For the purposes of this article, the focus will be on TMH, or telepsychology, and on clinical video telehealth (CVT), which is synchronous videoconferencing.

The extant literature suggests that TMH produces results that are comparable with in-person mental health care with respect to assessment, treatment outcomes, therapeutic relationship, retention, and both patient and provider satisfaction (Hyler, Gangure, & Batchhelder, 2005; Pruitt, Luxton, & Shore, 2014). Furthermore, TMH has been found to offer unique benefits when compared with in-person treatment, including increased disclosure in session (Gibson, O'Donnell, Coulson, & Kakepetum-Schultz, 2011), improved access to services, convenience, flexibility, and potential cost savings (Pruitt et al., 2014). In sum, TMH appears to be an effective, well-accepted, and cost-effective platform to deliver mental health treatment to those that may not otherwise be able to access such treatment (Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009).

Just as TMH serves as an effective bridge to providing care to individuals that may not otherwise be able to access such treatment, telesupervision has the potential to offer trainees and professionals access to supervision and consultation services that may otherwise be inaccessible. It is notable that trainees tend to stay and become employed in the location that they are trained, with over 60% of physician residents opting to live within 100 miles of their final residency program, and that psychology internship sites, in particular, may heavily influence location of newly trained psychologists' first jobs (Jameson & Blank, 2007; U.S Department of Veterans Affairs, 2018b). Thus, providing training, supervision, and consultation opportunities, by way of telesupervision, in geographical areas of mental health shortage may allow for the recruitment and retention of needed mental health professionals in these areas. Furthermore, through telesupervision, skilled providers in rural communities would be able to offer supervision, consultation, and training to trainees and professionals seeking additional support in working with rurally located individuals regardless of geographic location.

For the purposes of this article, the focus will be on the training of doctoral-level psychology interns and postdoctoral psychology residents in their individual supervision requirements. The VA has long been a primary source for psychology education, with a focus on training psychologists to care for rural and potentially underserved veterans (U.S. Department of Veterans Affairs, 2018a). Psychology training in the VA is governed by the Office of Academic Affiliations (VA OAA), which mandates that the VA assist in the training of health professionals for its own needs and those of the nation (Veterans' Benefits, 2014). For over 70 years, in accordance with the VA's 1946 Policy Memorandum No. 2 (U.S. Department of Veterans Affairs, 1946), the VA has partnered with university training programs to provide high-quality mental health care and to train new health professionals to meet the needs of America's veterans. To ensure that VA training is both current and consistent with the broader psychology training standards, VA psychology training programs are expected to maintain APA accreditation and Association of Psychology Postdoctoral and Internship Centers membership.

Currently, the APA (2015) Commission on Accreditation Standards of Accreditation supports up to 50% of the supervision requirement (for both internship and postdoctoral training programs) to be met via telesupervision (i.e., 1 hr [or less] of individual telesupervision per week and 2 hr [or less] of total [combined group and individual] supervision per week). The implementation regulations state that there may be benefits to in-person supervision (e.g., recognition of nonverbal cues), and thus the remaining supervision requirement should be met in person. Given APA support for telesupervision, it is notable that, at this time, the VA OAA (U.S. Department of Veterans Affairs, 2015) does not permit telesupervision as a general principle; however, programs may request special consideration of their telehealth training programs from VA OAA.

Given the wealth of information pointing to the efficacy of CVT and the APA standards supporting its use, the somewhat limited research found related to the use of CVT for telesupervision is surprising. In a review of the literature of technology-assisted supervision and training (TAST), Rousmaniere (2014) found 49 publications that had a significant focus on TAST. Twenty-six of the 49 publications reviewed consisted of original research, and 23 of the 49 consisted of discussions of new technologies, case examples, or reviews of the current literature. Out of the 23 original research studies, nine focused on web-based training programs, seven studied asynchronous technology (e.g., e-mail or text) as augments to supervision, nine examined group telesupervision, and there were no studies of individual supervision. Of the nine studies that examined group telesupervision, five examined telesupervision via phone or live chat (text only) and one examined the training content rather than the telesupervision itself. Because the focus of this article is CVT, the remaining three (Panos, 2005; Reese et al., 2009; Ruble, McGrew, Toland, Dalrymple, & Jung, 2013) of the nine studies identified by Rousmaniere (2014) will be discussed along with an additional three studies relating to telesupervision via CVT that were not a part of the Rousmaniere review (Bender & Dykeman, 2016; Gammon, Sørlie, Bergvik, & Høifødt, 1998; Marrow, Hollyoake, Hamer, & Kenrick, 2002).

