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4:00 p.m. Call to Order – Sherwood Randolph, LCSW, Chairperson

- Welcome/Introductions
-

Approval of Minutes

- November 13, 2024 -----Page 2
-

Follow-up from November Stakeholder Discussion

- Board of Health Professions Report on the Policies and Procedures for the Evaluation of the Need to Regulate Professions and Occupations-----Page 5
 - Guidance Document 75-2-----Page 17
 - Summary-----Page 38
 - 2000-2016 Virginia Pass/Fail Rates-----Page 39
 - Report to Senator Favola Regarding Efforts to Diversify and Strengthen the Clinical Social Work Workforce-----Page 44
 - Update on statements from stakeholders
 - Potential Survey of Licensees
 - Example: Kansas Survey-----Page 66
-

Discussion with Stakeholders

- Presentation from and dialogue with the Association of Social Work Boards (Tentative)
 - Potential interest and options for alternative pathways to licensure (limited to 20 minutes)
-

2025 Virginia General Assembly

Next Meeting

Adjournment

*Indicates a Board vote is required.

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the Board at the meeting. One printed copy of the agenda and packet will be available for the public to view at the meeting pursuant to Virginia Code Section 2.2-3707(F).



Virginia Department of
Health Professions
Board of Social Work

DRAFT

Virginia Board of Social Work
Ad Hoc Committee Meeting Minutes
Wednesday, November 13, 2024, at 4:00 p.m.
9960 Mayland Drive, Henrico, VA 23233
Board Room 4

BOARD MEMBERS PRESENT: Sherwood Randolph Jr., MSW, LCSW

BOARD MEMBERS ABSENT: Martha Meadows, MA, LCSW

BOARD STAFF PRESENT: Jaime Hoyle, JD, Executive Director
Jennifer Lang, Deputy Executive Director- Discipline (*remote via Webex*)
Charlotte Lenart, Deputy Executive Director- Licensing
Sharniece Vaughan, Licensing Supervisor
Rebecca Walker, Licensing Specialist

STAKE HOLDER ATTENDEES: Mark Smith, Virginia Society of Clinical Social Workers (VSCSW)
Denise Daly Konrad, Virginia Health Care Foundation (VHCF)
Susan Witt, LCSW, VSCSW (*remote via Webex*)
Kevin Holder, LCSW, Richmond Chapter of the Association of Black Social Workers (*remote via Webex*)
Joseph Lynch, LCSW (*remote via Webex*)
Matthew DeCarlo, Ph.D., LCSW (*remote via Webex*)

CALL TO ORDER: Mr. Randolph called the Committee Meeting to order at 4:08 p.m. Mr. Randolph stated that the Ad Hoc meeting was being held to discuss the racial disparities in the Association of Social Work Board (ASWB) examination and discuss alternative pathways to licensure.

Mr. Randolph also announced to everyone that since Ms. Meadows, the other committee member, was not present, that there would be no decisions made at this meeting, but the floor is open for discussion.

STAFF REPORTS: Ms. Hoyle addressed the Freedom of Information Act (FOIA) and how it relates to Board and Committee meetings.

Ms. Hoyle stated that after ASWB released the 2022 Pass Rate Analysis Examination Data Report, the Board discussed and received public comments at its September 23, 2022 board meeting. The Board requested staff to invite ASWB to its meeting in December 2022 and agreed to release a statement to its licensees and applicants which was published on November 15, 2022.

On behalf of the Virginia State Board of Social Work, we acknowledge the racial disparity recently highlighted in the ASWB clinical and masters' level exam pass rates. This disparity is unacceptable and alarming. The VA State Board of Social Work does not condone any discrimination, institutional or otherwise, and strives for equal opportunity and accessibility to entering the field of Social Work. Additionally, we recognize the need for effective, educated, and professional clinicians and we are certain that we can identify an equitable solution. We will work with the ASWB, the community, and other stakeholders to obtain more information on the possible causes of any disparities and pursue solutions to any issues found.

At its December 9, 2022 meeting, ASWB provided a presentation on its findings and answered questions from the Board. After discussion, the Board agreed to form an Ad Hoc Committee to address the results and determine if the Board had a further role.

DISCUSSION WITH STAKEHOLDERS:

Mr. Holder stated that he would like to participate on the Ad Hoc Committee. He added that other states have alternatives to passing the exam such as additional supervision hours and time and suggested that the Virginia Board of Social Work to consider these alternatives.

Mr. Lynch expressed concern that finding an alternative pathway to the exam could possibly affect current LCSWs and does not want it to undermine the current systems in place. He highlighted the Board role to protect the public. He stated he does not want a potential change to the requirements for examination to damage Virginia LCSW licensees ability to earn income in Virginia or other states.

Dr. DeCarlo mentioned that the Board should look at alternatives similar to Oregon, Illinois and Minnesota that allow additional supervision in lieu of passing the ASWB examination. He provided some helpful links (links listed below) and suggested a podcast for the Board to study. He also stated that Illinois required applicants to first fail the exam at least one time before an alternative pathway can be considered. He stated that these methods have yielded no ethical challenges. He stated that he would like to know how he can help the Board.

- <https://www.researchgate.net/publication/384147411>
- <https://socialworkpodcast.blogspot.com/2023/02/NASWIL.html>
- <https://www.socialworktoday.com/archive/MJ20p24.shtml>

Ms. Witt suggested that it would be helpful for ASWB to speak to the Board and provide updates on how they plan to address the issues with the examination.

Mr. Randolph added that the Board has previously invited ASWB for a meeting that he believes was beneficial.

Ms. Hoyle talked about her recent return from the ASWB Annual Conference and how alternative pathways to the exam was a very significant topic. She discussed that ASWB has been working very hard to address public concerns. ASWB will not be ready to release more data on some of the approaches they are exploring to address these issues until January 2025.

Ms. Daly Konrad briefly spoke about how any alternatives to the examination would affect the Virginia's ability to remain in the compact and how this alternative would hinder the licensee's mobility in the future.

Mr. Holder added that ASWB has made some changes to the exam such as reducing the 4 option questions to 3 to help with passing and by changing the testing centers due to cultural biases. He mentioned that the National Association of Black Social Workers knew the data was there when it came out on August 5, 2022, and that ASWB has no intention of implementing alternative pathways due to the possible reduction of revenue. He stated that he is not encouraged by ASWB coming back to talk with the Board since they do not support alternative pathways to the exam.

NEXT STEPS:

Mr. Randolph stated that in preparation for the next Ad hoc meeting staff should:

1. Research which states allow alternative pathways to examination and identify

those pathways.

2. Reach out to ASWB to participate in the next Ad hoc meeting to discuss their plan to address the racial disparities in their examination.
3. Ask stakeholders for a written official stance on alternative pathways.
4. Staff should include both social work reports in the agenda for the next meeting.

NEXT MEETING DATES:

The next meeting is scheduled for Wednesday, January 8, 2025, at 4:00p.m.

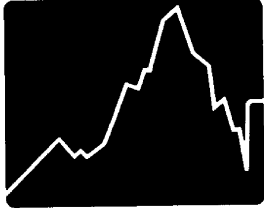
ADJOURNMENT:

Mr. Randolph adjourned the meeting at 4:57 p.m.

Sherwood Randolph Jr., MSW, LCSW

Jaime Hoyle, JD, Executive Director

DRAFT



VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

<https://www.dhp.virginia.gov/Boards/BHP/PractitionerResources/GuidanceDocuments/>

VIRGINIA BOARD OF HEALTH PROFESSIONS

Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions

TABLE OF CONTENTS

Introduction	3
Authority	4
Policy	5
• Statute	5
• The Criteria and Their Application	7
• Alternatives to Occupational and Professional Regulation	9
Procedures	9
• Who may request a study and how?	9
• How is a study conducted?	10
• What happens to the results?	12
Appendix	13

Introduction

Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions: 1998 was developed to inform interested parties concerning the Virginia Board of Health Professions' authority to investigate the need for state regulation of health care providers and its approach in conducting such investigations. This report revises and supersedes a document of the same title published in 1992. This revision was prompted by the results of a study mandated by the 1996 Session of the General Assembly as set forth in §54.1-2409.2 of the *Code of Virginia* (see insert).^{*} The study required an examination of the appropriateness of the Board's evaluation standards.

§54.1-2409.2. Board to set criteria for determining need for professional regulation.

The Board of Health Professions shall study and prepare a report for submission to the Governor and the General Assembly by October 1, 1997, containing its findings and recommendations on the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession. Such criteria shall address at a minimum the following principles:

1. Promotion of effective health outcomes and protection of the public from harm.
2. Accountability of health regulatory bodies to the public.
3. Promotion of consumers' access to a competent health care provider workforce.
4. Encouragement of a flexible, rational, cost-effective health care system that allows effective working relationships among health care providers.
5. Facilitation of professional and geographic mobility of competent providers.
6. Minimization of unreasonable or anti-competitive requirements that produce no demonstrable benefit.

The Board in its study shall analyze and frame its recommendations in the context of the total health care delivery system, considering the current and changing nature of the settings in which health care occupations and professions are practiced. It shall recognize in its recommendations the interaction of the regulation of health professionals with other areas of regulation, including, but not limited to, the following:

1. Regulation of facilities, organizations, and insurance plans;
2. Health delivery systems data;
3. Reimbursement issues;
4. Accreditation of education programs; and
5. Health workforce planning efforts.

The Board in its study shall review and analyze the work of publicly and privately sponsored studies of reform of health care workforce regulation in other states and nations. In conducting its study the Board shall cooperate with the state academic health science centers with accredited professional degree programs.

^{*} A copy of *The Study of the Appropriate Criteria to be Applied in Determining the Need for Regulation of Any Health Care Occupation or Profession* is available upon request.

Among the findings of this comprehensive study is that the Board's current seven criteria are appropriate: 1) risk of harm to the consumer, 2) specialized skills and training, 3) autonomous practice, 4) scope of practice, 5) economic impact, 6) alternatives to regulation, and 7) least restrictive regulation. A complete description of each is found on page 5. An accompanying finding, however, is that the application of the criteria could be strengthened by factoring in additional quantitative and qualitative evidence-based information.

In response to this finding, the Board now requires in its analysis consideration of a job analysis or role delineation study completed within the last two to three years as well as malpractice insurance coverage information. It is held that consistent review of these two sources of objective information should enable the Board to better apply Criteria One through Five.

Authority

The Virginia Board of Health Professions was established by the General Assembly in 1977 to advise the Governor and the General Assembly on matters related to the regulation of health occupations and professions and to provide policy coordination for the twelve health regulatory boards administered by the Virginia Department of Health Professions. It is comprised of seventeen members appointed by the Governor with five citizen members and a member from each of the twelve health regulatory boards.

The powers and duties of the Board are established in *Code of Virginia* § 54.1-2510. Among these duties is the following:

. . . [The Board shall] evaluate all health care professions and occupations in the Commonwealth, including those regulated and those not regulated by other provisions [of Title 54] *to consider whether each such profession or occupation should be regulated and the degree of regulation to be imposed* [emphasis added]. Whenever the Board determines that the public interest requires that a health care profession or occupation which is not regulated by law should be regulated, the Board shall recommend to the General Assembly a regulatory system to establish the appropriate degree of regulation.

It must be made clear that the General Assembly, and not the Board, is the body empowered to make the final determination of the need for state regulation of a health care profession or occupation. The General Assembly has the authority to enact legislation specifying the profession to be regulated, the degree of regulation to be

imposed, and the organizational structure to be used to manage the regulatory program (e.g., board, advisory committee, registry).

The Board's role is purely advisory. It has the authority and responsibility to study and make recommendations concerning the need to regulate new (i.e., currently unregulated) occupations and professions (i.e., a "sunrise" review) as well as to routinely re-examine the appropriateness of the regulatory schemes for currently regulated professions and occupations.

Policies

The Board's evaluation policies are grounded in the Commonwealth's philosophy on occupational regulation as expressed in statute and in the Board's own *Criteria for Evaluating the Need for Regulation* (i.e., the Criteria). Alternatives to regulation are also always considered.

Statute

The following statement epitomizes the Commonwealth's philosophy on the regulation of professions and occupations: ***The occupational property rights of the individual may be abridged only to the degree necessary to protect the public.*** This tenet is clearly stipulated in statute and serves as the Board's over-arching philosophy in its approach to all its reviews of professions or occupations:

. . . the right of every person to engage in any lawful profession, trade or occupation of his choice is clearly protected by both the Constitution of the United States and the Constitution of the Commonwealth of Virginia. The Commonwealth cannot abridge such rights except as a reasonable exercise of its police powers when it is found that such abridgement is necessary for the preservation of the health, safety and welfare of the public. (Code of Virginia §54.1-100)

Further statutory guidance is provided in this same *Code* section. The following conditions must be met before the state may impose regulation on a profession or occupation:

- 1. The unregulated practice of a profession or occupation can endanger the health, safety or welfare of the public, and the potential for harm is recognizable and not remote or dependent upon tenuous argument;**

2. The practice of the profession or occupation has inherent qualities peculiar to it that distinguish it from ordinary work or labor;
3. The practice of the profession or occupation requires specialized skill or training and the public needs, and will benefit by, assurances of initial and continuing professional and occupational ability; and
4. The public is not effectively protected by other means.

In addition, although the General Assembly has established that the following factors be considered in evaluating the need for the regulation of *commercial* occupations and professions, the Board has determined that these factors should be considered in evaluating proposals for the regulation of *health* professions, as well.

1. Whether the practitioner, if unregulated, performs a service for individuals involving a hazard to public health.
2. The opinion of a substantial portion of the people who do not practice the particular profession . . . on the need for regulation.
3. [Intentionally deleted]
4. Whether there is sufficient demand for the service for which there is no regulated substitute and this service is required by a substantial portion of the population.
5. Whether the profession or occupation requires high standards of public responsibility, character and performance of each individual engaged in the profession or occupation, evidence by established and published codes of ethics.
6. Whether the profession requires such skill that the public generally is not qualified to select a competent practitioner without some assurance that he has met minimum qualifications.
7. Whether the professional or occupational associations do not adequately protect the public from incompetent, unscrupulous or irresponsible members of the profession or occupation.
8. Whether current laws which pertain to public health, safety and welfare generally are ineffective or inadequate.
9. Whether the characteristics of the profession or occupation make it impractical or impossible to prohibit those practices of the profession or occupation which are detrimental to the public health, safety and welfare.
10. Whether the practitioner performs a service for others which may have a detrimental effect on third parties relying on the expert knowledge of the practitioner.

(Code of Virginia §54.1-311(B)1-2, 4-10)

The Criteria and Their Application

Based on the principles of occupational and professional regulation established by the General Assembly, the Board has adopted the following criteria to guide evaluations of the need for regulation of health occupations and professions.

VIRGINIA BOARD OF HEALTH PROFESSIONS CRITERIA FOR EVALUATING THE NEED FOR REGULATION

Initially Adopted October, 1991

Readopted February, 1998

Criterion One: Risk for Harm to the Consumer

The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

Criterion Two: Specialized Skills and Training

The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

Criterion Three: Autonomous Practice

The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

Criterion Four: Scope of Practice

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

Criterion Five: Economic Impact

The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

Criterion Six: Alternatives to Regulation

There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

Criterion Seven: Least Restrictive Regulation

When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently, depending upon the level of regulation which appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration (the three most commonly used methods of regulation) and specifies the criteria applicable to each level.

Licensure. Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.

RISK: High potential, attributable to the nature of the practice.

SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.

AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.

SCOPE OF PRACTICE: Definable in enforceable legal terms.

COST: High

APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

Statutory Certification. Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.

RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.

SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.

AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.

SCOPE OF PRACTICE: Definable, but not stipulated in law.

COST: Variable, depending upon level of restriction of supply of practitioners.

APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

Registration. Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.

RISK: Low potential, but consumers need to know that redress is possible.

SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.

AUTONOMY: Variable.

APPLICATION OF CRITERIA: When applying for registration, Criteria 1, 4, 5, and 6 must be met.

Professions currently practiced only with a license include medicine, nursing, dentistry, pharmacy, optometry, veterinary medicine, and psychology, among others. Rehabilitation

providers and massage therapists are certified by the state. Currently in Virginia, there are no health occupations or professions that are registered.

Alternatives to Occupational and Professional Regulation

When a risk or potential risk has been demonstrated but it is not substantiated that licensure, certification, or registration are appropriate remedies, other alternatives may be warranted. These alternatives should always be considered as less restrictive means of addressing the need to adequately protect the public health, safety, and welfare than restricting the occupational property rights of individuals.

Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods for protecting the public that do not require the regulation of specific occupations or professions.

Procedures

The Board has established general guidelines and procedures for the conduct of its evaluation studies. These procedures are intended to assist in the fair and equitable assessment of the need to regulate a profession or occupation or to determine the need for changing a current regulatory approach. These procedures are aimed at translating the Board's policies into operational terms. Three questions are addressed: Who may request a study and how? How is a study conducted? and What happens to the results?

Who may request a study and how? Requests for the Board to conduct an evaluation may come from a number of sources:

- the General Assembly
 - as a legislative resolution
 - as a request from an individual member,
- the Governor,
- the Director of the Department of Health Professions,
- Professional or Occupational Associations and Organizations,
- Concerned Members of the Public.

For requests from organizations or individuals, the review process commences with a formal letter of intent proposing the study. Because the time frame for such studies can require over a year (from request to recommendations), it is important that a contact person or persons be identified in this letter who will provide continuity to the review process. It should be noted that this time frame does not include consideration of the Board's recommendations by the Governor or General Assembly. Nor does it take into

account the extensive work that must be accomplished between the time the General Assembly may enact enabling legislation and the promulgation of regulations which would be required to implement such legislation.

Prior to filing a request, it is recommended that the responsible individual(s) meet with Director of the Department of Health Professions and the Executive Director for the Board. At this meeting, proposal preparation may be discussed in detail and a suggested timetable agreed upon.

How is a study conducted?

When a request for study is presented to the Board, the Board may agree to go forward or it may ask for additional information from the professional or organizational group in question. If the Board agrees to go forward with the study, the matter is referred to the Regulatory Research Committee, which conducts the study and prepares a report with recommendations for the full Board's review and final recommendations.

The Committee reviews and approves a staff prepared workplan, which details the background for the study, its scope, and the specific methodology to be employed. The specific questions to be addressed are detailed here and reflect those questions outlined in the Appendix. Traditional workplans include a comprehensive review of the relevant literature and provide opportunities for receipt of public comment. In some instances, further information is gathered through Board sponsored surveys of practitioners, other states, or other parties knowledgeable about the issues germane to the profession or occupation.

As discussed earlier, as a result of the recent review on the Criteria, it was determined that the evidentiary basis for application of the Criteria should be strengthened whenever possible. As such, the Board will now routinely refer to recent job analyses (or role delineation studies) and actuarial risk assessments of malpractice insurers.

Commonly used to develop credentialing examinations, a job analysis (or role delineation study) abstracts the knowledge, skills, and abilities that define a profession and help distinguish it from related professions. In its simplest terms, a job analysis provides a detailed job description. An occupation or profession is broken down into performance domains, which broadly define the profession being delineated. Then each performance domain is broken down further into tasks. The tasks are categorized further into knowledge, skills, and ability statements.

Malpractice insurance underwriters establish premium rates and the extent of coverage based upon their actuarial assessment of the risk posed by the insured group. Data on

civil suits, assessments of the type of work and work settings involved in practice, and evaluations of similar professions' claim histories, among other factors are considered.

Job analyses and data derived from malpractice insurance were selected to strengthen the Board's evidentiary basis for three reasons. First, they are generally readily available. Most health occupations and professions have professionally developed examinations based on job analyses, and most professions have malpractice insurance. Second, because they were designed for purposes other than to promote the regulation of the respective profession, these sources are viewed as relatively objective. Third, and most important, they are viewed as providing insight into better applying the most crucial criterion, Criterion One – Risk of Harm to the Consumer.

It has often been difficult or impossible to obtain objective information about actual harm to consumers gathered collectively by profession, precisely because the group is unregulated. The literature is usually unavailing, and evaluation of anecdotal evidence, alone, makes attributions to the profession (and not simply individuals) questionable. Thus, to make fair assessments about the *potential* risks to the public when actual data are lacking, the Board's evaluations of criticality based on recent job analyses and actuarial risk predictions found in the rationale for malpractice insurance coverage will be factored into the reasoning.

Job analyses and actuarial risk predictions are not only useful in applying Criterion One. To appropriately apply the entire Criteria, the Board must have a thorough understanding of what comprises the practice of the profession and the necessary educational and training background required for entry level competency.

To answer the questions posed by the Criteria, the Board will review the job analysis information garnered and apply its own measures of importance or *criticality*. Criticality "generally refers to the extent to which the ability to perform the task is essential to the performance on the job." (National Organization for Competency Assurance (1996) p.54).

To collect data on criticality, Likert-type scales will be used. The scales will vary depending upon specific issues being evaluated. For example, for Criterion One, information about potential harm that would result if the task were not performed competently would need to be evaluated. Scales such as those below would be appropriate. All major tasks will be reviewed, and the data tabulated to provide an overall score on each criterion for consideration by the Board.

Sample Criticality Scales for Rating Risk of Harm

Using the occupation as veterinary technician as an example, the following are sample scales for rating the risk of harm.

TASK 1: Scaling teeth above the gum line.

What is the effect of poor performance on public health & safety?

1. No risk
2. Little risk
3. Some risk
4. Significant risk
5. Severe risk

TASK 2: Preparing patient for surgery by shaving surgical area.

Could this activity be omitted on some occasions without having a major impact on client well-being?

1. Can sometimes omit – This activity could sometimes be omitted for some clients without a substantial risk of unnecessary complications, impairment of function or serious distress.
2. Can never omit – This activity could NEVER be omitted without a substantial risk of unnecessary complications, impairment of function, or serious distress.

Based on Correspondence with Kara Schmidt October 30, 1997 11:35 a.m.