In the six studies identified as examining telesupervision in a synchronous CVT format, overwhelmingly, the authors found no differences in satisfaction with the supervision process, supervisory working alliance, or perceived effectiveness or self-efficacy. It is notable that five of the studies were considered "exploratory" in nature and either included small samples or were nonparametric or qualitative in design (Bender & Dykeman, 2016; Gammon et al., 1998; Marrow et al., 2002; Panos, 2005; Reese et al., 2009). The remaining study was adequately powered to detect significant change (Ruble et al., 2013). Qualitative feedback across the studies included five themes. First, telesupervisees reported "feeling connected" to peers in the group supervision cohort (Panos, 2005). Second, paradoxically, the limited visual cues imposed by the CVT modality increased the emphasis on verbal aspects of communication and improved supervision process (Gammon et al., 1998). Third, because of the reliance on verbal communication, there was greater emphasis on staying on task and being clear with verbal content (Reese et al., 2009). Fourth, there were challenges related to technological difficulties and lack of training in the technology (Marrow et al., 2002; Reese et al., 2009). And lastly, fifth, it may have been important to have an established relationship in person prior to engaging in telesupervision (Reese et al., 2009).

Although no studies of individual telesupervision were found, the project leaders posit that there is growing and adequate support from the literature and from the APA Standards of Accreditation (APA, 2015) as well to implement telesupervision. Taken as a whole, the following justifications served as the basis for the current evidence-based practice (EBP) project: the review of the literature, APA support for telesupervision, the need for increased accessibility to supervision (particularly for clinicians and trainees in rural or remote areas), reductions in travel-related costs, improvements in flexibility of scheduling afforded by the technology, and increased access for peer consultation. Additionally, providing trainees with opportunities to both deliver and "receive" TMH (via telesupervision) may increase competency in a growing and cutting-edge platform for care as well as give trainees a unique opportunity to potentially experience the patient's perspective of "receiving" TMH.

VA Pacific Islands Health Care System (VAPIHCS) has received an exception to provide telesupervision, which is implemented in addition to the usual in-person supervision. Consequently, by providing telesupervision to psychology interns and residents, VAPIHCS is able to provide psychology trainees with training opportunities in rural areas and also increase access to care for rural veterans. The use of telesupervision also serves to modernize internal processes which is one of the five major goals of the Department of Veterans Affairs (U.S. Department of Veterans Affairs, 2018a). Thus, VAPIHCS is in a unique position to provide valuable information on the usefulness of telesupervision to VAPIHCS training programs and perhaps to the rest of the VA and other groups considering this method of supervision to trainees.

The current EBP project sought to assess any differences in VAPIHCS psychology trainees' satisfaction and working alliance perceptions of telesupervision to that of the current usual and standard practice of clinical supervision delivered in person. The quantitative and qualitative results of this project should help identify the practicality and feasibility of telesupervision at VAPIHCS and highlight potential strategies to improve the delivery of telesupervision in the VAPIHCS and perhaps in other training programs.

## Method

### Program and Trainees

The VAPIHCS Psychology Training Program is located in Honolulu, Hawaii. The program functions within a unique system with a vast catchment area spanning thousands of miles, providing telehealth services to Saipan, Guam, American Samoa, and the neighboring Hawaiian Islands. The psychology training program is primarily located within the main facility in Honolulu, while psychologists are located in geographical locations at different clinics throughout the system. Psychology trainees have the opportunity to provide TMH to these diverse geographical areas, providing needed care in rural settings while also gaining an enriched training experience. To ensure the highest competency in providing supervision, the training program identified psychologists providing TMH to (or at times located within) these remote clinics as most equipped to provide supervision to trainees based on their knowledge of providing TMH and competency in working with the particular rural patient population. The VAPIHCS pro-

gram training director wrote a detailed policy that outlined the rationale for use of telesupervision, including compliance with APA SoA. The policy was reviewed and approved by VA OAA, which served as the basis for granting of the waiver to allow telesupervision at VAPIHCS. This policy, included in the training manual and given to all trainees and supervisors, outlines (a) backup on-site supervision availability during telehealth encounters, (b) how to access emergency assistance, (c) ways for patients to access supervisors, and (d) the structure of telesupervision.

At the onset of the training year, all trainees participated in a baseline competency assessment to identify their strengths and growth edges. This information, along with a rank listing of their interests, was used to appropriately assign trainees to rotations. Rotations were 6 months in length, with trainees participating in two rotations concurrently (resulting in participation in a total of four rotations throughout the 12-month training year and resulting in trainees participating in a TMH rotation while participating in an in-person rotation in tandem). The in-person supervision rotations included outpatient and residential posttraumatic stress disorder (PTSD), Primary Care-Mental Health Integration, inpatient or critical care, outpatient general mental health, Homeless Patient Aligned Care Teams, and triage services that are located both at the main VA facility in Honolulu and at the Community Based Outreach Clinic on the west side of Oahu. The trainees in a TMH rotation provided telehealth services to neighboring Hawaiian Islands, American Samoa, Saipan, and/or Guam. The care within both in-person and TMH rotations included a wide array of clinical presentations and general mental health concerns (e.g., PTSD, suicidal behaviors, and personality disorders) within a highly diverse patient population representative of the various groups living within the Pacific Basin. As such, the process of rotation assignment, rotation experience (e.g., population served, hours of care), and supervisors within the rotations were the same for both interns and residents.

Of important note, the supervisors providing telesupervision were different than those who were providing in-person supervision. Telesupervisors were physically located on another island from the trainee and therefore trainees did not have physical access to the telesupervisor for day-to-day operations. At one point in the training year, the trainees traveled to one of the rural locations with a telesupervisor for approximately 1 week to provide in-person care, continuing to provide TMH for the remainder of the rotation period. During the TMH rotation, live observation of the trainee was achieved by the telesupervisor dialing in for a three-way connection using CVT, enabling the telesupervisor to observe the trainee in real time with the patient. The trainees participated in scheduled weekly individual supervision using CVT with their assigned telesupervisor, which was consistent with how they engaged in in-person supervision with their supervisor. Consequently, the in-person and telehealth rotations were parallel experiences, in that both included the same amount of direct clinical care; trainees met with supervisors for supervision individually on a weekly basis; trainees had access to supervisors (i.e., via in-person or technology) in between scheduled supervision sessions as needed; and trainees provided care to a veteran population within the Pacific Basin with a wide range of presenting mental health concerns.

The EBP project was developed to assess potential perceived differences in satisfaction and working alliance between telesuper-

vision and the current usual and standard in-person supervision being provided within the VAPIHCS training program. The EBP project underwent a rigorous review process and was approved by the VAPIHCS EBP Council and executive leadership. As a part of the review process, it was deemed that the project did not constitute human subjects research and would only use anonymous data routinely collected for purposes of program evaluation, and thus was not subject to institutional review board approval. After completion of training, the training director sent all psychology interns ($n = 8$) and postdoctoral residents ($n = 4$) who had participated in telesupervision (total, $N = 12$ trainees from 2015–2017) an invitation to complete an anonymous online questionnaire regarding their supervision experiences.

## Demographics

All 12 trainees (eight interns and four postdoctoral residents) who were sent the questionnaire completed it. The trainee participants were a varied sample to include diversity in gender (five female, six male, and one transgender), racial/ethnic group (five Asian American, six White, one mixed race/ethnicity, and age group (six late-20s/early-30s, two mid-30s/late-30s, and four late-30s/mid, 40s). The trainees participated in more in-person rotations during the training year than TMH rotations, consequently leading to more exposure to in-person supervisors. The in-person supervisors were both male and female genders, ranged in different races/ethnicities, and included both early and later career psychologists. There were two different supervisors providing telesupervision to the participants, with both being located on different islands from the trainees. One telesupervisor was male, White, and an early career psychologist. The other telesupervisor was female, White, and a late career psychologist. Both supervisors regularly provided TMH to the geographical regions in which the trainee participants were also providing TMH.