These scores, along with the malpractice insurance risk assessment, literature review, public comment, and any other sources of information the Committee would like to explore will serve as the basis to answer the questions expressed in the workplan. Their responses form the basis for their report and recommendations.

What happens to the results?

Once completed, the Committee's study report including recommendations is forwarded to the full Board. Upon adoption or revision of the report, the Board prepares its report for the consideration of the Director of the Department, the Secretary of Health and Human Resources, the Governor, and the General Assembly.

Once the final draft is approved, the Board or the source of the study may disseminate the report as they deem appropriate.

Appendix

QUESTIONS TO BE CONSIDERED FOR THE EVALUATION OF THE NEED FOR REGULATION OF A HEALTH OCCUPATION OR PROFESSION

A. GENERAL INFORMATION

1. What occupational or professional group is seeking regulation?
2. What is the level or degree of regulation sought?
3. Identify by title the association, organization, or other group representing Virginia-based practitioners. (If more than one organization, provide the information requested below for each organization.)
4. Estimate the number of practitioners (members and nonmembers) in the Commonwealth.
5. How many of these practitioners are members of the group preparing the proposal? (If several levels or types of membership are relevant to this proposal, explain these level and provide the number of members, by type).
6. Do other organizations also represent practitioners of this occupation/profession in Virginia? If yes, provide contact information for these organizations.
7. Provide the name, title, organizational name, mailing address, and telephone number of the responsible contact person(s) for the organization preparing this proposal.
8. How was this organization and individual selected to prepare this proposal?
9. Are there other occupations/professions within the broad occupational grouping? What organization(s) represent these entities? (List those in existence and any that are emerging).
10. For each association or organization listed above, provide the name and contact information of the *national* organizations with which the state associations are affiliated.

B. QUESTIONS WHICH ADDRESS THE CRITERIA

Criterion One: Risk for Harm to the Consumer. *The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.*

1. Provide a description of the typical functions performed and services provided by members of this occupational group.
2. Has the public actually been harmed by unregulated providers or by providers who are regulated in other states? If so, how is the evidence of harm documented (i.e., court case or disciplinary or other administrative action)? Was is physical, emotional, mental, social, or financial?
3. If no evidence of actual harm is available, what aspects of the provider group's practice constitute a potential for harm?
4. To what can the harm be attributed? Elaborate as necessary.
 - lack of skills
 - lack of knowledge
 - lack of ethics
 - lack of supervision
 - practices inherent in the occupation
 - characteristics of the client/patients being served
 - characteristics of the practice setting
 - other (specify)
5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent practitioner?
6. Does a potential for fraud exist because of the inability for third party payors to determine competency?

7. Is the **public** seeking regulation or greater accountability of this group?

Criterion Two: Specialized Skills and Training. The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

1. What are the educational or training requirements for entry into this occupation? Are these programs accredited? By whom?
 - Are sample curricula available?
 - Are there training programs in Virginia?
2. If no programs exist in Virginia, what information is available on programs elsewhere which prepare practitioners for practice in the Commonwealth? What are the minimum competencies (knowledge, skills, and abilities) required for entry into the profession? How were they derived?
3. Are there national, regional, and/or state examinations available to assess entry-level competency?
 - Who develops and administers the examination?
 - What content domains are tested?
 - Are the examinations psychometrically sound -- in keeping with *The Standards for Educational and Psychological Testing*?
4. Are there requirements and mechanisms for ensuring continuing competence? For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?
5. Why does the public require state assurance of initial and continuing competence? What assurances do the public have already through private credentialing or certification or institutional standards, etc.?
6. Are there currently recognized or emerging specialties (or levels or classifications) within the occupational grouping? If so,
 - What are these specialties? How are they recognized? (by whom and through what mechanisms – e.g., specialty certification by a national academy, society or other organization)?
 - What are the various levels of specialties in terms of the functions or services performed by each?
 - How can the public differentiate among these levels or specialties for classification of practitioners?
 - Is a “generic” regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?

Criterion Three: The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

1. What is the nature of the judgments and decisions which the practitioner must make in practice?
 - Is the practitioner responsible for making diagnoses?
 - Does the practitioner design or approve treatment plans?
 - Does the practitioner direct or supervise patient care?
 - Does the practitioner use dangerous equipment or substance in performing his functions?If the practitioner is not responsible for diagnosis, treatment design or approval, or directing patient care, who is responsible for these functions?
2. Which functions typically performed by this practitioner group are **unsupervised**, i.e., neither directly monitored or routinely checked?
 - What proportion of the practitioner’s time is spent in unsupervised activity?
 - Who is legally accountable/liable for acts performed with no supervision?
3. Which functions are performed **only under supervision**?
 - Is the supervision *direct* (i.e., the supervisor is on the premises and responsible) or *general* (i.e., supervisor is responsible but not necessarily on the premises)?
 - Who provides the supervision? How frequently? Where? For what purpose?
 - Who is legally accountable/liable for acts performed under supervision?
 - Is the supervisor a member of a regulated profession (please elaborate)?

- What is contained in a typical supervisory or collaborative arrangement protocol?
3. Does the practitioner of this occupation supervise others? Describe the nature of this supervision (as in #3 above).
 4. What is a typical work setting like, including supervisory arrangements and interaction of the practitioner with other regulated/unregulated occupations and professions?
 5. Does this occupational group treat or serve a specific consumer/client/patient population?
 6. Are clients/consumers/patients **referred to** this occupational group for care or services? If so, by whom? Describe a typical referral mechanism.
 7. Are clients/consumers/patients **referred from** this occupational group for care or services? If so, to what practitioners are such referrals made? Describe a typical referral mechanism. How and on what basis are decisions to refer made?

Criterion Four: The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

1. Which functions of this occupation are **similar to** those performed by other health occupational groups?
 - Which group(s)?
 - Are the other groups regulated by the state?
 - If so, why might the applicant group be considered different?
2. Which functions of this occupation are **distinct from** other similar health occupational groups?
 - Which group(s)?
 - Are the other groups regulated by the state?
3. How will the regulation of this occupational group affect the scope of practice, marketability, and economic and social status of the other, similar groups (whether regulated or unregulated)?

Criterion Five: The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

1. What are the range and average incomes of members of this occupational group in the Commonwealth? In adjoining states? Nationally?
2. What are the typical current fees for services provided by this group in the Commonwealth? In adjoining states? Nationally?
3. Is there any evidence that cost for services provided by this occupational group will increase if the group becomes state regulated? In other states, have there been any effects on fees/salaries attributable to state regulation?
4. Would state regulation of this occupation restrict other groups from providing care given by this group?
 - Are any of the other groups able to provide similar care at lower costs?
 - How is it that this lower cost is possible?
5. Are there current shortages/oversupplies of practitioners in Virginia? In the region? Nationally?
6. Are third-party payers in Virginia currently reimbursing services of the occupational group? By whom? For what?
 - If not in Virginia, elsewhere in the country?
 - Are similar services provided by another occupational group reimbursed by third-party payers in Virginia? Elsewhere? Elaborate.
7. If third-party payment does not currently exist, will the occupation seek it subsequent to state regulation?

Criterion Six: There are no alternatives to State regulation of the occupation which adequately protect the public. [Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.]

1. What laws or regulations currently exist to govern:
 - Facilities in which practitioners practice or are employed?
 - Devices and substances used in the practice?
 - Standards of practice?

2. Does the institution or organization where the practitioners practice set and enforce standards of care? How?
3. Does the occupational group participate in a nongovernmental credentialing program, either through a national certifying agency or professional association (e.g., National Organization for Competency Assurance)?
 - How are the standards set and enforced in the program?
 - What is the extent of participation of practitioners in the program?
4. Does a Code of Ethics exist for this profession?
 - What is it?
 - Who established the Code?
 - How is it enforced?
 - Is adherence mandatory?
5. Does any peer group evaluation mechanism exist in Virginia or elsewhere? Elaborate.
6. How is a practitioner disciplined and for what causes? Violation of standards of care? Unprofessional conduct? Other causes?
7. Are there specific legal offenses which, upon conviction, preclude a practitioner from practice?
8. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence (e.g., malpractice insurance, review boards that handle complaints)? How are challenges to a practitioner's competency handled?
9. What is the most appropriate level of regulation?



Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions

2019

Table of Contents

Introduction.....	3
Authority.....	3
Policies.....	4
Statute	4
The Criteria and Their Application	6
Alternatives to Occupational and Professional Regulation.....	8
Procedures.....	8
Who may request a study and how?.....	8
How is a study conducted?	9
Sample Criticality Scales for Rating Risk of Harm	10
What happens to the results?	10
Appendix.....	11
Reference Materials	15

Introduction

In 1992, the Virginia Board of Health Professions published *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions*, a standard reference that defines the evaluative criteria and methodologies to assess objectively the public's need for state protection through practitioner regulation. Its approach dates back to 1983.

In 1998, the Board updated the 1992 version in response to an independent analysis of its approach pursuant to *Code of Virginia* §54.1-2409.2.¹ The study reaffirmed the Board's policies and procedures but offered that additional sources of objective data could strengthen the approach. Hence, the Board added malpractice insurance information and job analysis data to the methodology.

Nearly twenty years have passed between updates. The Board undertook an environmental scan of the literature and relevant statutes, policies, and procedures of other states.² As of this publication, there are 12 other states with formal policies. The existing literature pertains to those states systems. There are differences among the states with regard to the empowered organizational structure and minor logistics, but the principles, criteria and policies employed essentially mirror Virginia's current practice. The 2019 revision updates statutory references, provides hyperlinks to cited materials, and clarifies language that has become outdated otherwise but does not reflect a significant change in overall procedure.

The remainder of this document references the Board's authority to conduct evaluative reviews and details specific policies and procedures.

Authority

In 1977, the General Assembly established the Virginia Board of Health Professions to advise the Governor and the General Assembly on matters pertaining to the regulation of health occupations and professions and to provide policy coordination for the boards administered within the Virginia Department of Health Professions.

Currently, the Board is comprised of 18 members appointed by the Governor: five citizen members and a member from each of the thirteen licensing boards.

Code of Virginia § 54.1-2510 provides that

... [The Board shall] evaluate all health care professions and occupations in the Commonwealth, including those regulated and those not regulated by other provisions [of Title 54] to consider whether each such profession or occupation should be regulated and the degree of regulation to be imposed [emphasis added]. Whenever the Board determines that the public interest requires that a health care profession or occupation which is not regulated by law should be regulated, the Board shall recommend to the General Assembly a regulatory system to establish the appropriate degree of regulation.

¹ Accessible at (<https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2409.2/>). The 1998 report, *Study of the Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupation or Profession* is accessible in executive summary and full report form from the Virginia General Assembly's House Document sites (<https://rga.lis.virginia.gov/Published/1998/HD8>) and <https://rga.lis.virginia.gov/Published/1998/HD8/PDF>, respectively.

² See the Appendix for References

The General Assembly, and not the Board, is the body empowered to make the final determination of the need for state regulation of a health care profession or occupation. Only the General Assembly has the authority to enact legislation specifying the profession to be regulated, the degree of regulation to be imposed and the organizational structure to be used to manage the regulatory program (e.g., board, advisory committee, or registry).

The Board's role is purely advisory. It has the authority and responsibility to study and make recommendations concerning the need to regulate new (i.e., currently unregulated) occupations and professions (i.e., a "sunrise" review) as well as to routinely re-examine the appropriateness of the regulatory schemes for currently regulated professions and occupations.

Policies

The Board's evaluation policies are grounded in the Commonwealth's philosophy on occupational regulation as expressed in statute and in the Board's own *Criteria for Evaluating the Need for Regulation* (i.e., the Criteria). Alternatives to regulation are also always considered.

Statute

The following statement epitomizes the Commonwealth's philosophy on the regulation of professions and occupations. ***The occupational property rights of the individual may be abridged only to the degree necessary to protect the public.*** This tenet is clearly stipulated in statute and serves as the Board's overarching philosophy in its approach to all its reviews of professions or occupations:

... the right of every person to engage in any lawful profession, trade or occupation of his choice is clearly protected by both the Constitution of the United States and the Constitution of the Commonwealth of Virginia. The Commonwealth cannot abridge such rights except as a reasonable exercise of its police powers when (i) it is found that such abridgement is necessary for the protection or preservation of the health, safety and welfare of the public and (ii) any such abridgement is no greater than necessary to protect or preserve the public health, safety, and welfare. (Code of Virginia 54.1-100 – amended by 2016 Acts of the Assembly Chapter 467)³

Additional statutory guidance is provided in the same *Code* section. The following conditions must be met before the state may impose regulation on a profession or occupation:

1. The unregulated practice of a profession or occupation can endanger the health, safety or welfare of the public, and the potential for harm is recognizable and not remote or dependent upon tenuous argument;
2. The practice of the profession or occupation has inherent qualities peculiar to it that distinguish it from ordinary work or labor;
3. The practice of the profession or occupation requires specialized skill or training and the public needs, and will benefit by, assurances of initial and continuing professional and occupational ability; and
4. The public is not effectively protected by other means.

³ Accessible at <http://leg1.state.va.us/cgi-bin/legp504.exe?161+ful+CHAP0467>

In addition, although the General Assembly has established that the following factors be considered in evaluating the need for the regulation of *commercial* occupations and professions, the Board has determined that these factors should be considered in evaluating proposals for the regulation of *health* professions, as well.

1. **Whether the practitioner, if unregulated, performs a service for individuals involving a hazard to the public health.**
2. **The opinion of a substantial portion of the people who do not practice the particular profession. . . on the need for regulation.**
3. **The number of states which have regulatory provisions similar to those proposed.**
4. **Whether there is sufficient demand for the service for which there is no regulated substitute and this service is required by a substantial portion of the population.**
5. **Whether the profession or occupation requires high standards of public responsibility, character and performance of each individual engaged in the profession or occupation, evidenced by established and published codes of ethics.**
6. **Whether the profession requires such skill that the public generally is not qualified to select a competent practitioner without some assurance that he has met minimum qualifications.**
7. **Whether the professional or occupational associations do not adequately protect the public from incompetent, unscrupulous or irresponsible members of the profession or occupation.**
8. **Whether current laws which pertain to public health, safety and welfare generally are ineffective or inadequate.**
9. **Whether the characteristics of the population or occupation make it impractical or impossible to prohibit those practices of the profession or occupation which are detrimental to the public health, safety and welfare.**
10. **Whether the practitioner performs a service for others which may have a detrimental effect on third parties relying on the expert knowledge of the practitioner.**

(Code of Virginia §54.1-311(B)1-2,4-10)

In addition to amending §54.1-100, Chapter 467 also created a new section, §54.1-310.1⁴ which governs the petitioning of state regulation for an unregulated commercial profession or occupation and details the Board of Professional and Occupational Regulation's sunrise review responsibilities. Subsection (A) mandates that evaluation requests be submitted no later than December 1 of any year for analysis and evaluation during the following year. Although the Board of Health Professions is not bound by this section, in order to allow sufficient time and resources for each study, preference for proposals submitted before December 1 will be considered.

⁴ Accessible at: <https://law.lis.virginia.gov/vacode/title54.1/chapter3/section54.1-310.1/>

The Criteria and Their Application

Based on the principles of occupational and professional regulation established by the General Assembly, the Board has adopted the following criteria to guide the evaluation of the need for regulation of a health occupation or profession.

VIRGINIA BOARD OF HEALTH PROFESSIONS CRITERIA FOR EVALUATING THE NEED FOR REGULATION

Initially Adopted 1991
Readopted 1998 and 2019

Criterion One: Risk for Harm to the Consumer

The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

Criterion Two: Specialized Skills and Training

The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

Criterion Three: Autonomous Practice

The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

Criterion Four: Scope of Practice

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

Criterion Five: Economic Impact

The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

Criterion Six: Alternatives to Regulation

There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

Criterion Seven: Least Restrictive Regulation

When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently depending upon the level of regulation which appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration (the three most commonly used methods of regulation) and specifies the criteria applicable to each level.

Licensure. Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.

RISK: High potential, attributable to the nature of the practice.

SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.

AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.

SCOPE OF PRACTICE: Definable in enforceable legal terms.

COST: High

APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

Statutory Certification. Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.

RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.

SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.

AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.

SCOPE OF PRACTICE: Definable, but not stipulated in law.

COST: Variable, depending upon level of restriction of supply of practitioners.

APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

Registration. Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.

RISK: Low potential, but consumers need to know that redress is possible.

SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.

AUTONOMY: Variable.

APPLICATION OF CRITERIA: When applying for registration, Criteria 1, 4, 5, and 6 must be met.

Alternatives to Occupational and Professional Regulation

When a risk or potential risk has been demonstrated but it is not substantiated that licensure, certification, or registration are appropriate remedies, other alternatives are available. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods for protecting the public that do not require the regulation of specific occupations or professions.

These alternatives are less restrictive means of addressing the need to adequately protect the public health, safety, and welfare than restricting the occupational property rights of individuals.

Procedures

The Board has established general guidelines and procedures for the conduct of evaluation studies. These procedures assure the fair and equitable assessment of the need to regulate a profession or occupation or to determine the need for changing a current regulatory approach. These procedures translate the Board's policies into operational terms. Three questions are addressed: Who may request a study and how? How is a study conducted? and What happens to the results?

Who may request a study and how?

Requests for the Board to conduct an evaluation may come from a number of sources:

- the General Assembly
 - as a legislative resolution
 - as a request from an individual member,
- the Governor,
- the Director of the Department of Health Professions,
- Professional or Occupational Associations and Organizations,
- Concerned Members of the Public.

Prior to filing a request, it is recommended that the responsible individual(s) meet with Director of the Department of Health Professions and the Executive Director for the Board. At this meeting, proposal preparation may be discussed in detail and a suggested timetable agreed upon.

For requests from organizations or individuals, the review process commences with a formal letter of intent proposing the study. Because the time frame for such studies can require over a year (from request to recommendations), it is preferred that requests be received by December 1 for consideration during the following year. It is important that a contact person or persons be identified in this letter who will provide continuity to the review process. It should be noted that this time frame does not include consideration of the Director's review or the Board's recommendations by the Governor or General Assembly. Nor does it take into account the extensive work that must be accomplished between the time the General Assembly may enact enabling legislation and the promulgation of regulations which would be required to implement such legislation.

When a request for study is presented to the Board, the Board may agree to go forward or it may ask for additional information from the professional or organizational group in question.

How is a study conducted?

If the Board agrees to go forward with the study, the matter is referred to the Regulatory Research Committee, which conducts the study and prepares a report with recommendations for the full Board's review and final recommendations.

The Committee reviews and approves a staff prepared workplan, which details the background for the study, its scope, and the specific methodology to be employed. The specific questions to be addressed are detailed and reflect those questions outlined in the Appendix. Traditional workplans include a comprehensive review of the relevant literature and provide opportunities for receipt of public comment. In some instances, further information is gathered through Board sponsored surveys of practitioners, other states, or other parties knowledgeable about the issues germane to the profession or occupation.

As discussed earlier, as a result of the Board's formal review of the Criteria conducted pursuant to §54.1-2409.2 of the *Code of Virginia*, the evidentiary basis for application of the Criteria was strengthened to include references to recent job analyses (or role delineation studies) and actuarial risk assessments of malpractice insurers.

Commonly used to develop credentialing examinations, a job analysis (or role delineation study) abstracts the knowledge, skills, and abilities that define a profession and help distinguish it from related professions. In its simplest terms, a job analysis provides a detailed job description. An occupation or profession is broken down into performance domains, which broadly define the profession being delineated. Then each performance domain is broken down further into tasks. The tasks are categorized further into knowledge, skills, and ability statements.

Malpractice insurance underwriters establish premium rates and the extent of coverage based upon their actuarial assessment of the risk posed by the insured group. Data on civil suits, assessments of the type of work and work settings involved in practice, and evaluations of similar professions' claim histories, among other factors are considered.

Job analyses and data derived from malpractice insurance were selected to strengthen the Board's evidentiary basis for three reasons. First, they are generally readily available. Most health occupations and professions have professionally developed examinations based on job analyses, and most professions have malpractice insurance. Second, because they were designed for purposes other than to promote the regulation of the respective profession, these sources are viewed as relatively objective. Third, and most important, they are viewed as providing insight into better applying the most crucial criterion, Criterion One – Risk of Harm to the Consumer.

It has often been difficult or impossible to obtain objective information about actual harm to consumers gathered collectively by profession, precisely because the group is unregulated. The literature is usually unavailing and evaluation of anecdotal evidence alone makes attributions to the profession (and not simply individuals) questionable. Thus, to make fair assessments about the *potential* risks to the public when actual data are lacking, the Board's evaluations of recent job analyses and actuarial risk predictions found in the rationale for malpractice insurance coverage are factored into the reasoning.

Job analyses and actuarial risk predictions are not only useful in applying Criterion One. To appropriately apply the entire Criteria, the Board must have a thorough understanding of what comprises the practice of the profession and the necessary educational and training background required for entry level competency.

To answer the questions posed by the Criteria, the Board reviews the job analysis information garnered

and may apply its own measures of importance or *criticality*. Criticality “generally refers to the extent to which the ability to perform the task is essential to the performance on the job.” (National Organization for Competency Assurance (1996) p.54). Scales such as those on the next page may be used. Here, all major tasks are reviewed and data tabulated to provide an overall score on each criterion.

Sample Criticality Scales for Rating Risk of Harm

Using the occupation as veterinary technician as an example, the following are sample scales for rating the risk of harm.

TASK 1: Scaling teeth above the gum line.

What is the effect of poor performance on public health & safety?

1. No risk
2. Little risk
3. Some risk
4. Significant risk
5. Severe risk

TASK 2: Preparing patient for surgery by shaving surgical area.

Could this activity be omitted on some occasions without having a major impact on client well-being?

1. Can sometimes omit – This activity could sometimes be omitted for some clients without a substantial risk of unnecessary complications, impairment of function or serious distress.
2. Can never omit – This activity could NEVER be omitted without a substantial risk of unnecessary complications, impairment of function, or serious distress.