## Measures

The anonymous online questionnaire included the Supervisory Working Alliance Inventory-Trainee Version (SWAI-T; Efstation, Patton, & Kardash, 1990) and qualitative items to explore perceptions of implementation, satisfaction, and efficacy of supervision. The SWAI-T is a 19-item measure that uses a 7-point Likert scale with response choices ranging from 1 (*almost never*) to 7 (*almost always*). Studies have found that the SWAI-T demonstrates good internal consistency (Cronbach's alpha = .70–.99; Efstation et al., 1990; Reese et al., 2009). Furthermore, Jackson (1993) reported high correlations between the SWAI-T and measures of supervisory style and supervisee self-efficacy, thus suggesting strong construct validity. Consistent with prior studies that have used this measure, the Rapport and Client Focus scales were combined (Patton & Kivlighan, 1997; Reese et al., 2009). The trainees were asked to complete the SWAI-T once in regard to their experience with their in-person supervisors and once in regard to their telesupervisors. The trainees were asked to respond to qualitative items asking about (a) differences in disclosure to supervisors between tele- and in-person supervisors, (b) barriers to engaging in telesupervision and how trainees overcame these barriers, and (c) benefits to telesupervision and recommendations to others participating in telehealth.

## Data Analysis

Quantitative data were analyzed using SPSS (Version 23) statistical software. These data were checked and screened for errors prior to running any analyses. Descriptive analyses were examined to assess for normality as well as obtain means and standard deviations for all the project's key elements. The Wilcoxon signed-ranks test was used for comparisons of SWAI-T scale score ratings across in-person and telesupervision modalities. Effect sizes were computed by dividing the $z$ score by the square root of the observations; effect sizes of $r > .3$ are considered medium, and $r > .5$ are considered large (Field, 2005). A $p$ value of 0.05 was used to determine statistical significance. A phenomenological-based thematic analysis approach was utilized to examine the qualitative data. Qualitative data were initially reviewed by both project leaders multiple times independently to gain familiarity with the data. Each project leader then independently coded the data to identify emerging patterns, utilizing an electronic log that included columns to delineate emerging themes and place relevant data within these themes. The project leaders subsequently met to review the emerging themes, while reexamining the raw data and identifying further themes and subthemes from the raw data. The project leaders then independently reviewed the data again to identify larger patterns of response, identified as superordinate themes. After finalizing the superordinate themes, themes, and subthemes, both project leaders then returned to the data to ensure the themes appropriately captured the nuanced meaning of the data.

## Results

### Quantitative Findings

The type of supervision platform (i.e., in-person vs. telesupervision) did not appear to impact the Client Focus scale of the SWAI-T ($z = -1.08$, $p = .28$, $r = .31$), with a mean scale score of 6.39 when evaluating in-person supervision experiences and 6.43 when evaluating telesupervision experiences. The type of supervision platform did appear to significantly impact the Rapport scale of the SWAI-T ($z = -2.49$, $p = .01$, $r = .72$), with a mean scale score of 6.26 when evaluating in-person supervision experiences and 6.79 when evaluating telesupervision experiences (see Table 1).

In response to a question regarding whether trainees would recommend telesupervision to others, 100% ($N = 12$) of trainees stated that they would recommend telesupervision to other trainees. In response to a question related to the quality of telesuper-

Table 1

*Wilcoxon Signed Ranks Test for the Client Focus and Rapport Scales of the Supervisory Working Alliance Inventory-Trainee Version Across In-Person and Telesupervision Modalities (N = 12)*

| Scale | In-person supervision M (SD) | Telesupervision M (SD) | z | r | p |
|---|---|---|---|---|---|
| Client Focus | 6.39 (.62) | 6.43 (.91) | −1.08 | .31 | .28 |
| Rapport | 6.26 (.65) | 6.79 (.18) | −2.49 | .72 | .01 |

vision, 83.3% ($n = 10$) of trainees stated that the quality of the supervision was not affected by the CVT modality. It is notable that of the two trainees who endorsed that the quality of supervision was affected by the CVT modality, one stated that the quality of telesupervision was better than in-person supervision and the other stated that the quality of telesupervision was worse than in-person supervision.

## Qualitative Findings

The qualitative data provide three superordinate themes in understanding the experience of trainees in using telesupervision: (a) challenges to telesupervision, (b) benefits to telesupervision, and (c) components of successful telesupervision. Within the three superordinate themes, themes and subthemes were identified (see Tables 2, 3, and 4). Overall, the quantity of qualitative data identifying benefits to telesupervision was greater than the identification of challenges to telesupervision. Although the overall quantitative results did not indicate any differences between in-person and telesupervision, a small quantity of qualitative data suggest there may be some trainees for which telesupervision is less ideal based on their learning and developmental needs: One trainee indicated that the quality of supervision was lower in telesupervision when compared with in-person supervision. It is notable that this trainee also self-identified as having more intensive learning needs and suggested that those trainees who have greater growth edges may have more difficulty engaging in telesupervision. The qualitative results further indicate that trainees may be a better fit for telesupervision if they do not have large competency concerns, exhibit traits of flexibility and ability to express needs, and desire to function more autonomously. All trainees recommended engaging in telesupervision, even those that identified experiencing some barriers.

## Discussion

The findings from both the quantitative and qualitative data from this EBP project are consistent with the research literature base. This project's findings suggest that telesupervision and in-person supervision are perceived to be equitable in overall quality from the trainee perspective. Although the quantitative data suggest that rapport with the supervisor is higher in telesupervision,

this finding interpreted within the context of the qualitative data suggests that it may have been the competency and supervisory ability of the assigned telesupervisor that led to this rapport. Based on the results, it is likely that differences between telesupervision and in-person supervision are related to individual variables of either the supervisor and/or the trainee rather than the platform of supervision implementation. Taken in sum, the findings from this study provide insight into the idea that the same components that create good supervision in person, such as a supportive relationship and strong working alliance (Falender & Shafranske, 2009), are important regardless of the platform.

The qualitative data lend credence to multiple areas of perceived value in telesupervision, with the majority of trainees expressing high value for their telesupervision experience. Findings support the importance of participating in TMH, both in clinical care and telesupervision. Within the delivery of mental health care, there is already an increasing use of technology for clinical care, further underscoring the high likelihood of psychology interns and residents currently in training being required to provide TMH in the future. The qualitative data suggest that one of the perceived benefits in receiving supervision via CVT was a better understanding of the patient experience by being on the receiving end of CVT services.

In addition, the qualitative data point toward telesupervision benefits related to exposure to certain clinical populations, such as those in rural settings, that they would not otherwise work with while gaining increased comfort using this platform. As stated earlier, rural populations represent populations in great need of clinical services, and these individuals are increasingly receiving care via CVT (VHA Office of Rural Health, 2016) as a means of filling gaps in resources. Thus, telesupervision has the potential to provide both unique opportunities related to rural patient care and diversity in training, which may lead to increases in the diversity of staff and trainees as well as competency in future providers working with underserved populations. Although on-site supervisors could provide supervision of the trainee's clinical encounters occurring over CVT, the supervisors most appropriate to supervise these cases would be other supervisors also providing TMH care to rural veterans. Telesupervision potentially serves the purpose of not only increasing access for clinical care in underserved populations but also allowing those psychologists who are most knowl-

Table 2

*Superordinate Theme: Challenges to Telesupervision*

| Theme | Subthemes | Statement | Count |
|---|---|---|---|
| Supervisory relationship | Disclosure | "I would potentially have been more vulnerable in supervision were this person accessible for in-person supervision." | 1 |
| | Effectiveness | "I do believe something was lost in the telehealth experience compared with my in-person supervision. I think in-person would have facilitated some more dialogue." | 2 |
| | Accessibility | "I could not simply stop by my supervisor's office with a question and accessibility through phone or e-mail were variable given the day." | 1 |
| Logistical barriers | Space/access technology issues | "At times there are technology difficulties, like the machines not connecting to the Internet." | 3 |
| Trainee comfort and need | Comfort with platform | "Getting adjusted initially to telehealth." | 3 |
| | Developmental needs | "For someone who is wanting to be able to observe, model, or conduct co-therapy with their supervisor, telehealth supervision would not work best." | 1 |