Based on Correspondence with Kara Schmidt October 30, 1997 11:35 a.m.

These scores, along with the malpractice insurance risk assessment, literature review, public comment, and any other sources of information the Committee would like to explore serve as the basis to answer the questions expressed in the workplan. The responses form the basis for the report and recommendations.

What happens to the results?

Once completed, the Committee’s study report including recommendations goes to the full Board for review. Upon adoption or revision of the report, the Board prepares its report for the consideration of the Director of the Department, the Secretary of Health and Human Resources, the Governor, and the General Assembly.

Once the final draft is approved, the Board or the source of the study may disseminate the report as they deem appropriate.

Appendix

QUESTIONS TO BE CONSIDERED FOR THE EVALUATION OF THE NEED FOR REGULATION OF A HEALTH OCCUPATION OR PROFESSION

A. GENERAL INFORMATION

1. What occupational or professional group is seeking regulation?
2. What is the level or degree of regulation sought?
3. Identify by title the association, organization, or other group representing Virginia-based practitioners. (If more than one organization, provide the information requested below for each organization.)
4. Estimate the number of practitioners (members and nonmembers) in the Commonwealth.
5. How many of these practitioners are members of the group preparing the proposal? (If several levels or types of membership are relevant to this proposal, explain these level and provide the number of members, by type).
6. Do other organizations also represent practitioners of this occupation/profession in Virginia? If yes, provide contact information for these organizations.
7. Provide the name, title, organizational name, mailing address, and telephone number of the responsible contact person(s) for the organization preparing this proposal.
8. How was this organization and individual selected to prepare this proposal?
9. Are there other occupations/professions within the broad occupational grouping? What organization(s) represent these entities? (List those in existence and any that are emerging).
10. For each association or organization listed above, provide the name and contact information of the *national* organizations with which the state associations are affiliated.

B. QUESTIONS WHICH ADDRESS THE CRITERIA

Criterion One: Risk for Harm to the Consumer. *The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.*

1. Provide a description of the typical functions performed and services provided by members of this occupational group.
2. Has the public actually been harmed by unregulated providers or by providers who are regulated in other states? If so, how is the evidence of harm documented (i.e., court case or disciplinary or other administrative action)? Was it physical, emotional, mental, social, or financial?
3. If no evidence of actual harm is available, what aspects of the provider group's practice constitute a potential for harm?
4. To what can the harm be attributed? Elaborate as necessary.
 - lack of skills
 - lack of knowledge
 - lack of ethics

- lack of supervision
 - practices inherent in the occupation
 - characteristics of the client/patients being served
 - characteristics of the practice setting
 - other (specify)
5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent practitioner?
 6. Does a potential for fraud exist because of the inability for third party payors to determine Competency?
 7. Is the public seeking regulation or greater accountability of this group?

Criterion Two: *Specialized Skills and Training.* *The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.*

1. What are the educational or training requirements for entry into this occupation? Are these programs accredited? By whom?
 - Are sample curricula available?
 - Are there training programs in Virginia?
2. If no programs exist in Virginia, what information is available on programs elsewhere which prepare practitioners for practice in the Commonwealth? What are the minimum competencies (knowledge, skills, and abilities) required for entry into the profession? How were they derived?
3. Are there national, regional, and/or state examinations available to assess entry-level competency?
 - Who develops and administers the examination?
 - What content domains are tested?
 - Are the examinations psychometrically sound -- in keeping with *The Standards for Educational and Psychological Testing*?
4. Are there requirements and mechanisms for ensuring continuing competence? For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?
5. Why does the public require state assurance of initial and continuing competence? What assurances do the public have already through private credentialing or certification or institutional standards, etc.?
6. Are there currently recognized or emerging specialties (or levels or classifications) within the occupational grouping? If so,
 - What are these specialties? How are they recognized? (by whom and through what mechanisms – e.g., specialty certification by a national academy, society or other organization)?
 - What are the various levels of specialties in terms of the functions or services performed by each?
 - How can the public differentiate among these levels or specialties for classification of practitioners?
 - Is a “generic” regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?
 -

Criterion Three: *The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.*

1. What is the nature of the judgments and decisions which the practitioner must make in practice?
 - Is the practitioner responsible for making diagnoses?
 - Does the practitioner design or approve treatment plans?

- Does the practitioner direct or supervise patient care?
 - Does the practitioner use dangerous equipment or substance in performing his functions?
- If the practitioner is not responsible for diagnosis, treatment design or approval, or directing patient care, who is responsible for these functions?
2. Which functions typically performed by this practitioner group are **unsupervised**, i.e., neither directly monitored or routinely checked?
 - What proportion of the practitioner's time is spent in unsupervised activity?
 - Who is legally accountable/liable for acts performed with no supervision?
 3. Which functions are performed **only under supervision**?
 - Is the supervision *direct* (i.e., the supervisor is on the premises and responsible) or *general* (i.e., supervisor is responsible but not necessarily on the premises)?
 - Who provides the supervision? How frequently? Where? For what purpose?
 - Who is legally accountable/liable for acts performed under supervision?

Is the supervisor a member of a regulated profession (please elaborate)?

 - What is contained in a typical supervisory or collaborative arrangement protocol?
 3. Does the practitioner of this occupation supervise others? Describe the nature of this supervision (as in #3 above).
 4. What is a typical work setting like, including supervisory arrangements and interaction of the practitioner with other regulated/unregulated occupations and professions?
 5. Does this occupational group treat or serve a specific consumer/client/patient population?
 6. Are clients/consumers/patients referred to this occupational group for care or services? If so, by whom? Describe a typical referral mechanism.
 7. Are clients/consumers/patients referred from this occupational group for care or services? If so, to what practitioners are such referrals made? Describe a typical referral mechanism. How and on what basis are decisions to refer made?

Criterion Four: The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

1. Which functions of this occupation are **similar to** those performed by other health occupational groups?
 - Which group(s)?
 - Are the other groups regulated by the state?
 - If so, why might the applicant group be considered different?
2. Which functions of this occupation are **distinct from** other similar health occupational groups?
 - Which group(s)?
 - Are the other groups regulated by the state?
3. How will the regulation of this occupational group affect the scope of practice, marketability, and economic and social status of the other, similar groups (whether regulated or unregulated)?

Criterion Five: The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

1. What are the range and average incomes of members of this occupational group in the Commonwealth? In adjoining states? Nationally?
2. What are the typical current fees for services provided by this group in the Commonwealth? In adjoining states? Nationally?

3. Is there any evidence that cost for services provided by this occupational group will increase if the group becomes state regulated? In other states, have there been any effects on fees/salaries attributable to state regulation?
4. Would state regulation of this occupation restrict other groups from providing care given by this group?
 - Are any of the other groups able to provide similar care at lower costs?
 - How is it that this lower cost is possible?
5. Are there current shortages/oversupplies of practitioners in Virginia? In the region? Nationally?
6. Are third-party payers in Virginia currently reimbursing services of the occupational group? By whom? For what?
 - If not in Virginia, elsewhere in the country?
 - Are similar services provided by another occupational group reimbursed by third-party payers in Virginia? Elsewhere? Elaborate.
7. If third-party payment does not currently exist, will the occupation seek it subsequent to state regulation?

Criterion Six: *There are no alternatives to State regulation of the occupation which adequately protect the public.* [Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.]

1. What laws or regulations currently exist to govern:
 - Facilities in which practitioners practice or are employed?
 - Devices and substances used in the practice?
 - Standards or practice?
2. Does the institution or organization where the practitioners practice set and enforce standards of care? How?
3. Does the occupational group participate in a nongovernmental credentialing program, either thorough a national certifying agency or professional association (e.g., Institute for Credentialing Excellence National Commission for Certifying Agencies).
 - How are the standards set and enforced in the program?
 - What is the extent of participation of practitioners in the program?
4. Does a Code of Ethics exist for this profession?
 - What is it?
 - Who established the Code?
 - How is it enforced?
 - Is adherence mandatory?
5. Does any peer group evaluation mechanism exist in Virginia or elsewhere? Elaborate.
6. How is a practitioner disciplined and for what causes?
 - Violation of standards of care?
 - Unprofessional conduct?
 - Other causes?
7. Are there specific legal offenses which, upon conviction, preclude a practitioner from practice?
8. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence (e.g., malpractice insurance, review boards that handle complaints)?
 - How are challenges to a practitioner's competency handled?
9. What is the most appropriate level of regulation?

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******SUMMARY******

Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions

Licensure. Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.

RISK: High potential, attributable to the nature of the practice.

SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.

AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.

SCOPE OF PRACTICE: Definable in enforceable legal terms.

COST: High

APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

Criterion One: Risk for Harm to the Consumer

The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

Criterion Two: Specialized Skills and Training

The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

Criterion Three: Autonomous Practice

The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

Criterion Four: Scope of Practice

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

Criterion Five: Economic Impact

The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

Criterion Six: Alternatives to Regulation

There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

Criterion Seven: Least Restrictive Regulation

When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.



Association of Social Work Boards

School Pass/Fail Summary

ASWB CLINICAL EXAM PASS RATE FOR VIRGINIA MSW PROGRAMS 2000-2016

	NORFOLK STATE UNIVERSITY		VIRGINIA COMMONWEALTH UNIVERSITY		RADFORD UNIVERSITY		GEORGE MASON UNIVERSITY	
	<i>PASS Rate</i>	<i>Total FIRST TIME AND REPEAT</i>	<i>PASS Rate</i>	<i>Total FIRST TIME AND REPEAT</i>	<i>PASS Rate</i>	<i>Total FIRST TIME AND REPEAT</i>	<i>PASS Rate</i>	<i>Total FIRST TIME AND REPEAT</i>
2000	48%	46	84%	119	100%	4	0%	0
2001	71%	41	71%	149	83%	12	100%	1
2002	46%	61	76%	167	73%	30	0%	0
2003	38%	39	73%	144	79%	19	0%	0
2004	40%	57	71%	159	70%	23	0%	0
2005	27%	59	71%	136	83%	23	0%	0
2006	28%	47	65%	161	61%	31	100%	1
2007	33%	61	62%	166	54%	31	100%	1
2008	28%	54	72%	163	60%	40	100%	1
2009	34%	68	71%	152	63%	32	0%	0
2010	25%	83	67%	169	50%	34	71%	7
2011	31%	85	73%	159	56%	41	100%	2
2012	35%	86	68%	148	72%	43	91%	11
2013	41%	68	77%	156	81%	36	89%	9
2014	25%	73	79%	171	76%	29	88%	16
2015	30%	87	70%	185	77%	31	73%	26
2016	43%	69	78%	162	57%	23	70%	33

This information is provided to the school/program for the sole purpose of internal evaluation of the social work program. This information shall not be used for comparison or ranking purposes with any other educational program.



Association of Social Work Boards

School Pass/Fail Summary

School: George Mason University

Examination: CLINICAL

The following table presents the numbers of examinations administered to candidates who indicated that they attended your college or university. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Clinical examination during the year(s) 2000-2016. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2000	0	0	0	0%	0	0	0	0%	0	0	0	0%
2001	1	0	1	100%	0	0	0	0%	1	0	1	100%
2002	0	0	0	0%	0	0	0	0%	0	0	0	0%
2003	0	0	0	0%	0	0	0	0%	0	0	0	0%
2004	0	0	0	0%	0	0	0	0%	0	0	0	0%
2005	0	0	0	0%	0	0	0	0%	0	0	0	0%
2006	1	0	1	100%	0	0	0	0%	1	0	1	100%
2007	1	0	1	100%	0	0	0	0%	1	0	1	100%
2008	1	0	1	100%	0	0	0	0%	1	0	1	100%
2009	0	0	0	0%	0	0	0	0%	0	0	0	0%
2010	3	2	5	60%	2	0	2	100%	5	2	7	71%
2011	2	0	2	100%	0	0	0	0%	2	0	2	100%
2012	10	1	11	91%	0	0	0	0%	10	1	11	91%
2013	7	1	8	88%	1	0	1	100%	8	1	9	89%
2014	12	2	14	86%	2	0	2	100%	14	2	16	88%
2015	18	5	23	78%	1	2	3	33%	19	7	26	73%
2016	22	4	26	85%	1	6	7	14%	23	10	33	70%

The following table provides the national percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2000-2016. These data are provided for comparative purposes only.

National Pass Rates			
Year	First-Time	Repeat	Total
2000	71%	39%	65%
2001	73%	41%	64%
2002	73%	38%	64%
2003	72%	33%	61%
2004	74%	36%	62%
2005	74%	33%	62%
2006	74%	31%	62%
2007	74%	31%	62%
2008	76%	31%	63%
2009	75%	30%	61%
2010	75%	32%	62%
2011	78%	37%	66%
2012	77%	41%	66%
2013	78%	37%	67%
2014	78%	38%	67%
2015	76%	35%	64%
2016	78%	36%	67%

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Association of Social Work Boards

School Pass/Fail Summary

School: Norfolk State University

Examination: CLINICAL

The following table presents the numbers of examinations administered to candidates who indicated that they attended your college or university. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Clinical examination during the year(s) 2000-2016. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2000	16	11	27	59%	6	13	19	32%	22	24	46	48%
2001	27	5	32	84%	2	7	9	22%	29	12	41	71%
2002	21	15	36	58%	7	18	25	28%	28	33	61	46%
2003	11	9	20	55%	4	15	19	21%	15	24	39	38%
2004	20	7	27	74%	3	27	30	10%	23	34	57	40%
2005	14	15	29	48%	2	28	30	7%	16	43	59	27%
2006	11	9	20	55%	2	25	27	7%	13	34	47	28%
2007	13	10	23	57%	7	31	38	18%	20	41	61	33%
2008	13	17	3	43%	2	22	24	8%	15	39	54	28%
2009	16	12	28	57%	7	33	40	18%	23	45	68	34%
2010	15	20	35	43%	6	42	48	12%	21	62	83	25%
2011	13	17	30	43%	13	42	55	24%	26	59	85	31%
2012	17	16	33	52%	13	40	53	25%	30	56	86	35%
2013	17	17	34	50%	11	23	34	32%	28	40	68	41%
2014	9	11	20	45%	9	44	53	17%	18	55	73	25%
2015	17	23	40	42%	9	38	47	19%	26	61	87	30%
2016	14	16	30	47%	16	23	39	41%	30	39	69	43%

The following table provides the national percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2000-2016. These data are provided for comparative purposes only.

Year	National Pass Rates		
	First-Time	Repeat	Total
2000	71%	39%	65%
2001	73%	41%	64%
2002	73%	38%	64%
2003	72%	33%	61%
2004	74%	36%	62%
2005	74%	33%	62%
2006	74%	31%	62%
2007	74%	31%	62%
2008	76%	31%	63%
2009	75%	30%	61%
2010	75%	32%	62%
2011	78%	37%	66%
2012	77%	41%	66%
2013	78%	37%	67%
2014	78%	38%	67%
2015	76%	35%	64%
2016	78%	36%	67%

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Association of Social Work Boards

School Pass/Fail Summary

School: Radford University

Examination: CLINICAL

The following table presents the numbers of examinations administered to candidates who indicated that they attended your college or university. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Clinical examination during the year(s) 2000-2016. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2000	4	0	4	100%	0	0	0	0%	4	0	4	100%
2001	9	2	11	82%	1	0	1	100%	10	2	12	83%
2002	21	6	27	78%	1	2	3	33%	22	8	30	73%
2003	12	2	14	86%	3	2	5	60%	15	4	19	79%
2004	12	5	17	71%	4	2	6	67%	16	7	23	70%
2005	17	2	19	89%	2	2	4	50%	19	4	23	83%
2006	17	6	23	74%	2	6	8	25%	19	12	31	61%
2007	16	11	27	59%	4	6	10	40%	20	17	31	54%
2008	19	3	22	86%	5	13	18	28%	24	16	40	60%
2009	18	2	20	90%	2	10	12	17%	20	12	32	63%
2010	15	7	22	68%	2	10	12	17%	17	17	34	50%
2011	17	10	27	63%	6	8	14	43%	23	18	41	56%
2012	19	6	25	76%	12	6	18	67%	31	12	43	72%
2013	24	5	29	83%	5	2	7	71%	29	7	36	81%
2014	19	3	22	86%	3	4	7	43%	22	7	29	76%
2015	22	3	25	88%	2	4	6	33%	24	7	31	77%
2016	12	5	17	71%	1	5	6	17%	13	10	23	57%

The following table provides the national percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2000-2016. These data are provided for comparative purposes only.

Year	National Pass Rates		
	First-Time	Repeat	Total
2000	71%	39%	65%
2001	73%	41%	64%
2002	73%	38%	64%
2003	72%	33%	61%
2004	74%	36%	62%
2005	74%	33%	62%
2006	74%	31%	62%
2007	74%	31%	62%
2008	76%	31%	63%
2009	75%	30%	61%
2010	75%	32%	62%
2011	78%	37%	66%
2012	77%	41%	66%
2013	78%	37%	67%
2014	78%	38%	67%
2015	76%	35%	64%
2016	78%	36%	67%

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Association of Social Work Boards

School Pass/Fail Summary

School: Virginia Commonwealth University

Examination: CLINICAL

The following table presents the numbers of examinations administered to candidates who indicated that they attended your college or university. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Clinical examination during the year(s) 2000-2016. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2000	96	12	108	89%	4	7	11	36%	100	19	119	84%
2001	98	27	125	78%	8	16	24	33%	106	43	149	71%
2002	113	26	139	81%	14	14	28	50%	127	40	167	76%
2003	93	18	111	84%	12	21	33	36%	105	39	144	73%
2004	103	22	125	82%	10	24	34	29%	113	46	159	71%
2005	82	18	100	82%	15	21	36	42%	97	39	136	71%
2006	92	19	111	83%	13	37	50	26%	105	56	161	65%
2007	88	30	118	75%	15	33	48	31%	103	63	166	62%
2008	102	14	116	88%	15	32	47	32%	117	46	163	72%
2009	99	21	120	82%	9	23	32	28%	108	44	152	71%
2010	93	22	115	81%	20	34	54	37%	113	56	169	67%
2011	96	19	115	83%	20	24	44	45%	116	43	159	73%
2012	85	18	103	83%	15	30	45	33%	100	48	148	68%
2013	111	11	122	91%	9	25	34	26%	120	36	156	77%
2014	119	11	130	92%	16	25	41	39%	135	36	171	79%
2015	115	33	148	78%	15	22	37	41%	130	55	185	70%
2016	115	13	128	90%	12	22	34	35%	127	35	162	78%

The following table provides the national percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2000-2016. These data are provided for comparative purposes only.

Year	National Pass Rates		
	First-Time	Repeat	Total
2000	71%	39%	65%
2001	73%	41%	64%
2002	73%	38%	64%
2003	72%	33%	61%
2004	74%	36%	62%
2005	74%	33%	62%
2006	74%	31%	62%
2007	74%	31%	62%
2008	76%	31%	63%
2009	75%	30%	61%
2010	75%	32%	62%
2011	78%	37%	66%
2012	77%	41%	66%
2013	78%	37%	67%
2014	78%	38%	67%
2015	76%	35%	64%
2016	78%	36%	67%

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COMMONWEALTH of VIRGINIA

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TO: The Honorable Barbara Favola
Chair, Senate Committee on Rehabilitation and Social Services

FROM: Arne W. Owens
Director, Virginia Department of Health Professions

DATE: November 21, 2024

RE: Report Regarding Efforts to Diversify and Strengthen the Clinical Social Work Workforce.

This report is submitted by the Department of Health Professions in compliance with the request from the Chair of the Senate Committee on Rehabilitation and Social Services to review HB606, which was passed by indefinitely during the 2024 General Assembly Session.

Should you have questions about this report, please feel free to contact me at (804) 367-4648 or arne.owens@dhp.virginia.gov.

AO/EB
Enclosure

CC: Janet V. Kelly, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with the request submitted pursuant to Rule 20(o) of the Rules of the Senate, under which rule the Chair of the Senate Committee on Rehabilitation and Social Services directed the Board of Social Work to review the current regulations related to the licensure of clinical social workers and evaluate the effectiveness of the exam as a regulatory instrument.

The Board's review and evaluation of the examination requirements related to the licensure of clinical social workers follows.

Contents

I.	Executive Summary	1
II.	Background	2
A.	Virginia Licensed Clinical Social Worker Workforce	2
B.	Current Licensure Requirements for Licensed Clinical Social Workers	3
III.	Anti-Bias Measures	5
IV.	Current and Proposed Methods to Diversify the Clinical Social Worker Workforce, Improve Instruction, and Improve Support at Virginia’s Schools of Social Work	7
V.	Steps Taken by Other States Regarding Alternative Licensure Pathways	9
VI.	Capacity of Virginia Board of Social Work to Manage Alternative Pathways	11
VII.	Steps the Virginia Board of Social Work is Currently Taking	13
VIII.	Impact on Social Work Licensure Compact	15
IX.	Summary of ASWB Research Efforts	16
X.	Conclusions and Next Steps	18

I. Executive Summary

Pursuant to Rule 20(o) of the Rules of the Senate of Virginia, the Senate Committee on Rehabilitation and Social Services referred the subject matters contained in House Bill 606 (Delegate Price) of the 2024 General Assembly to the Board of Social Work “Board” for review by letter from the Chair. House Bill 606, which failed to report from the Committee on Rehabilitation and Social Services, had directed the Board to amend the regulations for the licensure of clinical social workers to allow applicants to obtain an additional 1,500 hours of supervised experience as an alternative to passing the examination. The subsequent letter encouraged the Board to consider the following:

1. The use of any anti-bias measures currently required of professional-level licensure exams;
2. Current and proposed efforts the Board has made to diversify the clinical social worker workforce and improve instruction and support at Virginia’s schools of social work;
3. Steps other states are actively taking related to creating alternative licensure pathways. This analysis should include any positive or negative implications or outcomes including cautionary indicators;
4. The Board’s capacity to manage any alternative pathway including one that may include at least 1500 hours of supervised clinical experience beyond what is currently required;
5. Additional, objective oversight measures that might be utilized by the Board in the absence of the exam. This review should include the consideration of objective, alternative competence measurements that could be consistently utilized by the Board as the regulators of the clinical social work license;
6. Any steps the Board is taking towards strengthening supervision, credentialing, oversight, and accountability to include an evaluation of supervisory hours as an equivalent replacement for an exam and a step towards licensure; and
7. The state-level impact on the Social Work Licensure Compact if Virginia moves forward with an alternative licensure pathway. This review should include the impact on the Commonwealth’s ability to remain in the Compact but also on individuals who earn their license through an alternative path being eligible for the multi-state license.