Table 3

*Superordinate Theme: Benefits to Telesupervision*

| Theme | Subthemes | Statement | Count |
|---|---|---|---|
| Supervisory relationship | Higher disclosure | "I did share more with my telehealth supervisor than with some of my other in-person supervisors because it was a stronger supervisory relationship." | 3 |
| | Equitable disclosure | "No difference. I found her to be incredibly relatable, caring, and understanding, so I would have shared and built a bond with her regardless of the modality." | 5 |
| | Efficiency/depth | "I had to be more attuned to the 'here and now' process of supervision . . . having supervision over telehealth kept me more mindful and connected into what was happening in the moment, where in person it can be easier to tune in and out, or get distracted." | 4 |
| Opportunity | Experience with telehealth | "Having the opportunity to practice it (telehealth) as a provider and supervisee was a useful skill to learn." | 4 |
| | Care to diverse/rural population | "Providing telehealth care is a wonderful opportunity to give care to those who may not otherwise receive it, and being able to have supervision for this care over telehealth is an equally unique and growing experience." | 5 |
| | Access to off-site supervisor | "Learning from others that would not be otherwise accessible. I think that supervision is an opportunity to learn and having more learning opportunities is an asset to facilitate growth." | 1 |
| Therapeutic growth | Flexibility/comfort with platform | "It hones flexibility in therapy." | 2 |
| | Greater understanding of clinical issues | "Engagement in telehealth substantially extended my reach to provide services to individual in underserved areas." | 4 |

edgeable about the platform and population being served to effectively provide supervision. Finally, the use of telesupervision could enhance the experience of psychology trainees by providing opportunities to draw on the professional expertise of providers who may work in clinics that are located at a distance from the main facility as well as generally add to the number of psychologists that are able to provide supervision in TMH. These increases in opportunities and diversity of staff and trainees have the potential to increase access and improve costs for both patient care and training.

The findings from this study also provide insight that the functioning of the technology system can impact the quality of the telesupervision experience. The importance of technology assistance and backup supervision are both important aspects of successful telesupervision. Thus, it is not just having competent telesupervisors available but also how the educational program and technology system are set up to provide quality supervision that appear to influence positive supervision outcomes.

## Suggestions for Use of Telesupervision

Although the overall results suggest that the experience of the trainee is equitable across telesupervision and in-person supervision modalities, the qualitative data also point toward the need for training programs to be thoughtful in the implementation of telesupervision. Based on the review of the literature and findings from this project, the following suggestions are made for the efficacious implementation of telesupervision. First, training programs need to have a clear policy on the use of telesupervision that adheres to APA SoA. Aligning with APA SoA requirements (APA, 2015), this policy should highlight the following: emergency procedures in case of patient crisis, how live supervision/observation is achieved, on-site supervision resources, protocol for

accessing supervision resources between scheduled sessions, and ways for patients to be able to access supervisors.

Second, based on the findings from this project, it would be prudent to screen trainees to determine the goodness of fit and readiness to engage in telesupervision. Because telesupervision does require trainees to be somewhat proactive in how they avail themselves of supervisors, trainees who have greater difficulty with self-initiative (e.g., problem-solving technology difficulties, asking for what they need in supervision, initiating/responding to contact with supervisor vs. running into them in clinic) may find telesupervision more challenging. One potential reason for this difficulty might be that the technology and physical distance between the supervisor and trainee may add additional stress in getting needs met, adding a greater burden to trainees already in need of more intensive supervision. A baseline competency assessment that includes both an understanding of the trainee's learning needs and competencies, goals, and their individual approaches to learning may help to better identify those trainees more likely to engage more easily in telesupervision.

Third, both based on the results of this project and the extant literature, trainees need to have clear instruction on how to effectively utilize the technology, ways to problem solve technology issues and how to obtain technological support, and an opportunity to adjust to being supervised by this platform (Marrow et al., 2002; Reese et al., 2009). The supervision experience will be more successful if trainees are given the opportunity to discuss initial discomfort (in both providing clinical care and engaging in supervision) with CVT. Thus, there needs to be more investment in the beginning of a training experience involving telesupervision compared with in-person supervision. It is not as simple as matching a trainee to a supervisor and briefly telling them how to use the equipment.