The mission of the Board is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to practitioners and the public. Within that mission, this report includes background on the current licensed clinical social worker workforce in Virginia, current regulations related to the licensure of clinical social workers, as well as an evaluation of the available data related to competency measures, alternative pathways to licensure, and efforts to ensure a diverse and highly qualified social worker workforce in the Commonwealth.

II. Background

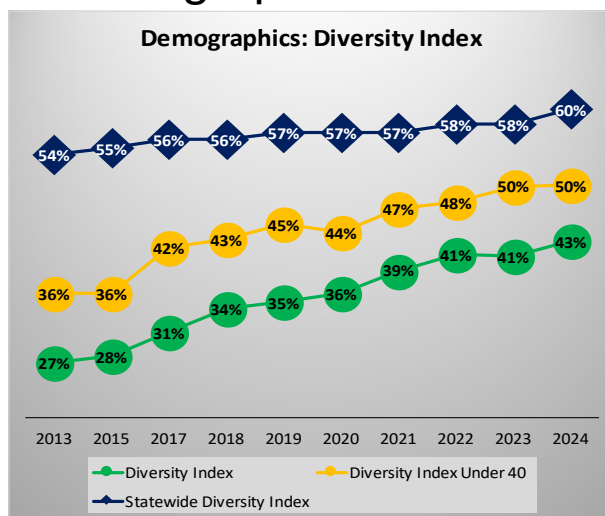
A. Virginia Licensed Clinical Social Worker Workforce

The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers a survey to Licensed Clinical Social Workers (LCSWs) in Virginia during the license renewal period, which occurs every year on June 30th, and includes this information in an annual report. In 2024, 9,732 LCSWs voluntarily participated in this survey, which reflects 85% of the 11,493 LCSWs licensed in Virginia and 97% of renewing practitioners.¹

The number of licensed social workers in Virginia continues to increase. The report indicates that since 2019, the number of licensed LCSWs has increased by 58% (11,493 vs. 7,291) and has also become younger, with the median age of the LCSW workforce now being 48 versus 50. At the same time, Virginia's LCSW workforce has become more diverse (43% vs. 35%), and this is also true among those LCSWs who are under the age of 40 (50% vs. 45%). Among other factors, the report measures the diversity index. The diversity index indicates that, in a random encounter between two LCSWs, there is a 43% chance that they would be of different races or ethnicities. This diversity index increases to 50% for those LCSWs who are under the age of 40. By comparison, for Virginia's entire population, the comparable diversity index is 60%.



Trends in Demographics



Used by permission of HWDC

¹ *Virginia Licensed Clinical Psychologist Workforce: 2024*, Healthcare Workforce Data Center, Virginia Department of Health Professions, 2024.

B. Current Licensure Requirements for Licensed Clinical Social Workers

As outlined by the Regulations Governing the Practice of Social Work (18VAC140-20-10 *et seq.*), Virginia licenses initial applicants for licensure as a clinical social worker via the licensure by examination pathway. An applicant pursuing an initial license as a clinical social worker (“LCSW”) submits an application to the Virginia Board of Social Work (“Board”) for licensure by examination, indicating that the final step prior to obtaining the license is passage of the required national examination. The Association of Social Work Boards (“ASWB”) administers the social work examinations, and applicants cannot register with the ASWB to take the examination without prior approval from the Board. The Board approval indicates that the applicant has met the education and supervised experience requirements.

Virginia requires LCSW applicants provide evidence of a master’s degree in social work with a clinical course of study from a program accredited by the Council on Social Work Education (“CSWE”). The vast majority of United States jurisdictions require graduation from a CSWE master’s program as a prerequisite to licensure. Boards rely on the CSWE to ensure the quality and integrity of the education programs. Exceptions include states like Virginia that require a course transcript review to ensure a minimum of clinical course content as CSWE does not differentiate between clinical and non-clinical MSW degree programs. The New York State Education Department only accepts degree programs it accredits for clinical licensure.

Additionally, Virginia requires applicants for the LCSW to provide evidence of having completed a minimum of 3,000 hours of supervised post-master’s degree experience in the delivery of clinical social work services and in ancillary services that support such delivery. This supervised experience requires applicants obtain 100 hours of face-to-face supervision with no more than 50 hours being obtained in group supervision. The Board approves the supervisors, who must be LCSWs with a minimum of two years of experience and must complete the required supervisor training. Supervision of an LCSW applicant must be completed in no more than four years. Some employers offer supervision as a perk of employment, but most supervisees must pay for their supervision. All United States jurisdictions require a period of supervised experience as a prerequisite to licensure, with the vast majority requiring 3,000 hours.

Once the education and supervised experience requirements are met and the Board approves the applicant to take the examination, the applicant registers with the ASWB to take the examination. The ASWB sets the passing score. The Board requires that the applicant pass the examination within two years of the Board’s initial approval. The ASWB allows applicants to take the exam every 90 days. However, waivers to this policy are permitted under certain circumstances. Once the applicant receives a passing score on the examination, the Board issues a license. Until recently, all United States jurisdictions shared this requirement. As of 2024, all jurisdictions except Minnesota and Utah require passage of the clinical examination as a prerequisite to licensure as an LCSW. In Illinois, individuals must attempt the clinical exam at least one time to be eligible for an alternative path. Each of these states requires applicants for the clinical license alternative to complete an additional period of supervised practice experience which has additional implications and unintended consequences.

In 2022, the ASWB published examination data that indicated pass rates disparities across different racial/ethnic groups.² With this release, the ASWB points out that the data reflects a multitude of factors that can affect performance on a licensing exam, including educational background, preparation, and length of time between graduation and testing. The differences in pass rates also reflect societal opportunity gaps for historically underrepresented groups, and illuminates the historical burdens of racial trauma, marginalization, and social injustice to which Black candidates may have been subjected along their journey to licensure.

In response to the data publication, regulators throughout the United States have been exploring avenues to address this issue in a variety of ways. States have been asking for context and conducting additional research and engaging with stakeholders. The majority of state regulatory boards are monitoring the data publication and engaging with the ASWB to learn more about exam development and ongoing process improvements, as well as understand research findings into variables impacting disparate outcomes. Many are also looking to understand why pass rate differences vary depending on the degree program of test takers. While a handful of states have either eliminated the exam requirement (Minnesota) or created alternative pathways, several, including Virginia, have created ad hoc committees to examine the data publication further and make potential recommendations.

² 2022 ASWB Exam Pass Rate Analysis: Final Report. Association of Social Work Boards.

III. Anti-Bias Measures

The ASWB follows a structured and rigorous exam development process to ensure that its licensure exams are fair, valid, and reflective of social work practice. This process involves multiple steps, from the creation of test questions to ongoing review and psychometric analysis.³

The ASWB has implemented several anti-bias measures within its exam development to promote fairness and inclusivity, and to ensure that the exam does not disadvantage any group based on race, ethnicity, gender, or other characteristics. The exam development process begins with a survey, called a practice analysis, of thousands of social workers to ensure representation from various backgrounds and geographic areas. The ASWB surveys licensed social workers across different jurisdictions to gather data on the tasks they perform, and the competencies needed in their roles. The results of this survey help to establish the content for measured competencies and form the basis for the exam content outline which defines the areas of knowledge tested in each exam.

The ASWB then recruits a diverse group of social workers with various backgrounds and experiences to write and review exam questions. The ASWB intentionally selects these item writers to reflect multiple perspectives that encompass diverse cultural backgrounds, geographic regions, work settings, and areas of expertise to reduce potential bias in the development of exam content. These professionals develop test questions based on the exam content outline. The ASWB trains the item writers in best practices for writing high-quality, fair, and clear test questions. The training also includes strategies to avoid bias and ensure cultural sensitivity in the items they develop.

After the item writers produce the initial questions, committees of social work professionals conduct several rounds of reviews. They review the questions for accuracy, relevance, clarity, and fairness. All exam questions go through a bias and sensitivity review process. This review is designed to identify and remove questions that could be interpreted as biased, culturally insensitive, not reflective of diverse populations, or that could disadvantage specific groups. The review also ensures the exam questions measure cultural competency and reflect the cultural diversity of clients that social workers may encounter in practice, including consideration of the role of cultural factors in diagnosis, treatment, and intervention. The ASWB does not have a formal definition of cultural competency but follows the general definition established within the social work profession where it is understood to mean the ability to work effectively across diverse cultural backgrounds with sensitivity, respect, and an understanding of the impact of culture on an individual's experience. The National Association of Social Workers (“NASW”) describes cultural competence as a set of behaviors, attitudes, and policies that enable social workers to work effectively in cross-cultural situations. This includes understanding and respecting the cultural and personal values of clients and being self-aware of one’s own cultural perspective and biases. The NASW understands cultural competency as an ethical obligation and has incorporated it into its Code of Ethics. The CSWE includes cultural competence as a core competency in its Educational Policy and Accreditation Standards (“EPAS”). This standard

³ More information on the ASWB examination development process *available at:* <https://www.aswb.org/exam/exams-for-the-future-of-social-work/webinars/>.

requires social workers to understand diversity and difference in practice, apply knowledge of how diversity shapes human experiences, and recognize how social structures and personal biases affect individuals and communities. CSWE encourages social work students to engage in self-reflection and develop critical thinking around cultural influences. Items that fail to meet bias and sensitivity standards are revised or removed entirely.

Psychometricians also review the statistical properties of the items to ensure they function well in measuring the intended skills and knowledge. The ASWB conducts psychometric analyses of the exam data to detect any patterns of differential item functioning (“DIF”), which identifies if any specific question is more difficult for demographic groups. Questions flagged through this analysis are reviewed and either revised or removed if bias is detected. Before new questions are scored, they are introduced as pre-test items that do not count toward the candidate’s score. This allows the ASWB to analyze the performance of questions across different demographic groups. Questions indicating signs of bias during pre-testing are also flagged for review and possible revision or removal.

After exams are administered, the ASWB conducts a statistical analysis to ensure that the test questions continue to perform well. This analysis includes detecting any questions that may have performed unexpectedly or unfairly. The ASWB uses a process called equating to ensure that all exam forms are of comparable difficulty so that passing scores are consistent across different versions of the exam. The ASWB convenes a panel of social work experts to determine the passing score for each exam. The panel reviews the exam’s difficulty and ensures that the passing score reflects the level of competence required for safe and effective practice. The panel considers the equitable impact of the exam on different groups. Item performance and expert recommendations may lead to an adjustment in the passing score. The ASWB carefully evaluates the passing score to ensure it reflects competency without being influenced by systemic bias.

The ASWB continuously monitors the exams to ensure they remain valid and reflective of current social work practices. Monitoring includes regular updates based on changes in social work standards, ethics, and practices. The ASWB also collects feedback from exam candidates and licensed professionals to inform future revisions and improvements. If candidates feel that a question is biased or unfair, they can submit comments to the ASWB. The exam development team reviews the comments and assists to gather additional data on potential biases from a broad range of test-takers.

IV. Current and Proposed Methods to Diversify the Clinical Social Worker Workforce, Improve Instruction, and Improve Support at Virginia’s Schools of Social Work

As stated in the Executive Summary to this report, the mission of the Board is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to practitioners and the public. The Board’s authority stems from statute and regulations and focuses on the licensing and discipline of its regulated professions. Although the Board requires applicants for licensure to meet education requirements and graduate from accredited institutions, it does not have authority over the accrediting body or the colleges and universities to impact instruction. The Board depends on the expertise of accrediting bodies to oversee the curricula of these programs and take action against colleges and institutions that fail to meet or adhere to the accreditation standards. Currently, the CSWE is the only accrediting body for social work programs in Virginia and across the United States.

A scan of the national and state landscape reveals efforts by organizations and educational programs to diversify the workforce and support schools. The CSWE has initiated several key efforts to improve test outcomes and promote diversity within the clinical social work workforce.⁴ These initiatives aim to address disparities in education, training, and licensure outcomes, particularly among underrepresented groups. CSWE’s Educational Policy and Accreditation Standards (“EPAS”) ensures that accredited social work programs emphasize diversity, equity, and inclusion (“DEI”) in their curriculum. These standards require social work schools to prepare students for culturally competent practice, which is essential for diversifying the workforce and improving outcomes for historically marginalized populations. The EPAS framework includes specific competencies focused on anti-racism, social justice, and culturally responsive care. These competencies are embedded into the curriculum to ensure students are better prepared to serve diverse populations and succeed in licensure exams. Additionally, the CSWE’s Commission on Diversity and Social and Economic Justice works on advancing DEI across social work education, focusing on diversifying the student and faculty pipeline, thereby contributing to a more diverse workforce in clinical social work. In response to the ASWB’s release of the examination data, the CSWE’s Commission on Accreditation removed licensing exam pass rates from the 2022 EPAS accreditation standards.

The CSWE provides resources for schools to address structural racism and develop more inclusive teaching practices. It encourages schools to adopt policies and programs that support students from diverse backgrounds, which potentially indirectly influences their success in clinical social work licensure exams. The CSWE has also encouraged social work programs to provide additional resources such as tutoring, mentorship, and test preparation specifically for students who are preparing for clinical licensure exams.

The CSWE has also partnered with the National Association of Social Workers (“NASW”) and the ASWB to examine disparities in licensure exam pass rates. These collaborations aim to analyze and address the root causes of these disparities, including factors such as any bias inherent in the test development, as well as educational preparation and access to resources that may play

⁴ See <https://www.cswe.org/> for more detailed information on CSWE's initiatives.

a larger role in the disparate outcomes. The organizations have been working together to ensure the licensure exam is fair and reflective of diverse social work practices.

The CSWE promotes various scholarship programs, including the Minority Fellowship Program (“MFP”), which supports students from underrepresented groups pursuing careers in social work. This program helps to diversify the pipeline of future clinical social workers by providing financial assistance and mentorship to those from racial and ethnic minority groups. The MFP is a significant initiative aimed at increasing diversity in the workforce, addressing mental health disparities, and improving educational outcomes for these populations.

Additionally, the National Association of Deans/Directors (“NADD”) of Social Work Programs formed a task force to develop an action plan in relation to the data released on pass/fail rates on the national licensing exam. The task force is creating resources for state-level stakeholders to examine potential revisions to regulations aimed at increasing the numbers and diversity of social workers nationally and exploring alternative pathways to licensure.

V. Steps Taken by Other States Regarding Alternative Licensure Pathways

The majority of states have reacted to the release of the ASWB exam data by engaging with stakeholders, conducting research, and monitoring the activity with the national associations to address the disparities and provide recommendations. Connecticut went a step further and paused the use of the master's exam for the master's license in 2023 until mid-2026 to await recommendations from the national organizations. Illinois and Utah eliminated the use of the master's and bachelor's exam for licensure, and Colorado eliminated the use of the master's exam for the master's license.⁵ Minnesota recently eliminated the requirement for passing the national social work exam for initial licensure at all social work license levels, including the Licensed Independent Clinical Social Worker ("LICSW"). Instead of the exam, Minnesota introduced a provisional licensure pathway that involves completing 2,000 hours of supervised practice and 37.5 hours of direct supervision.⁶

At the clinical level, research and surveys of licensed social workers indicate that the majority of jurisdictions and licensees see the value of requiring an exam, as it is the only competency measure that provides uniformity and consistency across jurisdictions. The ASWB data release revealed there is no perfect measure and there is an ongoing need and responsibility to ensure that competency-based measures protect the public without unfairly obstructing entrance into the workforce. States are exploring the possibility of creating alternative licensure pathways for clinical social workers. So far, these alternative licensure pathways focus on work experience, supervised clinical practice, and competency-based evaluations. These alternative pathways generally require an applicant to have failed the exam before the alternative pathway becomes an option. In April of 2024, however, the Oregon Board of Licensed Social Workers established the Oregon Alternative Pathways to Social Work Committee. The recommendations made were to abolish the use of the ASWB exam for all licensure levels and rather than establishing an alternative pathway, establish a new pathway that does not ever taking or passing an examination. These recommendations remain at the recommendation stage.

Illinois recently implemented alternative licensure pathways for social workers, allowing candidates to fulfill competency requirements without passing the traditional the ASWB exam. Illinois, Public Act 103-433, effective January 1, 2024, enables an alternative path for LCSW applicants who have made at least one attempt at the ASWB exam within the past five years. These individuals can qualify for licensure by completing an additional 3,000 hours of supervised professional experience under the guidance of various licensed professionals.

Other than additional supervision, these alternative assessments can involve various evaluation methods. Case scenarios require candidates to analyze hypothetical scenarios to demonstrate their ability to apply relevant competencies effectively. Practical evaluations involve simulations or direct observations of candidates in practice settings, and this allows evaluators to assess their performance in real-time. Portfolio Assessments require candidates to compile evidence of their competencies through documentation of their experiences, such as case studies, reflective journals, and supervisor evaluations. Competency-based licensing initiatives aim to

⁵ Note that these actions were taken for licensure categories other than LCSWs.

⁶ More information is available through the Minnesota Chapter of the National Association of Social Workers, available at: <https://naswmn.socialworkers.org/Advocacy/Legislative-Updates>.

evaluate a candidate's ability to demonstrate the skills and knowledge required for clinical practice rather than relying solely on traditional exams.

Provisional or temporary licenses are issued in some states to social workers who have met most of the licensure requirements but still need to pass the ASWB exam or complete final steps. For instance, Massachusetts offers a temporary license to those who have completed their education and supervision requirements but are still preparing for the ASWB exam. This allows them to work in clinical settings while studying for the exam, improving job security, and reducing financial strain.

California allows for extended supervised practice options, where social workers can work clinically while gaining the required supervision hours for licensure. These pathways offer flexibility to applicants who may not be able to pass the licensure exam on their first attempt but are ready to practice under supervision. California is also developing a competency-based assessment model as part of their ongoing efforts to address disparities in licensure outcomes. This approach is seen as an avenue to better align assessments with the skills and knowledge required for effective social work practice.

States like New Mexico, Colorado, and Washington have proposed or implemented apprenticeship or fellowship programs that allow recent graduates or social workers from non-traditional backgrounds to gain licensure through extended supervised practice or training programs. These programs typically offer mentorship and structured training in clinical settings, helping candidates develop the competencies needed for licensure. Colorado has been proactive in implementing alternative pathways, such as a focus on portfolio-based assessments for candidates. This allows applicants to demonstrate their competencies through a comprehensive review of their education, experience, and professional achievements, rather than relying solely on standardized tests. Washington has been exploring competency-based licensure alternatives, including performance-based assessments. These models may involve evaluating practical skills through clinical simulations or portfolio-based assessments, which focus on real-world competency rather than standardized test results.

VI. Capacity of Virginia Board of Social Work to Manage Alternative Pathways

Depending on the alternative pathway utilized, the Board has limited capacity to objectively measure competence. It should be noted that it is the combination of requirements, and not one requirement alone, that provides the objective measures. For instance, even though licensure requires graduation from an accredited social work program, accreditation acts only as a partial safeguard to the quality of the programs. Programs and students are not created equally. The quality of the professors, the grading scale, and the student's abilities vary from program to program and student to student.

Likewise, supervision depends on the quality of the supervisor, and sometimes the dynamic between the supervisor and the supervisee. The Board ensures that the supervisor meets the requirements to be a supervisor but cannot ensure that the supervision is in fact occurring as reported. The Board lacks the personnel resources⁷ to audit the supervision and relies on the honesty and the evaluative abilities of each supervisor. The Board recognizes that the Commonwealth has many wonderful supervisors, but a financial incentive to provide supervision exists because supervisees often must pay for their supervision. Additionally, the Board currently has no regulations governing the number of supervisees a supervisor can supervise, and some worry less about the quality of the supervision they provide and more about the quantity. The regulations only require that the supervisor have an active LCSW that has been in good standing for the last two years and have taken certain continuing education hours in supervision. In fact, the Board recently streamlined its regulations to reduce ongoing supervision requirements. If the Board adopts an alternative pathway to the examination, it will need to strengthen the regulations governing supervision to ensure greater accountability. Under the current requirements, applicants submit a Verification of Supervision form⁸ that is signed and notarized by the supervisor and the applicant and lists the supervised hours and the type of supervision received. Staff reviews the forms for accuracy, but in actuality, must rely on the honesty and integrity of the applicant and the supervisor. If an alternative pathway does not change this review, additional staff would not be required. However, if supervision becomes the main competency measure and guardrail to protect the public, staff should audit the supervision, which would require additional staff.

Additional alternative pathways, such as portfolio reviews, would require significant additional resources. The Board would need to either utilize Board members to review and approve the alternative pathway chosen or would need to hire professional staff to conduct these reviews. The Board has nine volunteer members defined in statute.⁹ At times, not all Board member spots are filled.¹⁰ Given the small size of the Board and the fact that members are volunteers, staff currently face difficulties scheduling meetings and hearings due to limited Board member availability and lack of a quorum. Placing more responsibility on the Board members could delay

⁷ Personnel resources to ensure quality supervision would likely require three fulltime employees solely dedicated to a continual audit of supervision ongoing in the Commonwealth. Licensure staff for the Board of Social Work currently numbers two full-time and two part-time individuals. Discipline workload would likely increase as well and the Board of Social Work currently has part-time staff dedicated to processing complaints.