Table 4

*Superordinate Theme: Components of Successful Telesupervision*

| Theme | Subthemes | Statement | Count |
|---|---|---|---|
| Supervisory relationship | Attributes | "I believe the characteristics of the supervisor, and not the platform, has a bigger impact on the training." | 2 |
| | Allowing for trainee adjustment | "My telehealth supervisor treated me like how my other supervisors were treating me. After the initial adjustment period, I felt in sync with my supervisor." | 1 |
| | Openness | "My supervisor was open in discussing my initial discomfort with telehealth." | 1 |
| Reducing barriers | Planning for space/technology issues | "Occasional technical difficulties that affected connectivity, but I found that these obstacles were adequately address by utilizing alternative means of communication (telephone, Skype)." | 5 |
| | Increase comfort of trainee | "There can be tremendous autonomy in this work, but there can also be isolation depending on comfort in contacting the telehealth team." | 2 |
| | Plan for supervisor access | "I would recommend speaking with your supervisor up front about how to best reach them when not in supervision." | 2 |
| | Pairing experience with in-person contact | "The rotation paired with another one in which they are more closely integrated into a treatment team and can be observed directly." | 1 |
| Attributes of the trainee | Flexibility | "Be flexible/do what you need to do to handle your own anxiety or hang-ups. Telehealth is meant to meet exactly this need for flexible problem-solving, so working rigidly will be frustrating for you as well as for the clinics and those you serve." | 2 |
| | Variable needs | "Works best for an independent trainee who is more interested in honing their own clinical skills independently with minimal direct observation and didactic supervision. "Treat it as if it were in-person supervision." | 2 |
| | Interest | "Telehealth supervision is best for someone with the following goals: intends to practice telehealth treatment in the future and likes to work independently and has solid clinical skills entering the rotation." | 1 |

Fourth, based on the qualitative feedback collated in this project, it may be important to provide a clear opportunity and format for supervisors to provide live supervision/observation of patient interactions. CVT can be used to connect multiple sites simultaneously, which can be used to bring supervisors into the same virtual room as the patient and trainee clinician. The way in which the supervisor connects with the trainee and provides timely and meaningful feedback is especially important given the physical distance. Finally, the training program would benefit from careful consideration regarding the supervisors selected to provide telehealth supervision. Just as trainees may need to make effort to engage outside of regularly scheduled supervision sessions (i.e., informal supervision will not be achieved by dropping by the supervisors office but may be achieved via instant message, telephone, or CVT), supervisors who are less willing to be available for consultation in between supervision sessions or are less responsive via e-mail, phone, or instant message are not ideal candidates for telesupervision regardless of their other supervisory or clinical strengths.

As part of the sustainment of this project and ongoing efforts to continue to improve implementation of telesupervision, the VAPIHCS Psychology Training Program will continue to assess learning and developmental needs as part of a baseline competency assessment at the start of the internship and residency training years. This information will be used to better ensure that trainees assigned to the telehealth rotation will be an appropriate fit for telesupervision. In addition, the training program has developed more specific instructions related to logistics and access to on-demand supervi-

sion to ensure maximum benefit from telesupervision. Finally, trainees receiving telesupervision will continue to be paired with a rotation with on-site supervision.

## Limitations and Future Directions

Although the current EBP project provides valuable information on the engagement of trainees in telesupervision at a VA facility, the data also have limitations related to the nature of the project. Because this project was based on a limited number of trainees that were naturally not randomized, the generalizability of results is limited. This project included only interns and residents; however, it did not delineate between different developmental levels of trainees of interns or residents and did not include practicum-level students. Thus, a future project may include assessing the influence of the developmental level of the trainee on participation in telesupervision, which may provide valuable information on how to best meet the developmental needs of supervisees.

Another limiting factor is the potential confound between supervisor and supervision modality. The two telesupervisors provided only telesupervision. and the in-person supervisors provided only in-person supervision. Thus, it is possible that any findings are related to the supervisors rather than the modality of treatment. That said, there were two different telesupervisors and several different in-person supervisors, thus mitigating the potential effect of this limitation. All the same, future research on telesupervision with a greater sample of supervisors and supervisees would add to the generalizability of this project.

This project highlights possible areas that could be further explored, specifically in relationship to how telesupervision is implemented. With the increase in TMH, the need to examine the supervision impact continues to increase. This EBP project had a qualitative component that identifies some areas that may be suitable for a research approach. For example, the individual variables of trainees that would most benefit from telesupervision and examining whether telesupervision affects the skill development of trainees with regard to how they are performing on competency-based evaluations within their training experience may benefit from further research. Although not cited specifically in any of the qualitative responses as a contributor to a positive telesupervision experience, the trainees in this program did meet in person and collaborate with the telesupervisor for 1 week in the rural setting at some point in the rotation experience. It is currently unknown the extent to which this is an important component of the telesupervisory experience and is an empirical question for future research. It would also be beneficial to examine the use of telesupervision from the perspective of the supervisor. Given the continuing expansion of the use of technology in the daily work of psychologists, including the delivery of clinical care, it is important to ensure that the knowledge base of the use of technology within supervision continues to expand in tandem.

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