⁸ Available at <https://www.dhp.virginia.gov/media/dhpweb/docs/sw/forms/ClinicalSupervisionVerification.pdf>.

⁹ Va. Code § 54.1-3703.

¹⁰ There are currently two vacancies on the Board, leaving the Board with seven members.

the licensure process. Hiring professional staff to conduct such reviews would have an impact on the cost to obtain a license to practice as a social worker in the Commonwealth. The Department of Health Professions is a special fund agency, meaning that its licensing boards must fund operations from collection of licensure fees.¹¹ Hiring additional staff ultimately requires raising fees imposed for licensure to compensate for the increased operations costs of the Board.

¹¹ Va. Code § 54.1-113.

VII. Steps the Virginia Board of Social Work is Currently Taking

Over the past five years, the Board progressively reduced unnecessary barriers to the workforce and streamlined its regulations and requirements to encourage licensure while still protecting the public and allowing for mobility. In comparison to other jurisdictions, Virginia's requirements are aligned and the ASWB considers Virginia's supervision processes, such as registering supervision and requiring a supervision contract, best practice. Virginia requires supervisors to hold an active, unrestricted license as a licensed clinical social worker with at least two years of post-licensure clinical social work experience. The regulations also require the supervisor to have received professional training in supervision, consisting of a three credit-hour graduate course in supervision or at least fourteen hours of continuing education. Ongoing supervision requires the supervisor to obtain seven hours of continuing education in supervision within the five years preceding any supervision.¹² The Board recently reduced the number of hours of continuing education required after initial supervisor approval from fourteen to seven in an effort to reduce barriers to supervision and encourage more LCSWs to serve as supervisors. Additionally, to facilitate the supervision process for applicants, the Board created a Supervisor Registry that publicizes the supervisors that the Board has approved for supervision.¹³ If the Board pursues an alternative pathway to licensure that includes more extensive supervision, it will need to revisit the reduction in continued education for supervisors.

Virginia utilizes available mechanisms for evaluating supervision with minimum resources required in other jurisdictions. Candidates for licensure must complete 3,000 hours of supervised post-master's degree experience that includes at least 100 hours of face-to-face supervision. The Board requires initial supervision contracts and reporting of supervision hours, but oversight of supervision remains limited. For example, the Board does not restrict the number of supervisees that a single supervisor may supervise. If the Board pursues an alternative pathway to licensure that includes additional supervision, it may want to consider limiting the number of supervisees per supervisor to help ensure supervisors focus on the quality of the supervision.

In response to the ASWB data release, on November 15, 2022, the Board issued the following statement:

On behalf of the Virginia State Board of Social Work, we acknowledge the racial disparity recently highlighted in the ASWB clinical and masters' level exam pass rates. This disparity is unacceptable and alarming. The [Virginia] Board of Social Work does not condone any discrimination, institutional or otherwise, and strives for equal opportunity and accessibility to entering the field of Social Work. Additionally, we recognize the need for effective, educated, and professional clinicians and we are certain that we can identify and equitable solution. We will work with the ASWB, the community, and other stakeholders to obtain more information on

¹² 18VAC140-20-50(B).

¹³ Va. Code § 54.1-3705(8).

the possible causes of any disparities and pursue solutions to any issues found.¹⁴

The Board subsequently formed an ad hoc committee to collect information related to the disparities, engage with stakeholders, and identify and recommend to the Board any potential actions the Board can implement to address racial bias and disparities in the licensure process that prevents competent and qualified professions from entering the profession. The work of the ad hoc committee is ongoing.

¹⁴ Announcement *available at*:
<https://www.dhp.virginia.gov/Boards/SocialWork/AbouttheBoard/News/announcements/Content-701893-en.html>.

VIII. Impact on Social Work Licensure Compact

The exam is the only objective measure available to regulators that offers assurance that social workers licensed elsewhere are competent to practice in their jurisdiction. Because of this consideration, compact legislation for all professions typically requires an exam as a key feature. Jurisdictions that do not require an exam for a specific category of license may be ineligible to participate in the compact for that category of license. This may cause social workers licensed in that jurisdiction to have a limited ability for cross-jurisdictional practice.

Specifically, the Social Work Compact grants individuals in member jurisdictions a multistate authorization to practice, which is equivalent to a license, and allows holders of this multistate license the privilege to practice social work in any other member jurisdiction. As stated in Section 3 of the Compact, states do not have to require the Qualifying National Exam for all licensees. However, they must require the Qualifying National Exam for licensees applying for a multistate license. The use of a Qualifying National Exam does not prohibit a state from establishing alternative competency measures for licensure.¹⁵

Section 4 of the Compact gives the commission flexibility to determine if there are other alternative competency assessments that would be deemed “substantially equivalent” to the Qualifying National Exam. The Compact Commission, the governing body whose membership comprises a delegate from each member state, will define “substantial equivalency” by rule. This provision may give flexibility to states to allow for alternative pathways to the examination; however, the amount of flexibility is yet to be determined.¹⁶ Rather than allowing alternative pathways that lack uniformity, the Compact Commission could identify another broadly used competence measure. Since compacts thrive on uniformity, the “substantial equivalency” would need to reflect uniform standards of competency rather than a variety of alternative pathways.

For states that want to remain in the compact but also implement alternative pathways, compact states could grant two pathways to licensure: single state and multistate. For example, Virginia could require passage of the examination for the multistate license and implement changes to modify exam requirements for a single state license. This framework may present unintended consequences and equity issues. Individuals with a single state license may face mobility issues and will likely be required to pass the examination to obtain licensure and practice in other jurisdictions. Employers may also choose to screen and not hire individuals who have not taken and passed the licensing exam.

¹⁵ See generally Va. Code § 54.1-3709.4, § 3.

¹⁶ See generally Va. Code § 54.1-3709.4, § 4.

IX. Summary of ASWB Research Efforts

Since the proactive data publication in 2022, the ASWB has been actively working to do its part to address the disparities revealed in the exam passage rates. The ASWB efforts include working with stakeholders to do their part to address concerns with examination preparation, reviewing and improving the examination development process where needed, and investing in research. For example, concurrent with the data publication in 2022, ASWB demonstrated a commitment to working with social work education programs by making a suite of free exam resources for educators available to use to prepare their students more equally for the exams and licensure. The suite includes the free downloadable *ASWB Examination Guidebook*, the Educator Guide to the Social Work Exams with Group Review Practice Questions, detailed reports on student pass rates (including information on content area performance), and a free training in writing questions according to ASWB standards.

Beginning in January 2023, ASWB began a partnership with FifthTheory, a minority-owned firm with expertise in high-stakes testing and occupational assessment. During the pilot period, select test-takers received access to the Test Mastery Inclusion program, which includes a research-based assessment and resources designed to help individuals taking a high-stakes exam reflect on and develop essential mindset competencies. This program is offered at no cost to all registered test-takers.

In 2022, the ASWB convened the Social Work Workforce Coalition, a group that includes a range of U.S. and Canadian social work organizations that represent diverse perspectives, to provide input into the Social Work Census and the Community Conversations research initiative. The data from the Social Work Census, which was open from March to June 2024, will be aggregated and used to develop a comprehensive and up-to-date picture of the demographics of social workers for use by the profession. The Social Work Census will gather robust data on what they do to inform the content of the next iteration of the social work licensing exams. The Community Conversations program, that operated from January to May 2023, consisted of a series of facilitated conversations with social workers about their unique experiences with the licensing exams. Each session centered around the test-taker experiences of exam preparation, administration, and outcomes.

The ASWB is also revisiting the exam structure and exam administration practices to increase equitable access. It is working toward redesigning the exam to use a module-based format, allowing test-takers who are unsuccessful on an exam to retake only necessary sections, thereby reducing costs and other barriers.

The ASWB has invested in a regulatory research agenda, in partnership with educational institutions and researchers, to consider alternative competence measurement formats, contextual factors impacting disparate outcomes, and other alternatives for regulators to have a voice in their licensure decisions. The ASWB awarded a grant to researchers at Western Kentucky University¹⁷ to address three research areas: factors impacting disparity in pass rates for social work licensure;

¹⁷ More information available at: <https://www.wku.edu/news/articles/index.php?view=article&articleid=11486>.

the impact of disparity in licensure pass rate on the social work profession; and, solutions to reduce disparity in pass rates for social work licensure.

Finally, to contextualize more precisely the systemic factors that influence pass rates, the ASWB has partnered with Joy Kim, MSW, Ph.D., of Rutgers, The State University of New Jersey. Dr. Kim and her associate, Michael Joo, MSW, Ph.D., have conducted an inquiry into the sources of pass rate disparities that includes analyses of pass rates that control for the individual, institutional, and community factors that test-takers carry with them throughout their lives. The research will help identify individual, school, and community factors that affect candidates' exam pass/fail outcomes and analyze the data to unveil the effects of those factors and assist with contextualizing examination pass rate data publication with additional research and insights. They have delivered three mini-reports in August 2024 focused on:

- Demographic profile of exam-takers;
- Determinants of exam outcomes from other professions; and
- Net effects of race/ethnicity on ASWB exam outcome.

The series begins with a report that profiles social work license examinees using ASWB data.¹⁸ The report describes the racially patterned educational and training journey individuals experience before they sit for a licensing exam. The report concludes that “demographic, educational, and employment characteristics of examinees from historically marginalized groups — particularly Black examinees — signal that their educational and training journeys to the profession might have been disturbed by cumulative lifetime disadvantages.”¹⁹

The second report reviews other professions' literature on licensing/certification exam pass rate disparities.²⁰ Dr. Kim finds that significant racial/ethnic disparities are consistently documented across numerous professions, including medicine, nursing, and psychology. Her report emphasizes the need for more empirical research to understand and begin to reduce pass rate disparities.

The final report returns to the social work licensing exams, focusing on the effects of race/ethnicity on clinical exam outcomes.²¹ Using the limited data available, Dr. Kim's findings suggest that if historically marginalized groups had the same individual, educational, and employment characteristics and lived in similar institutional and community environments as white examinees, the Black–white disparity in the Clinical exam outcomes could be reduced by about 20%, and the Hispanic/Latino–white disparity by around 28%.

¹⁸ Joy Kim, MSW, PhD & Michael Joo, MSW, PhD, “The Profile of Social Work License Examinees: A Racially Patterned Educational and Training Journey Before the Exams,” Rutgers School of Social Work (2024).

¹⁹ <https://www.aswb.org/wp-content/uploads/2024/08/1.-Kim-Joo-2024-Profile-of-Social-Work-License-Examinees-07-30-2024.pdf> at 2.

²⁰ Joy Kim, MSW, PhD & Michael Joo, MSW, PhD, “The Determinants of Licensing Exam Outcomes: The Compounding Effects of Individual, Institutional, and Community Factors,” Rutgers School of Social Work (2024).

²¹ Joy Kim, MSW, PhD & Michael Joo, MSW, PhD “The Effects of Race/Ethnicity on Clinical Exam Outcomes: Diminished (Yet Persistent) Effects When Other Determinants are Controlled,” Rutgers School of Social Work (2024).

X. Conclusions and Next Steps

The Board will continue to engage with stakeholders, both passively and with intention. Intentionally, the Board will include stakeholder discussion as an agenda item in its ad hoc committee meetings. The ad hoc committee will invite stakeholders to present information, help shape the discussion and provide input into the development of any recommendations. The Board and staff will attend the ASWB biannual conferences to stay involved and knowledgeable about research and activity at the national level and with other states. Passively, the Board receives public comment at every meeting, and all meetings are open to the public. Ongoing engagement with associations and stakeholders should lead to additional public and stakeholder involvement at meetings.

At future Board meetings, the Board will review other states' alternative pathways and determine the feasibility and desirability of such implementation in Virginia for effectively measuring competency and ensuring protection of the public. Likewise, the Board will continue to review its regulations on an ongoing basis to ensure sufficient accountability and also reduce unnecessary barriers.

Specifically, the Board will seek flexibility in the administration of the examination. For instance, determining what changes can be made to allow applicants to take the LCSW licensure examination at any time, rather than having to wait until after completion of their supervision. Such flexibility would allow applicants to take the examination closer to completion of their education. Other professions, such as licensed professional counselors and licensed marriage and family therapists, allow this flexibility.

Reworking the current structure of the Licensed Master's Social Worker ("LMSW") and the registration of supervisees in social work may also address this issue. Currently, the LMSW is a non-clinical license. It requires a master's degree in social work from a CSWE program and passage of the ASWB master's level exam. Individuals with an LMSW must practice under supervision but this scope of practice does not include the provision of clinical social work services. Individuals with a master's in social work who want to provide clinical services and eventually pursue their LCSW must register with the Board as "supervisees in social work." These "supervisees in social work" can provide clinical social work services while under supervision and obtaining their required hours of supervision towards the LCSW. A license at the master's level is not a prerequisite to the LCSW, but registration as a "supervisee in social work" is a prerequisite. This structure causes confusion because many other jurisdictions require an LMSW, with passage of the exam, as a prerequisite to the LCSW and allow this LMSW to provide clinical services. Redefining the LMSW to incorporate "supervisees in social work" and allowing for those LMSW to provide clinical social work services under supervision indefinitely, would provide flexibility and support to those individuals pursuing an LCSW but having difficulty passing the examination. Currently "supervisees in social work" have two to four years to complete their supervision and pass the clinical examination. If they fail the examination, they are required to restart supervision. If Virginia instead required an LMSW, which was not necessarily a prerequisite to the LCSW, those who want to pursue the LCSW and practice independently could do so while under supervision and provide those services indefinitely. If this LMSW failed the clinical exam, then they would remain under supervision until they passed the examination, and the supervisor could

work with LMSW to pass the exam. If they never pass the examination, then they just remain practicing under supervision. This approach would protect the public as the candidate would remain known to the Board and not be engaging in autonomous, unregulated practice. This pathway would give the candidates support, remove the pressure of having to pass the examination within a given amount of time, and allow candidates to continue working. This approach would simultaneously address some workforce needs by expanding the pool of individuals who can provide clinical social work services, with this pool being transparent to employers and the public.

The Board remains committed to its mission to protect the public and license qualified professionals. This commitment means remaining responsive to and engaged with stakeholders to address competency, fairness, and workforce issues as they arise.

Behavioral Sciences Regulatory Board

Survey of Social Workers

February 2024

Introduction	3
<u>Question 1.</u> In what county/counties do you practice social work?	4
<u>Question 2.</u> Do you practice in a predominantly urban area, rural area, or frontier area?	20
<u>Question 3.</u> What is the highest level of social work license you have attained in Kansas?	21
<u>Question 4.</u> Would bachelor’s-level social workers be interested in moving from a single-state license to a multi-state license if Kansas joins a multi-state compact?	22
<u>Question 5.</u> Would master’s-level social workers be interested in moving from a single-state license to a multi-state license if Kansas joins a multi-state compact?	23
<u>Question 6.</u> Would clinical-level social workers be interested in moving from a single-state license to a multi-state license if Kansas joins a multi-state compact?	24
<u>Question 7.</u> Should Kansas discontinue requiring passage of a national examination as a license requirement for a bachelor's-level permanent social work license?	25
<u>Question 8.</u> Should Kansas discontinue requiring passage of a national examination as a license requirement for a master's-level permanent social work license?	26
<u>Question 9.</u> Should Kansas discontinue requiring passage of a national examination as a license requirement for a clinical-level permanent social work license?	27
<u>Question 10.</u> If you provided clinical-level supervision to practitioners over the past two years, have you provided any supervision by televideo, rather than in-person?	28
<u>Question 11.</u> If you provided clinical-level supervision by televideo over the past two years, based on your experiences, do you believe this flexibility has resulted in mostly positive changes, mostly negative changes, or something else? Based on what you have observed, has the ability to provide supervision remotely helped individuals better access supervision?	29
<u>Question 12.</u> If you received clinical-level supervision over the past two years, have you received any supervision by televideo, rather than in person?	42
<u>Question 13.</u> If you received clinical-level supervision by televideo over the past two years, do you believe the quality of supervision provided remotely has been mostly positive, mostly negative, or something else? Has the ability to receive supervision remotely helped with accessing supervisors? ...	43
<u>Question 14.</u> Do you believe lowering the required number of continuing education hours from 40 hours to 30 hours would negatively affect professionalism and safe practice?	61
Additional Comments.....	62

Introduction

In the fall of 2023, members of the Social Work Advisory Committee for the Kansas Behavioral Sciences Regulatory (BSRB) requested the creation of a survey for social work licensees under the BSRB. The purpose of the survey was to collect input on matters affecting the social work profession and topics relevant to the work of the Advisory Committee. (The BSRB previously collected input from social work licensees using surveys in 2015 and 2021.) The Advisory Committee requested the Executive Director draft potential questions for a survey concerning the topics of clinical supervision, supervision by televideo, a proposed multi-state compact for the social work profession, the license examinations for each level of permanent license, and continuing education.

At the December 5, 2023, meeting of the Social Work Advisory Committee, the Executive Director presented draft questions to the members of the Advisory Committee for review and consideration. The members of the Advisory Committee expressed support for the questions and requested a short survey to obtain both qualitative and quantitative data. Additionally, questions were included on the survey to determine whether responses were submitted by a broad range of practitioners, including social workers practicing in urban, rural, and frontier areas.

As of January 12, 2024, the number of social workers with a permanent license under the BSRB totaled 8,288, including practitioners with associate level licenses, bachelor's level licenses, master's level licenses, and clinical level licenses. On Friday, February 2, 2024, all permanently licensed social workers under the BSRB received an e-mail from the BSRB stating that a message would be sent directly to them from SurveyMonkey.com with a link to complete a fourteen-question survey from the Social Work Advisory Committee for the BSRB, on topics relevant to the social work profession, and those individuals were encouraged to complete the survey. Licensees were asked to complete the survey no later than the end-of-the day on Friday, February 9, 2024. Reminder messages were sent to licensees who had not yet completed the survey on Wednesday, February 7, 2024, and Friday, February 9, 2024. The survey was officially closed at noon on Saturday, February 10, 2024.

Over the period of time that the survey was open for responses, 2,716 social workers completed the survey (compared to 1,087 social workers who completed a similar survey offered by the BSRB in December 2021). The results of the 2024 survey are included on the following pages.

Note: the following pages include survey responses from the social workers who completed the survey. Identical responses were groups and small edits were made for spelling and grammar, but otherwise language in this report reflects responses as they were provided in the survey.

Question 1. In what county/counties do you practice social work?

0

27

16 north west Kansas counties

17 Northwest Kansas

23 County's in SW KS.

Across the state in multiple and varying counties

Across the state, primarily Douglas

All (46 Responses)

All 105 counties (Statewide position)

All counties in the states of Kansas and Missouri

All counties in the states of Kansas and Oregon

all Kansas and Nebraska counties

All Kansas counties via Telehealth

All of Kansas telehealth

All of Kansas via telehealth

All of rural KS

All over NW and SW KS

All State of Kansas Counties

All via telehealth, Shawnee in person

All, practice located in Johnson

Allen (2 Responses)

Allen and Neosho

Allen, Anderson, and Neosho

Allen, Anderson, Clark, Finney, Ford, Gray, Haskell, Hodgeman, Johnson, Meade, and Seward

Allen, Crawford, Labette, Neosho, and Woodson

Allen, Labette, Montgomery, Neosho, Wilson, and Woodson

Allen, Neosho, and Woodson

Allen, Neosho, Wilson, and Woodson (2 Responses)

Allen, Neosho, Woodson, Wilson

America, Kansas, NE counties

Anderson

Anderson, Douglas, and Johnson

Anderson, Douglas, Johnson, Leavenworth, and Wyandotte

Anderson, Kansas, United States

Anderson, Linn, and Miami

Anderson/Allen

Arizona - returning to Kansas this year

Atchison (8 Responses)

Atchison and Leavenworth

Atchison and Leavenworth (2 Responses)

Atchison, Brown, and Leavenworth

Atchison, Brown, Clay, Jackson, Jefferson, and Nemaha

Atchison, Brown, Jackson, and Shawnee

Atchison, Douglas, Franklin, Johnson, and Shawnee

Atchison, Douglas, Johnson, Leavenworth, and Wyandotte (2 Responses)

Atchison, Douglas, Johnson, Leavenworth, Miami, Wyandotte

Atchison, Douglass, Johnson, Leavenworth, and Wyandotte

Atchison, Jefferson, Leavenworth, Miami, and Wyandotte

Atchison, Johnson, Leavenworth, Shawnee, and Wyandotte

Atchison, Leavenworth, and Wyandotte

Atchison, Leavenworth, and Wyandotte (2 Responses)

Atchison/Brown

Available in all due to virtual option but mostly Johnson and where K-State is

BA BU CL EK GW HP KM PR SU

Barber, Butler, Cowley, Elk, Greenwood, Harper, Kingman, Pratt, Sedgwick, and Sumner

Barber, Butler, Cowley, Elk, Greenwood, Harper, Kingman, Pratt, Sedgwick, and Sumner

Barber, Butler, Cowley, Harper, and Sedgwick

Barber, Harper, Kingman, and Pratt

Barber, Harper, Kingman, Pratt, and Sumner

Barber, Harper, Kingman, Pratt, Reno, and Sedgwick

Barber, Kingman, Pratt, Harper, Sumner, Cowley, Butler, Elk, Greenwood

Barton (3 Responses)

Barton and Ellis telehealth throughout the state

Barton and Pawnee

Barton, Butler, Ellsworth, Leavenworth, Norton, Pawnee, Reno, and Shawnee, and Sumner

Barton, Cedar, and Vernon

Barton, Ford, Pawnee, and Russell

Barton, Pawnee, Reno, and Sedgwick

Barton, Pawnee, Rice, and Stafford

Barton, Pawnee, Stafford

Barton, Rice, Stafford, Pawnee, Reno, Saline

Based in Sedgwick, but practice across the state

Bexar, TX

Bourbon (4 Responses)

Bourbon, Cherokee, Crawford, and Linn

Bourbon, Cherokee, Crawford, and Linn and others

Bourbon, Crawford, Cherokee, Labette, Montgomery

Bourbon, Crawford, Linn, and Miami

Brown (3 Responses)

Brown and Jackson

Brown and Nemaha

Brown Jackson Doniphan Nemaha

Brown, Atchison, Doniphan, Nemaha, and Jackson counties

Brown, Doniphan, Jackson, and Nemaha

Brown, Doniphan, Jackson, Johnson, Marshall, Nemaha, and Shawnee

Brown, Doniphan, Leavenworth, and Marshall

Brown, Doniphan, Nemaha, Marshall, Jefferson, Jackson, Pottawatomie, Wabaunsee.
Sometimes Shawnee.

Brown, Nemaha

Brown, Nemaha, and Shawnee

Buchanan, MO (2 Responses)

Buchanan, MO, and all surrounding.

Butler (22 Responses)

Butler and Sedgwick

Butler and Sedgwick (5 Responses)

Butler, Barber, Comanche, Cowley, Clark, Chase, Edward's, Greenwood, Kingman, Kiowa,
Marion, Pratt, Rice, Reno, Stanford, Harvey, Harper and Sumner

Butler, Chase, Cowley, Elk, Greenwood, Harper, Harvey, Kingman, Marion, McPherson, Reno,
Saline, Sedgwick, and Sumner

Butler, Cowley, Elk, Greenwood, Kingman, Pratt, Sedgwick, and Sumner

Butler, Cowley, Harper, Harvey, Kingman, Sedgwick, Sumner

Butler, Cowley, Harvey, Kingman, Reno, Sedgwick, and Sumner

Butler, Cowley, Harvey, Reno, and Sedgwick

Butler, Cowley, McPherson, Reno, Rice, and Sedgwick

Butler, Cowley, Pratt, Sedgwick, and Sumner

Butler, Elk, and Greenwood

Butler, Elk, Greenwood, and Sedgwick

Butler, Ellsworth, Norton, Pawnee, Reno, Sedgwick, and Shawnee

Butler, Harvey, and Sedgwick (2 Responses)

Butler, Harvey, Jackson, Sedgwick, Wilson, and any county in KS for virtual needs

Butler, Harvey, Sedgwick, and Sumner

Butler, Kingman, Sedgwick, and Sumner

Butler, Labette, and Montgomery

Butler, Pratt, and Sedgwick

Butler, Reno, Saline, and Sedgwick

Butler, Sedgwick (5 Responses)

Butler, Sedgwick, Harvey

Butler, Sedgwick, McPherson

Butler, Sedgwick, Sumner

Butler, Sedgwick, Sumner, Cowley, multiple other counties across Kansas.

Cass and Johnson

Cass, Clay, and Jackson

Cass, Clay, Douglas, Jackson, Jefferson, Johnson, Jefferson, and Miami

Cass, Clay, Jackson, Johnson, and Wyandotte

Cass, Clay, Jackson, Johnson, Platte, and Wyandotte

Cass, Clay, Jackson, Johnson, Shawnee, and Wyandotte

Cass, Clay, Jackson, MO, Johnson, and Wyandotte

Cass, MO (2 Responses)

Chase

Chase, Coffey, Greenwood, Lyon, Morris, Osage, and Wabaunsee

Chase, Geary, Harper Lyon, Marion, McPherson, and Reno

Chase, Lyon, and Morris

Chautauqua

Chautauqua, Cowley, Elk, Montgomery, and Wilson

Chautauqua, Cowley, Elk, Montgomery, and Wilson

Chautauqua, Cowley, Elk, Montgomery, and Wilson

Chautauqua, Elk, Greenwood, Montgomery, and Wilson

Chautauqua, Greenwood, Montgomery, and Wilson

Cherokee (5 Responses)

Cherokee and Crawford

Cherokee, Crawford, Labette

Cherokee, Labette, Crawford, Montgomery

Cheyenne, Decatur, Ellis, Gove, Graham, Logan, Norton, Osborne, Phillips, Rawlins, Rooks, Sherman, Smith, Thomas, Trego, and Wallace

Cheyenne, Ellis, Finney, Greely, Gove, Hamilton, Kearny, Lane, Logan, Ness, Rawlins, Rush, Russell, Scott, Sheridan, Sherman, Thomas, Trego, Wallace and Wichita

Clark, Comanche

Clark, NV (2 Responses)

Clay (11 Responses)

Clay and Jackson

Clay and Johnson

Clay and Ray counties for one job (school job). I work in downtown Kansas City at Children's Mercy where we serve a wide range of counties from both Kansas and Missouri.

Clay, Cloud, Geary, Jewell, Johnson, Mitchell, Pottawatomie, Republic, Riley, Washington, and Wyandotte

Clay, Cloud, Geary, Jewell, Marshall, Mitchell, Pott, Republic, Riley, and Washington

Clay, Cloud, Marshall, and Republic

Clay, Cloud, Marshall, Republic, Riley, Washington

Clay, Cloud, Washington, Mitchell, Republic

Clay, Dickinson, Geary, Marshall, Morris, and Riley

Clay, Dickinson, Geary, Pottawatomie, Republic, Riley, and Washington

Clay, Dickinson, Lincoln, Ottawa, and Saline

Clay, Jackson, and Johnson (4 Responses)

Clay, Jackson, and Platt

Clay, Jackson, Johnson, and Platte

Clay, Jackson, Johnson, Platte, and Ray

Clay, Jackson, Johnson, Platte, and Wyandotte

Clay, Jackson, Platte, and Wyandotte

Clay, Jackson, Ray in Mo and Johnson and Wyandotte in Kansas

Clay, Johnson, and Wyandotte

Clay, Johnson, Lawrence, Platte, Shawnee, and Wyandotte

Clay, MO, and Johnson, KS (2 Responses)

Clay, Phillips, and Riley
Clay, Pottawatomie, and Riley
Clay, Ray, and Platte counties in Missouri
Clay, Washington, Riley, Marshall, Republic, Cloud

Cloud (3 Responses)

Cloud and surrounding 64 counties.
Cloud republic
Cloud, although telehealth in Kansas
Cloud, Dickinson, Ellsworth, Kingman, Lincoln, McPherson, Saline, and Sedgwick
Cloud, Geary, and Riley
Cloud, Harvey, Lincoln, Marion, Republic, and Saline
Cloud, Jewell, Lincoln, Mitchell, and Republic
Coffee, Jackson, Lyon, Riley, and Shawnee

Coffey (2 Responses)

Coffey and Lyon
Contiwa, Greene, Phelps, and St. Louis
Cook, IL

Cowley (15 Responses)

Cowley and Montgomery
Cowley and Sumner
Cowley, Chautauqua, Montgomery
Cowley, Crawley, Ellis, Harvey, Reno, Sedgwick, and Sumner
Cowley, Elk, Montgomery, and Wilson
Cowley, Sedgwick, and Sumner

Cowley, Sumner (3 Responses)

CQ and Elk

Crawford (26 Responses)

Crawford and Cherokee
Crawford, Bourbon, Linn
Crawford, Johnson, and Wyandotte
Crawford, Montgomery, and Neosho
Crowley, Harvey, Sedgwick, and Sumner
Cumberland, ME

Currently employed as a Nurse not a Social Worker
Currently live overseas as a military spouse

Currently not practicing (4 Responses)

Currently not practicing. Spouse is active-duty military and we live out of state
Currently out of state
currently out of state. looking for telehealth options
Currently, none.

Dallas

Daviess, Grundy, Livingston, Caldwell, Carroll, Linn, Harrison (MO)

Decatur
Denton
Denton, TX
Denver
Dickenson, McPherson, Ottawa, and Saline
Dickinson (3 Responses)
Dickinson, Ellsworth, Ottawa, and Saline
Dickinson, Geary, and Riley
Dickinson, Geary, Potawatomie, and Riley
Dickinson, Geary, Sedgwick
Dickinson, Johnson, Leavenworth, McPherson, Saline, and Wyandotte
Dickinson, Saline, Geary, Clay
Do not practice in Kansas.
Douglas (134 Responses)
Douglas and Franklin
Douglas and Jackson
Douglas and Jefferson (2 Responses)
Douglas and Johnson (12 Responses)
Douglas and Leavenworth
Douglas and Miami
Douglas and Shawnee (8 Responses)
Douglas and throughout Belgium, Spain, and Portugal.
Douglas, but Jefferson and Shawnee people come to the office
Douglas, Ellis, Johnson, and Wyandotte
Douglas, Franklin, Jackson, Jefferson, Johnson, Leavenworth, Miami, Shawnee, Wabaunsee, and Wyandotte
Douglas, Franklin, Jefferson
Douglas, Franklin, Johnson, and Miami (2 Responses)
Douglas, Franklin, Johnson, Leavenworth, Linn, Miami, and Wyandotte
Douglas, Franklin, Johnson, Leavenworth, Miami, and Wyandotte
Douglas, Franklin, Johnson, Linn, and Miami
Douglas, Franklin, Johnson, Osage, Wyandotte
Douglas, Geary, Johnson, Riley, and Shawnee
Douglas, Geary, Johnson, Shawnee, and Wyandotte
Douglas, Geary, Marshall, Riley, and Shawnee
Douglas, Harvey, Leavenworth, Sedgwick, and Sumner
Douglas, Jackson, and Johnson
Douglas, Jackson, Jefferson, and Shawnee
Douglas, Jackson, Johnson, and Shawnee
Douglas, Jackson, Johnson, Shawnee, and Wyandotte
Douglas, Jackson, Osage, and Shawnee
Douglas, Jackson, Osage, Shawnee, and Wabaunsee
Douglas, Jefferson, and Shawnee (2 Responses)

Douglas, Johnson, and Wyandotte (4 Responses)

Douglas, Johnson, Leavenworth, and Shawnee
Douglas, Johnson, Leavenworth, and Wyandotte
Douglas, Johnson, Lyon, Pottawatomie, and Shawnee
Douglas, Johnson, Miami, Pottawatomie, and Shawnee
Douglas, Johnson, Pottawatomie, Shawnee, and Wabaunsee
Douglas, Johnson, Reno, Scott, Shawnee, Wyandotte
Douglas, Johnson, Riley, Shawnee, and Wyandotte
Douglas, Johnson, Sedgwick, Franklin, Shawnee
Douglas, Johnson, Shawnee, and Wyandotte
Douglas, Leavenworth, and Shawnee
Douglas, Leavenworth, and Wyandotte
Douglas, Osage, and Shawnee
Douglas, plus Iowa and Nebraska.
Douglas, Shawnee, Johnson, Wyandotte, Edwards
Douglas, Wyandotte, Johnson

Edwards (3 Responses)

Edwards and Ford

Ellis (10 Responses)

Ellis and Trego
Ellis, Ellsworth, Russell, and Rush
Ellis, Ford, Phillips, Russell, and Rush
Ellis, Morris, Neosho, Pawnee, Reno, and Sedgwick
Ellis, Norton, Osborne, Phillips, and Smith
Ellis, Norton, Osborne, Russell, and Smith
Ellis, Phillips, Thomas
Ellis, Sedgwick, Wyandotte
Ellsworth
Ellsworth, Ottawa, and Saline
Ellsworth, Saline, and cover other counties as needed.

Entire State

Federal level

Finney (17 Responses)

Finney and Ford
Finney, Ford, Grant, and surrounding.
Finney, Gray, Scott, Lane, Kearny, Hamilton, Ford Hodgeman
Finney, Kearney, Hamilton
Finney, Scott
Finney, Scott, and Thomas
Finney, Scott, Ford, Greeley, Wichita, Lane
Finney, Seward, Lane

Florida (2 Responses)

Ford

Ford (7 Responses)

Ford and Gray

Ford and Sedgwick

Ford and Shawnee

FR, CF, OS, AN, MI, LN, BB

Franklin (5 Responses)

Franklin and Miami

Franklin and Wyandotte

Franklin, Anderson, Coffey and Osage counties

Franklin, Harvey, Johnson, and Wyandotte

Franklin, Johnson, Leavenworth, Miami, and Wyandotte

Franklin, Lyon, and Osage

Franklin, Miami, Osage, Anderson, Allen, Linn, Coffey, Neosho, Woodson, Wilson, Bourbon, Crawford, Cherokee, Labette, Montgomery, Chautauqua

From Geary Co east to the state line, and from Nebraska to Oklahoma

Geary (25 Responses)

Geary and Manhattan

Geary and Riley

Geary and Riley (7 Responses)

Geary, Lyon, and Morris

Geary, Lyon, Riley, and Saline - wherever I am needed.

Geary, Marshall, Morris, Pottawatomie, Riley, and Wabaunsee

Geary, Marshall, Pottawatomie, and Riley

Geary, Morris

Geary, Pottawatomie, and Riley

Geary, Riley, and Shawnee

Geary, Riley, Pottawatomie

Geary, Riley, Wabaunsee

Grant, Johnson and surrounding areas

Gray

Greene

Greenwood

Greenwood, Lyon, Osage, and Wabaunsee

Harper

Harper, Kingman, and Sedgwick

Harvey (19 Responses)**Harvey and McPherson (2 Responses)****Harvey and Reno (2 Responses)****Harvey and Sedgwick (9 Responses)**

Harvey, Kingman, Lyons, McPherson, Reno, and Stafford

Harvey, Marion, and McPherson (4 Responses)

Harvey, Marion, and Saline

Harvey, Marion, McPherson

Harvey, Marion, McPherson, and Sedgwick (2 Responses)

Harvey, Marion, McPherson, Reno, and Rice

Harvey, Marion, McPherson, Reno, Rice, and Sedgwick

Harvey, Reno, and Sedgwick

Hawaii

Hays

I am dual licensed and work on the Missouri side.

I am in Jackson, MO, and I practice on zoom in KS and MO, where I am licensed.

I am not currently employed as a social worker but continue to hold my license.

I am telehealth only in Kansas, based in St Louis MO

I currently work out of state.

I do not currently practice because I am parenting/ living in TX.

I don't practice in Kansas.

I Live in New Mexico. I am retired.

I practice in Colorado Springs but am licensed in both Colorado and Kansas. El Paso, CO.

I practice in Jackson Co. Missouri

I retired from DCF but will answer because I maintain my license and will continue to earn CEUs to maintain license.

I work for the Federal Government so I practice on military installations

I work virtually.

I work virtually so I can see clients in every Kansas county, but I am in Sedgwick.

I'm not practicing at this time.

I'm retired but maintain my license. I spent my last 21 years working in Reno.

I'm licensed but don't currently practice SW.

In Kansas Johnson Co in Missouri several counties.

Jackson (57 Responses)

Jackson (MO), Johnson, and Wyandotte

Jackson and Johnson (10 Responses)

Jackson and Platte Counties in MO - I serve MO and KS patients.

Jackson and Pottawatomie

Jackson and Shawnee (3 Responses)

Jackson and Wyandotte

Jackson MO telehealth

Jackson primarily (2 Responses)

Jackson, Jefferson, Shawnee, and surrounding.

Jackson, Johnson, and Leavenworth

Jackson, Johnson, and Wyandotte

Jackson, Johnson, and Wyandotte

Jackson, Johnson, and Wyandotte (2 Responses)

Jackson, MK, and Johnson, KS

Jackson, MO (24 Responses)

Jackson, MO and Leavenworth, KS

Jackson, MO, and Johnson, KS (20 Responses)

Jackson, MO, and Wyandotte, KS

Jackson, MO, Johnson, and Wyandotte

Jackson, MO, Telehealth Johnson, KS

Jasper (2 Responses)

Jefferson (5 Responses)

Jefferson and Shawnee (2 Responses)

Jefferson, Johnson, Shawnee, and Wyandotte

Jefferson, Ks, but I am an online practitioner, so I have clients from all over the state.

Jefferson, Leavenworth, Shawnee, Douglas, and Wyandotte

Jewell

JO, WY, DG, LV, AT

John

Johnson (348 Responses)

Johnson and JA, MO

Johnson and Leavenworth (2 Responses)

Johnson and Miami

Johnson and Miami

Johnson and Overland Park

Johnson and Sedgwick

Johnson and Shawnee (7 Responses)

Johnson and surrounding counties

Johnson and Wilson

Johnson and Wyandotte (50 Responses)

Johnson Douglas Franklin Miami Wyandotte

Johnson Douglas-in Kansas and Jackson-in Missouri

Johnson mostly

Johnson primarily but I am clinically licensed in KS and MO.

Johnson, but I have staff across northeastern Kansas.

Johnson, Douglas, Franklin, Leavenworth, Miami, and Wyandotte

Johnson, Kingman, and Wilson

Johnson, KS, and Clay, MO

Johnson, Leavenworth, and Wyandotte (5 Responses)

Johnson, Leavenworth, Linn, Miami, and Wyandotte

Johnson, Leavenworth, Wyandotte (2 Responses)

Johnson, Leavenworth, Wyandotte, Jackson (MO)

Johnson, Lyon, Osage, and Shawnee

Johnson, Miami (2 Responses)

Johnson, Miami, and Wyandotte

Johnson, Miami, and Wyandotte (5 Responses)

Johnson, Ray, Clay, and Platte, MO

Johnson, Sedgwick, and Shawnee (2 Responses)

Johnson, Shawnee, and Wyandotte (3 Responses)

Johnson, St. Louis, Wyandotte

Johnson, Wyandotte, and others

Johnson, Wyandotte, KC Metro

Johnson, Wyandotte, whole KC metro

Kansas (16 Responses)

Kansas and Missouri

Kansas City, KS

Kansas City, MO (previously Johnson Co)

Kansas remote

Kansas Telehealth

Kansas, Missouri

Kansas-retired

KC metro

KC MO and KC KS metro areas and surrounding

Kearny

Kingman (2 Responses)

Kingman and Pratt

Kiowa

KS and AZ

KS and Missouri. Office in Johnson

Ks and MO counties. Mainly metro KC area

Labette (12 Responses)

Labette and Neosho

Labette and Newton

Labette, Montgomery, and Neosho

Lake

Lane

Lauren

Lawrence

Leavenworth (32 Responses)

Leavenworth and Ellis

Leavenworth and Shawnee (4 Responses)

Leavenworth and Wyandotte (2 Responses)

Leavenworth, Sedgwick, and Shawnee

Licensed in KS. Working in MO.

Lincoln

Lincoln and Russell

Logan and Sheridan

LV, DP, JO, AT, WY, DG, FR

Lyon (10 Responses)

Lyon and Greenwood

Lyon and Osage

Lyon, Morris, and Shawnee

Lyon, Pottawatomie, and Shawnee

Mainly Reno but can reach all in Kansas.

Manatee

Many, I work virtually.

Many.

Marion (5 Responses)

Marion and McPherson

Marion and Shawnee

Marion, McPherson, and Reno

Marion, Reno, Saline, and Sedgwick

Marshall (2 Responses)

Marshall and Nemaha

Marshall and Washington

Marshall primarily and others via telehealth as needed/requested.

Marshall, Nemaha, Pottawatomie, Shawnee, and Wabaunsee

McPherson (11 Responses)

McPherson and Reno (2 Responses)

McPherson, Reno, and Saline

Meade and Seward

Miami

Miami (18 Responses)

Miami and Franklin

Missouri (9 Responses)

Missouri Clay Platte Ray

Missouri- Clay, Platte, Jackson. Occasionally Shawnee, KS

Missouri, US

Mitchell (3 Responses)

MO, KS, SD, IA

Monmouth

Montgomery

Montgomery (2 Responses)

Montgomery and Wilson

Montgomery, Cowley, Wilson, Elk, CQ

Montgomery, MD

Morris

Morris and Shawnee

Most of Kansas (2 Responses)

Mostly in the KC area, I just got licensed in Missouri as well due to the proximity, but I haven't needed to utilize it yet.

Multiple -- all for metro KC

Multiple (4 Responses)

My office is in Saline. I see people from the surrounding area via telehealth, e.g., Ellsworth, Finney, and Lincoln.

My team practices across Kansas

N/A - not currently practicing (2 Responses)

N/A (10 Responses)

Nassau Florida

NE Kansas, Douglas, Johnson, Osage, and Shawnee

Nebraska (DCF PRC part time work)

Nemaha (2 Responses)

Neosho (2 Responses)

No longer practice.

None (11 Responses)

None (Out of State)

None in KS. I am in Indiana right now.

None right now

None, currently. I just moved back from practicing in North Carolina.

None. Retired. (3 Responses)

None-currently retired, volunteer with common table

North central

Northeast Kansas Counties (primarily Johnson, Leavenworth, and Wyandotte)

Norton (2 Responses)

Norton, Phillips, Rooks, Sherman, Smith, and Thomas

Not currently employed/practicing (5 Responses)

Not currently practicing/disabled

Not currently practicing; retired from DCF in 2023

Not in KS just keep license.

Nowata

NT, GH, TR, DC, SD, GO, LO, TH, RA, CH, SH, WA

Oklahoma, OK

Osage (3 Responses)

Osage and Shawnee

Osage and Shawnee (2 Responses)

Osage, Riley, and Shawnee

Osborne, Phillips, Rooks, Russell, and Smith

Ottawa (3 Responses)

Out of state (2 Responses)

Out of State, practice out of Ohio (Cuyahoga)

Outside of Kansas - Fairfax, VA

Oversee multiple staff serving Wyandotte, Johnson and majority of counties in Missouri.

Pawnee (7 Responses)

Phillips (2 Responses)

Physically work in Geary but serve counties across the state via telehealth.

Pinellas

Platte (5 Responses)

Pott and Riley

Pottawatomie (4 Responses)

Pottawatomie and Riley

Pottawatomie and Riley (5 Responses)

Pottawatomie and Shawnee

Pottawatomie and Wabaunsee

Pottawatomie and Wabaunsee

Practiced in Reno

Pratt (2 Responses)

Pratt Kiowa Stafford Rice

Primarily Clinical SW in Douglas, Jackson, Johnson, and Shawnee

Primarily Douglas

Primarily in Missouri

Primarily in the state of Maine, but also Douglas, Rawlins and Morris in Kansas, Boulder in Colorado

Primarily Jefferson- occasionally Shawnee

Primarily Johnson and Wyandotte

Primarily Johnson for my main job. I also work as a virtual therapist and have clients throughout KS and MO.

Primarily Sedgwick, Reno

Remote only

Reno (38 Responses)

Reno and Sedgwick (4 Responses)

Reno, McPherson, Rice, Stafford, Harvey

Reno, Rice, McPherson (2 Responses)

Reno, Rice, McPherson, Barton, Pawnee, Stafford

Retired (5 Responses)

Retired Johnson

Retired still have active license Barton.

Retired was Sedgwick.

Retired/Western Ks previously

Rice (2 Responses)

Riley (52 Responses)

Riley and Pottawatomie (2 Responses)

Riley and Shawnee (2 Responses)

RN, SG,KM, LY, Pt, hV others as assigned

Rural counties in Kansas

Rush

Russell

Saint Louis

Saline (35 Responses)

Saline and surrounding- also MO

Saline primary and multiple other

Saline, Shawnee, and statewide by telemedicine

Sedgwick (396 Responses)

Sedgwick and others with teletherapy
Sedgwick and Shawnee (2 Responses)
 Sedgwick and surrounding
Sedgwick, Butler (8 Responses)
 Sedgwick, live in Kingman.
 Sedgwick, Telehealth across Kansas
 Several
 Several in SW Kansas, mostly in Ford
Seward (3 Responses)
 SG and BU
 SG, BU, Harvey, SU, CL, Reno
 Shawnee - KS; Travis - TX
Shawnee (193 Responses)
Shawnee and surrounding counties (2 Responses)
 Shawnee and Wabaunsee
 Shawnee and Wyandotte
 Shawnee -not working at this time
 Shawnee, Kansas in general via telehealth.
 Shawnee, physical location & see clients virtually all over Kansas.
 Sheridan
Sherman (3 Responses)
Southeast Kansas (3 Responses)
Southwest Kansas (2 Responses)
 Stafford
 State of Kansas
 Statewide supervision
 Statewide but based in Douglas.
 Statewide via Telehealth
 Stay at home mom, applying to MSW program.
 Sumner
Sumner (4 Responses)
 Telehealth
 Telehealth so all are possible. Johnson currently.
Telehealth throughout the state (2 Responses)
 Telehealth, all counties
 Terrent, TX
 The United States
Thomas (2 Responses)
 Topeka/statewide
United States (50 Responses)
 USA/ Riley
 Utah
 Various

Virtual (2 Responses)

Wabaunsee

Washington, DC

Western 65 counties of Kansas

Western half of Kansas

Western Kansas

Western Kansas counties

Wichita

Williamson

Wilson

Woodson

Working through remote/telehealth in Douglas through an agency that serves Brown, Doniphan, Jackson, and Nemaha

WY JO FR MI DG

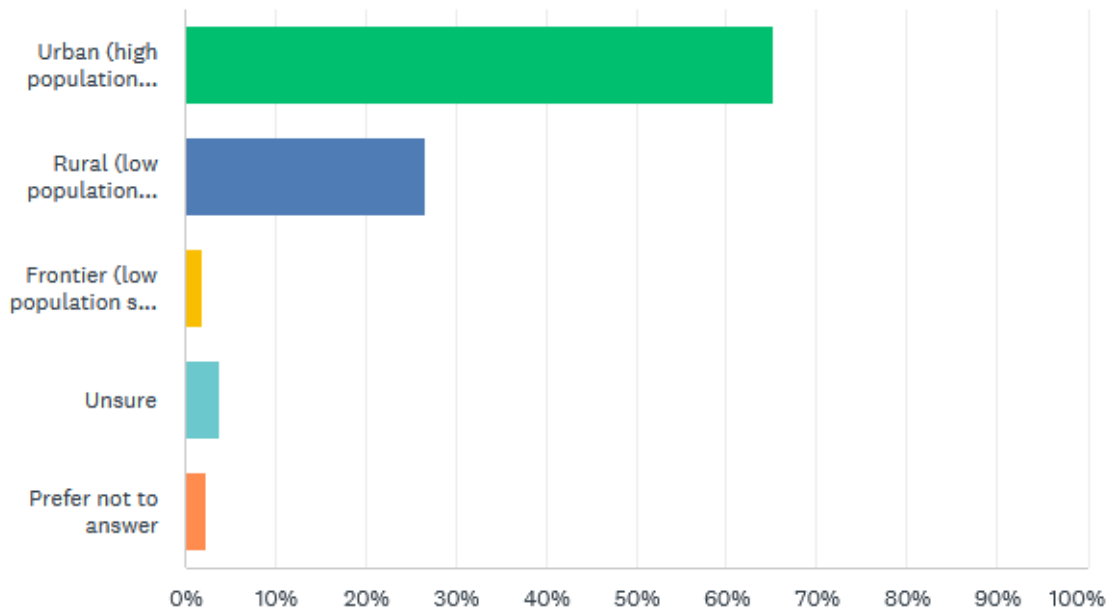
WY/JO/DG/LV/AT

Wyandotte (95 Responses)

Wyandotte (but support KS patients from many counties)

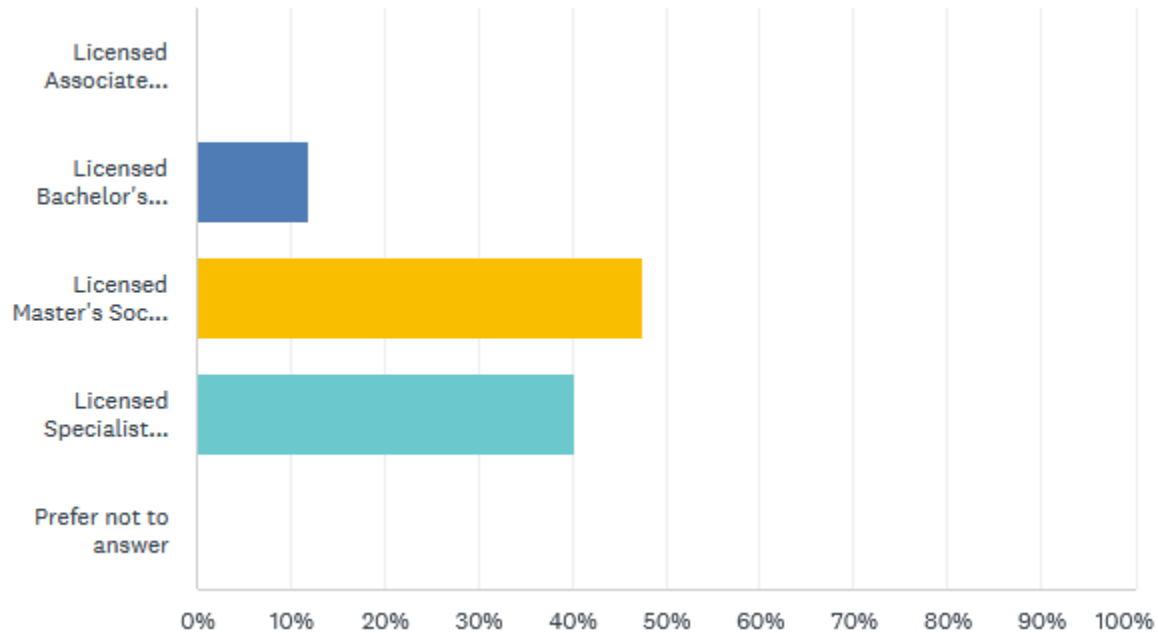
Wyandotte primarily

Question 2. Do you practice in a predominantly urban area, rural area, or frontier area?



ANSWER CHOICES	RESPONSES	
▼ Urban (high population size)	65.23%	1,756
▼ Rural (low population size)	26.63%	717
▼ Frontier (low population size and high geographic remoteness)	2.01%	54
▼ Unsure	3.75%	101
▼ Prefer not to answer	2.38%	64
TOTAL		2,692

Question 3. What is the highest level of social work license you have attained in Kansas?

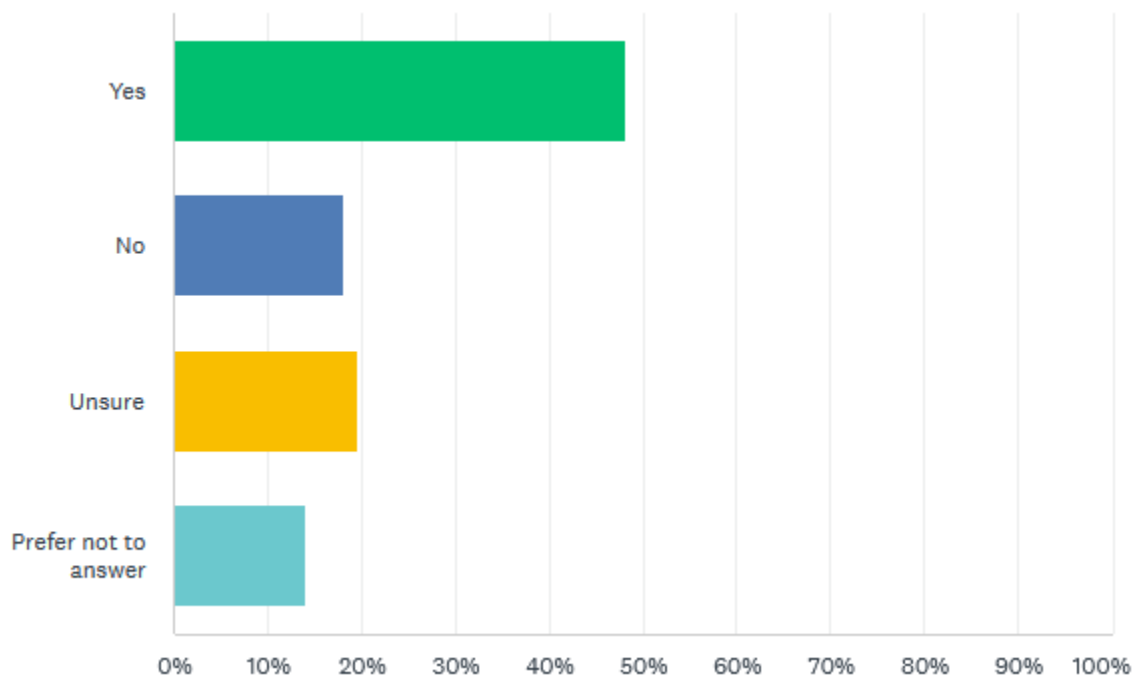


ANSWER CHOICES	RESPONSES	
▼ Licensed Associate Social Work (LASW) license	0.11%	3
▼ Licensed Bachelor's Social Work (LBSW) license	11.91%	323
▼ Licensed Master's Social Work (LMSW) license	47.51%	1,288
▼ Licensed Specialist Clinical Social Work (LSCSW) license	40.21%	1,090
▼ Prefer not to answer	0.26%	7
TOTAL		2,711

Question 4. This question is for bachelor's-level social work licensees. 2024 HB 2484 would add Kansas to a multi-state compact for the social work profession, which would allow Kansas to continue to offer single-state licenses (for practice in Kansas only) or multi-state licenses (which would allow a licensee to practice in Kansas AND all other states that join the multi-state compact).

According to information on the social work compact website swcompact.org, the primary eligibility requirements for an individual to hold a LBSW multi-state license includes: (1) attaining an accredited bachelor of social work degree or higher; (2) passing a qualifying national exam; (3) holding or being eligible for an active, unencumbered license in the home state; (4) payment of any applicable fees; and (5) passage of a background check conducted by the home state.

Currently, the price of an original LBSW license in Kansas is \$100 and the price of a two-year license renewal is \$50. **If totals remained consistent for a single-state license, and prices for multi-state licenses totaled \$200 for an original license and \$100 for a 2-year license renewal, would you be interested in moving from a single-state license to a multi-state license?**

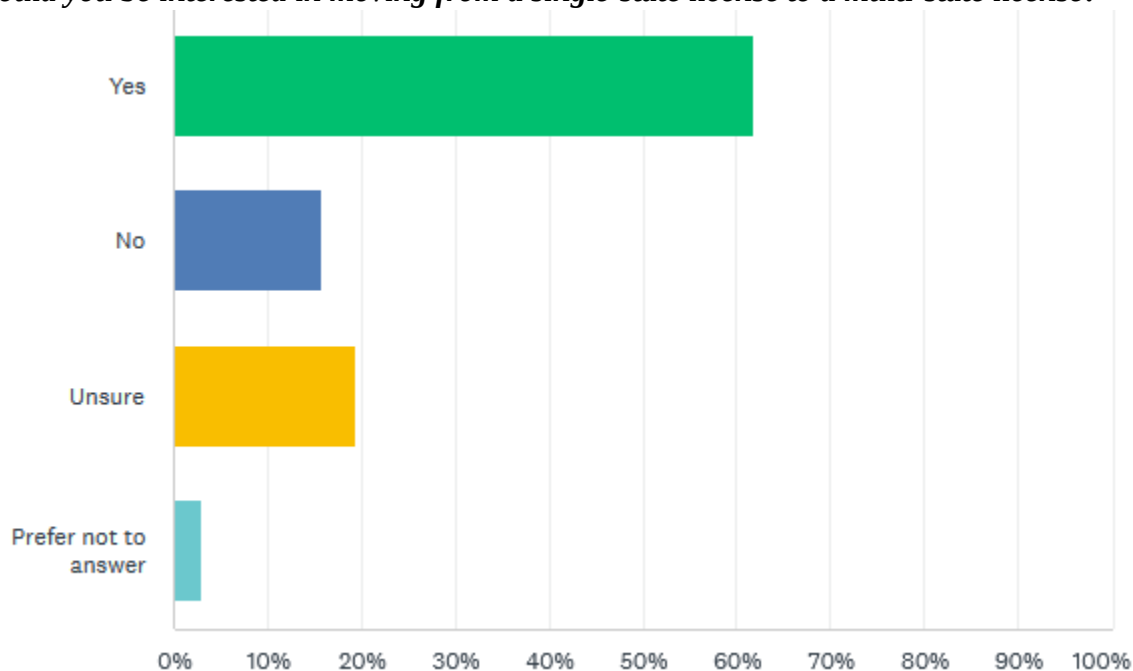


ANSWER CHOICES	RESPONSES	
▼ Yes	48.18%	265
▼ No	18.18%	100
▼ Unsure	19.64%	108
▼ Prefer not to answer	14.00%	77
TOTAL		550

Question 5. This question is for master's-level social work licensees. 2024 HB 2484 would add Kansas to a multi-state compact for the social work profession, which would allow Kansas to continue to offer single-state licenses (for practice in Kansas only) or multi-state licenses (which would allow a licensee to practice in Kansas AND all other states that join the multi-state compact).

According to information on the social work compact website swcompact.org, the primary eligibility requirements for an individual to hold a LMSW multi-state license includes: (1) attaining an accredited master's of social work degree or higher; (2) passing a qualifying national exam; (3) holding or being eligible for an active, unencumbered license in the home state; (4) payment of any applicable fees; and (5) passage of a background check conducted by the home state.

Currently, the price of an original LMSW license in Kansas is \$150 and the price of a two-year license renewal is \$75. **If totals remained consistent for a single-state license, and prices for multi-state licenses totaled \$300 for an original license and \$150 for a 2-year license renewal, would you be interested in moving from a single-state license to a multi-state license?**

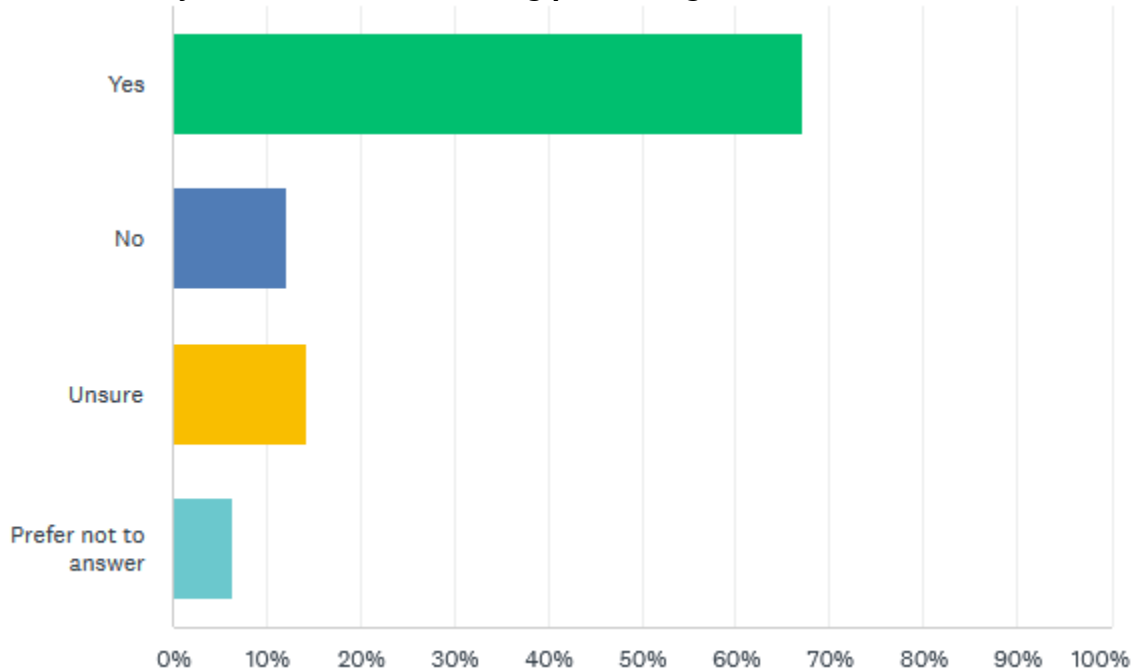


ANSWER CHOICES	RESPONSES	
▼ Yes	61.84%	977
▼ No	15.70%	248
▼ Unsure	19.49%	308
▼ Prefer not to answer	2.97%	47
TOTAL		1,580

Question 6. This question is for clinical-level social work licensees. 2024 HB 2484 would add Kansas to a multi-state compact for the social work profession, which would allow states to continue to office single-state licenses (for practice in Kansas only) or multi-state licenses (which would allow a licensee to practice in Kansas AND all other states that join the multi-state compact).

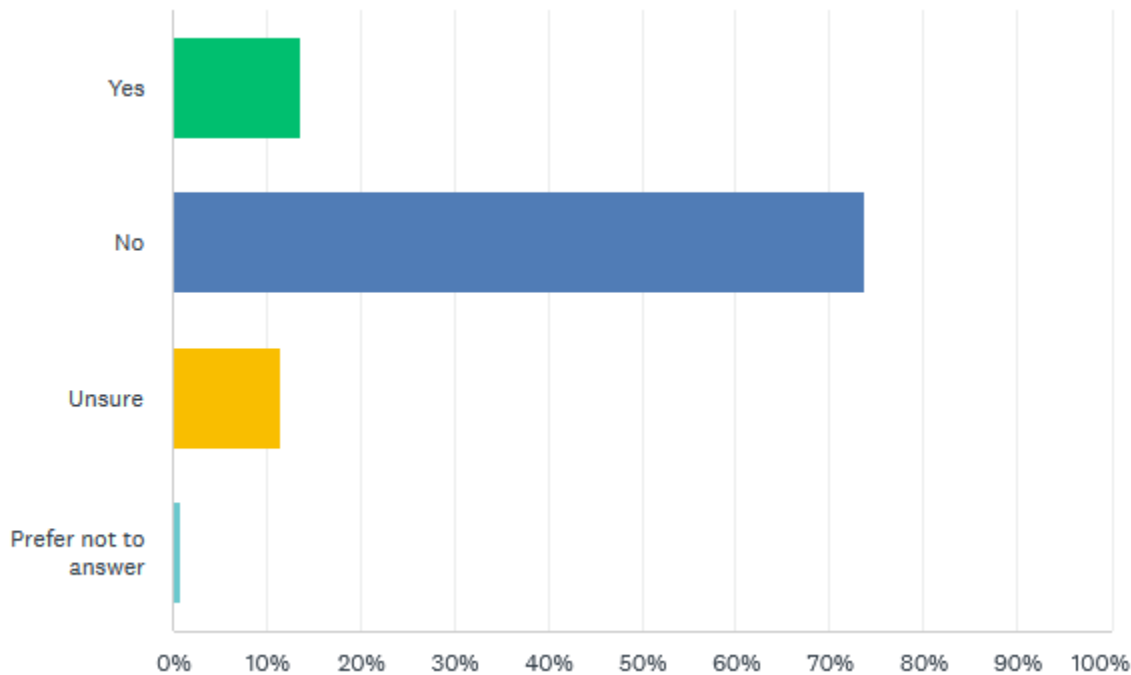
According to information on the social work compact website swcompact.org, the primary eligibility requirements for an individual to hold a clinical social work multi-state license includes: (1) attaining an accredited bachelor of social work degree or higher; (2) passing a qualifying national exam; (3) completion of 3,000 hours or 2-years of post-graduate supervised clinical practice; (4) holding or being eligible for an active, unencumbered license in the home state; (5) payment of any applicable fees; and (6) passage of a background check conducted by the home state.

Currently, the price of an original clinical social work license in Kansas is \$150 and the price of a two-year license renewal is \$100. **If totals remained consistent for a single-state license, and prices for multi-state licenses totaled \$300 for an original license and \$200 for a 2-year license renewal, would you be interested in moving from a single-state license to a multi-state license?**



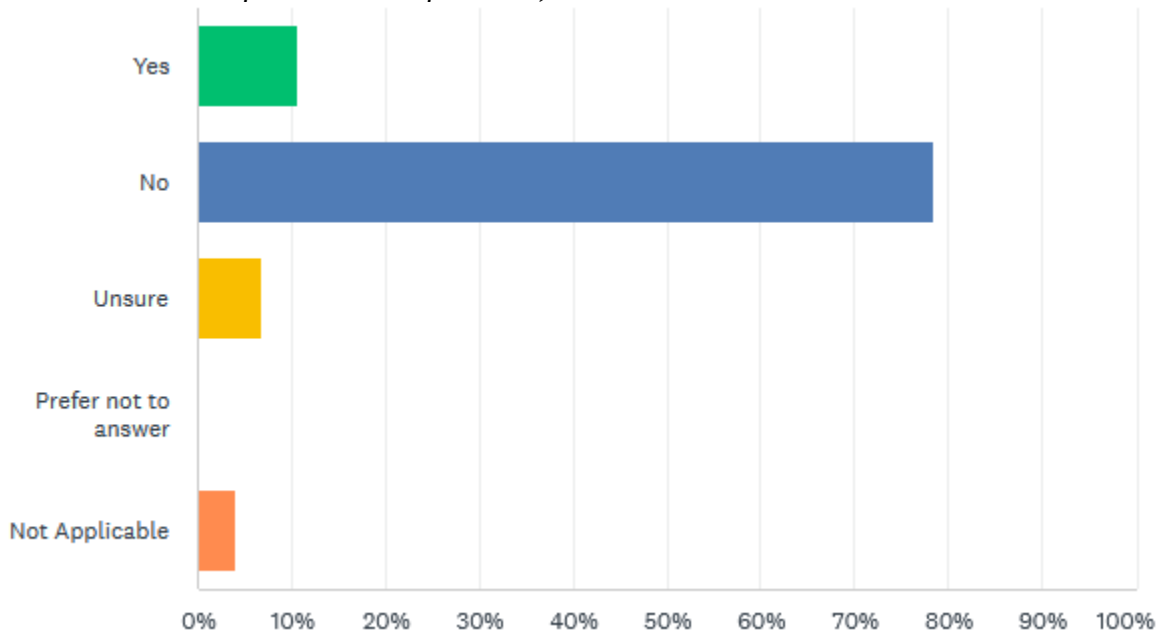
ANSWER CHOICES	RESPONSES	
▼ Yes	67.06%	855
▼ No	12.24%	156
▼ Unsure	14.35%	183
▼ Prefer not to answer	6.35%	81
TOTAL		1,275

Question 7. This question is for all social work licensees. Should Kansas discontinue requiring passage of a national examination as a license requirement for a bachelor's-level permanent social work license? (Note: A change to this requirement would require a change to law. Also, the social work multi-state compact requires passage of a national examination for this level of license.)



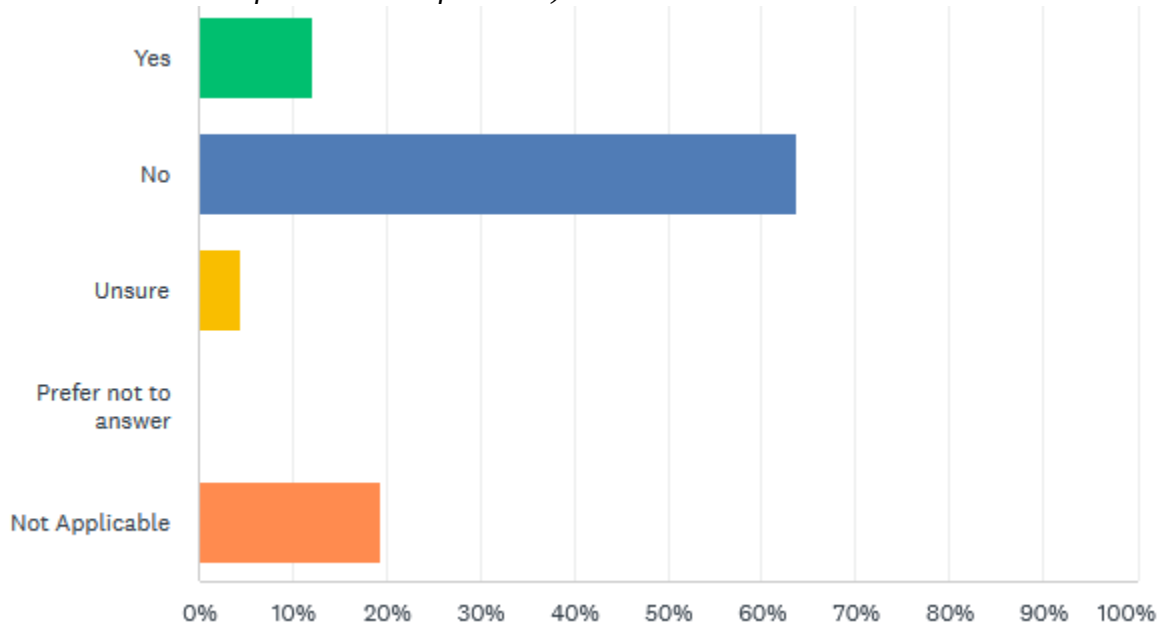
ANSWER CHOICES	RESPONSES	
▼ Yes	13.71%	360
▼ No	73.80%	1,938
▼ Unsure	11.54%	303
▼ Prefer not to answer	0.95%	25
TOTAL		2,626

Question 8. This question is for master's-level and clinical-level social work licensees. Should Kansas discontinue requiring passage of a national examination as a license requirement for a master's-level permanent social work license? (Note: A change to this requirement would require a change to law. Also, the social work multi-state compact requires passage of a national examination for this level of license.)



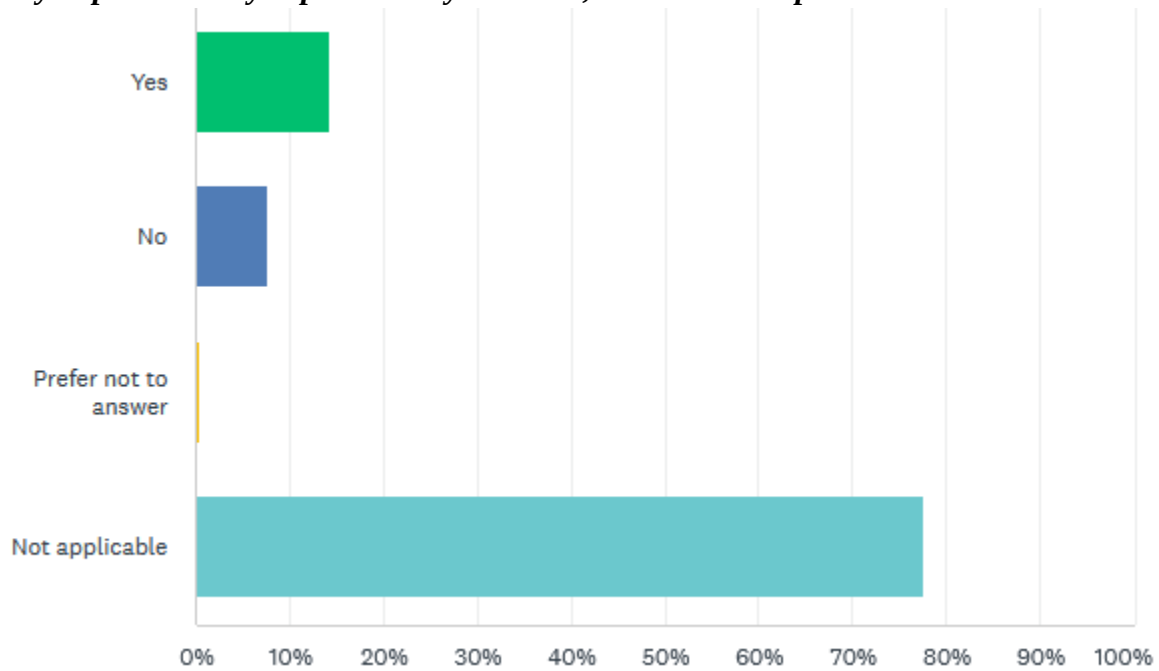
ANSWER CHOICES	RESPONSES	
▼ Yes	10.57%	250
▼ No	78.36%	1,854
▼ Unsure	6.85%	162
▼ Prefer not to answer	0.21%	5
▼ Not Applicable	4.02%	95
TOTAL		2,366

Question 9. This question is for clinical-level social work licensees. Should Kansas discontinue requiring passage of a national examination as a license requirement for a clinical-level permanent social work license? (Note: A change to this requirement would require a change to law. Also, the social work multi-state compact requires passage of a national examination for this level of license.)



ANSWER CHOICES	RESPONSES	
▼ Yes	12.11%	212
▼ No	63.85%	1,118
▼ Unsure	4.57%	80
▼ Prefer not to answer	0.17%	3
▼ Not Applicable	19.30%	338
TOTAL		1,751

Question 10. If you provided clinical-level supervision to practitioners over the past two years, have you provided any supervision by televideo, rather than in-person?



ANSWER CHOICES	RESPONSES	
▼ Yes	14.30%	277
▼ No	7.64%	148
▼ Prefer not to answer	0.41%	8
▼ Not applicable	77.65%	1,504
TOTAL		1,937

Question 11. If you provided clinical-level supervision by televideo over the past two years, based on your experiences, do you believe this flexibility has resulted in mostly positive changes, mostly negative changes, or something else? Based on what you have observed, has the ability to provide supervision remotely helped individuals better access supervision? Please explain: (Note: Individual text responses were provided by survey responders, which are included below (answers with the same response were grouped together and are bolded):

1. 100% positive, removes many barriers
2. A specified amount of in person time necessary.
3. Absolutely critical to allow televideo supervision given our rural and frontier practice area
4. Absolutely improved access to supervision and feels important for those who may work in more rural locations and lack access to appropriate supervision.
5. Absolutely it creates better access.
6. Absolutely positive in terms of flexibility and not cutting in to service time with commuting.
7. Absolutely! Combining in-person with video allowed for more flexibility in scheduling. I like doing a mix of the two and definitely appreciated saving the drive time during me busier months.
8. Absolutely. Supervision has been very successfully through televideo. I provide both supervision in person and through video and there has been no difference in quality of supervision. It has been extremely helpful for my supervisees in regard to money spent traveling to me, and trying to find childcare.
9. Absolutely. The ability to use televideo supervision has reduced accessibility issues, allowed for more schedule flexibility, and in general been helpful for more options.
10. All positive
11. All positive. It provides for flexibility in scheduling for all parties. It also allows access to a supervisor across the state.
12. Allows to reduce travel or exposure to illness. Please do not reverse.
13. Based on my experience, this increased flexibility has resulted in positive change demonstrated by reduced disruption in the supervision schedule and increased access to supervisors in other parts of the state.
14. Being able to offer televideo has made clinical supervision so much more accessible and offers more options to people in rural areas. Televideo is 100% successful and has been a game changer for social work supervision. Never take this option away - it would be detrimental to our field.
15. Being able to provide supervision via televideo has been extremely positive. I provide supervision for those social workers who see clients from a very specific population. Providing specialized supervision allows them to see an LSCSW who is more familiar with relevant issues within the population etc and they aren't forced to try and find an in person LSCSW around them. Televideo has done amazing things for therapy and therapy access and it's doing the same things for supervision. Increasing access to good supervision is how we get more social workers and rise to meet the needs in our community.
16. Being able to use remote for supervision has increased flexibility.
17. Better access
18. Better experience with flexibility and positive changes
19. completely benefited. Can literally not think of a negative reason to not allow it.

20. Considering drive time for some to meet, and if there's an unexpected cancellation, it's MUCH easier to reschedule and meet virtually. It just allows for greater flexibility scheduling and overall access. Changes have felt positive for me.
21. definitely a positive impact
22. Definitely helped with accessibility of supervision and has made scheduling sessions easier without drive time or the supervisee having to leave work or home. I have been able to provide supervision for social workers who live in areas where supervision is less available.
23. Definitely positive. It's as effective as in person and provides flexibility and ease of commitment.
24. Did not provide any clinical-level supervision in past two years.
25. Due to COVID, supervision could continue even if there were health related concerns on either end--supervisor or supervisee. It also allowed for working supervisee's to not have to miss a larger chunk of work time to receive their supervision--lunch hour, etc. The quality is unchanged whether you are in person or on telehealth--just make it easier, cheaper, and benefits both parties.
26. Especially in rural areas, cutting "windshield" time is a significant quality of life improvement. When self-care is optimal, learning is also optimized. In both therapy and in supervision, individuals who are vested in learning and moving forward, will do so whether they do it face-to-face or in a telehealth platform.
27. Harder to judge emotions at times
28. Has made access to supervision more convenient and has not impacted quality/outcome.
29. Have not
30. Helped
31. I believe it absolutely results in positive changes making it easier for supervisor schedule and supervisee scheduling. I do prefer in-person but my work schedule doesn't always allow that. I do include in-person supervision regularly.
32. I believe it provides the flexibility needed which allows better access to those who are not able to receive quality supervision in their area.
33. I believe post covid that the accessibility to televideo helped with time constraints and with the needs of supervisees to complete their work/employment without travel concerns.
34. I believe that the televideo supervision is a great advantage for both the supervisor and the supervisee. It cuts down on travel expenses and allows for both to have additional time to see clients if needed.
35. I believe the availability of televideo has increased access to supervision for supervisees. I believe it is a functional method of providing supervision and will continue to utilize televideo.
36. I believe this has been a great change. In group sup, it allows SWKs from multiple places to work together and discuss issues.
37. I didn't provide clinical level supervision over the past two years.
38. I do a combination of both in-person and online supervision sessions. I feel it has offered the most flexibility to clinicians trying to pursue their clinical licensure.
39. I do believe that the option of virtual supervision makes the service more accessible and gives licensees more options. It also, unfortunately, can then make supervision of these clinicians more difficult if they are in a private practice setting. If the licensee is receiving oversight as part

of a larger practice, then I 100% support virtual. However, without that oversight, I have concerns...based on my current experience with a licensee.

40. I feel it has given people the flexibility with their job and time. It does have its negative impact on people who struggle with the discipline it takes to work remotely. But I find I'm more available online to help my staff.

41. I feel it is positive as it allows for flexibility but continues to offer high standard of interactions

42. I feel it was a very positive experience.

43. I felt it was positive. We met remotely when I was out ill.

44. I have an intern and we do supervision via teams weekly. It's easy to connect and screen share etc.

45. I have done a blend of in person and video. This has increased access for supervision in highly rural areas.

46. I have done this under my MO license, not my KS license but it definitely provides better access to supervision in either case.

47. I have had no problems with supervision remotely and people have responded positively

48. I have not but I would not be opposed

49. I have not supervised anyone in the past 2 years for a social work license but am supervising social workers for gambling counselor certification using tele-video sessions.

50. I have observed positive changes, allowing individuals to attend supervision when it may have been canceled in the past (due to work schedule with travel restrictions, transportation struggles etc). Also, clinicians who have moved to a different city have been able to continue supervision with a change to a different supervisor.

51. I haven't but having this flexibility is important. Telehealth is valid. Supervision via televideo is valid.

52. I oversee clinical programs at the agency in which I am employed. Others do provide clinical supervision. With shortage of eligible therapist in Kansas, the ability to connect virtually has been beneficial and mostly positive.

53. I prefer live face to face supervision, but I have met with Clinical candidates via Televideo when I was sick or out of town or the candidate was out of town. This allowed for myself and my Clinical candidates to not have to make up missed days of supervision.

54. "I provide my most recent clinical supervisee initial in-person supervision until the pandemic and the notification from BSRB that supervisors could provide supervision via HIPPA compliant telehealth platforms. I used a HIPPA compliant platform called Simple Practice which was great. I found televideo supervision sessions to be very useful communication-wise and truly allowed my supervisee to gain much better access and often allowed less time away from their social work employment because of the travel time to meet in-person. NOTE: I really appreciate that BSRB reached out to social workers in order to understand and share our perspectives. This is certainly a more equitable organizational action. Thank you!!"

55. I provide supervision in Missouri and have for 5 years. I have done that via video even before COVID. It is the only way to coordinate schedules and allow for access.

56. I see televideo supervision as mostly positive. I have consistently supervised LMSWs over the past several years, and I find that eliminating the travel time associated with in-person supervision is a significant benefit to me and my supervisees.
57. I think it is the key to growing our Mental health force in the nation.
58. I think it offers an opportunity for more familiarity with Telehealth
59. I think it was a useful option.
60. I think televideo helps clinicians receive the supervision they need, especially when their current job cannot provide clinical supervision. It has only been a positive experience.
61. I think this has allowed positive changes to occur. This allows for people in outlying counties to seek supervision and not spend hours of their day driving to and from. It has helped us retain employees as we are able to offer supervision.
62. I use televideo when convenient due to various reasons. Car trouble, having a cold, etc. A time saver in general related to travel. I see very little differences, although most people including myself, prefer in-person
63. improved access- rural communities especially need flexibility of televideo- saved so many hours of driving time and created opportunities for student and new social workers to proceed with education and obtaining licenses
64. In person is better.
65. In the last two years, I have only done supervision in the same room but provided it through televideo extensively in the past. I see no difference in the quality of supervision between the two modalities. It makes it possible for social workers in remote areas to access supervision.
66. In the past 2-3 years, supervision has mostly consisted of master's level social work students and the occasional master's level student. The few times illness or poor weather required tele-meetings, the process ensued with little disruption to our usual meet-ups. That said, I would not prefer to conduct tele-supervision on a regular basis. Too much information/understanding, etc. can missed. And for many students, they want the 1:1, in-person, feeling of really "being heard"!
67. Increased access to supervisors with expertise in specialized populations such as eating disorders
68. Indifferent
69. It 100% has provided positive changes due to the flexibility and consistency for my supervisee's. I've had one supervisee move from the local area and televideo allowed us to continue our work and progress together. Televideo has also allowed me to continue work with another supervisee who is undergoing chemo and needs to isolate at home.
70. It allowed for better access to supervision and continuity.
71. It allows to continue getting supervision in all weather and health conditions, also helps while working if our schedules are too busy.
72. It certainly has been positive and flexible.
73. It has absolutely been a positive experience. I believe social workers should be at the forefront if not leading the way to changes. We have to figure out ways to meet people where they are.
74. It has absolutely improved access to supervision! I would t have been able to provide supervision more often than not if it wasn't an option.

75. It has been a generally positive experience. I have been able to provide more frequent supervision at various accessible times.
76. It has been a mostly positive change. It allows supervision to occur more often with less invasion into work time, and less cancellations.
77. It has been a necessary evil. The supervisor and supervisee cannot be as present under such circumstances as they can in person.
78. It has been a positive experience as it has removed barriers: cost of gas, traveling time, schedule problems, inclement weather conditions that could have disrupted supervision.
79. It has been a very positive change and helps individuals more easily access supervision without question.
80. It has been mostly positive. The majority of supervision sessions were conducted in person however due to scheduling conflicts or being out of town, the option to do televideo allowed supervision to occur without any interruptions.
81. It has been positive, allowing for more flexibility.
82. It has been positive, due to my supervisee and I working in two different office locations within our group practice.
83. It has been positive. We were able to meet when one or both of us were out of town and/or sick and the quality of supervision was the same. Both of us were prepared for session and created a private/confidential space to focus on supervision tasks, skill building, etc.
84. It has definitely been positive and has improved access.
85. It has markedly increased access and consistency of attendance.
86. It has resulted in positive changes, allowing for more flexibility and allowing supervisees to have more options in selecting a supervisor that is a good fit for them
87. It increases flexibility which is nice. I don't believe anything is lost.
88. It is convenient in cases of illness or other complications, but my supervisees continue to prefer in-person. I'm in an urban area, though, and I can see it benefiting those in rural areas.
89. It was a convenient way to get supervision in as we are in different states
90. It was a very helpful option to have. Normally we met in-person but it allowed supervision to happen even if one person had a cold or was feeling a little unwell.
91. It was helpful on being flexible with schedules on both individuals. It helped also when there was illnesses and were able to still meet and meet their minimum requirement.
92. It was not as good as in person.
93. It works for supervision, but not for direct service provision to consumers.
94. It would help immensely in the frontier areas.
95. It's been positive. Provides more opportunities for SW who don't have access to supervisors in their area. Offers more flexibility in scheduling. Less gas money/time spent traveling. Occasional technical issues can be annoying, but tolerable.
96. I've found this to be a positive change that allows for greater flexibility in scheduling my supervisees, particularly those that reside in rural communities.
97. more availability. I think the standard needs to be there, but now people can do it without issues of distance and time constriction.
98. Mostly positive (4 Responses)

99. Mostly positive - has allowed me to provide supervision even while traveling for work and made me more willing to be a supervisor for master's level social workers seeking supervision
100. Mostly positive - this assists with time management covering material and insight from group supervisions
101. Mostly positive and better access
102. Mostly positive and better access.
103. Mostly positive as it has reduced the difficulty of participating and increased access on a more consistent basis.
104. Mostly positive by far - the flexibility it provides myself and my supervisees far outweighs any small technical issues that rarely arises. It cuts commute time and expenses for both parties and maintains work/client schedules much easier for each party as well.
105. Mostly positive change, yes it has helped individuals better access supervision.
- 106. Mostly positive changes (2 Responses)**
107. mostly positive changes and has increased access
108. mostly positive changes, flexibility- even for those in the same area- but in different office locations, or if one is out sick due to COVID/quarantine
109. Mostly positive changes, gives easier access to supervision in rural areas where you may have to travel for in-person resulting in possible significant loss of billable services.
110. Mostly positive changes. Individuals have more access and can acquire the hours needed
111. Mostly positive changes. It allows greater flexibility with differing schedules, time off etc. Allows supervisors to reach students who live far away without traveling costs.
112. Mostly positive changes. The world is much different since after covid and being able to meet via televideo is essential. It is also helpful for clinicians in rural areas where they would have to drive significant miles to meet with a supervisor in person.
113. "Mostly positive changes. All LMSW's I supervised lived in the same town that I practice, but during COVID the Telehealth option provided a safe and effective way to continue their clinical hours. It also provided flexibility with scheduling and attending individual and group supervision appointments."
114. Mostly positive changes--supervisees have worked on the other side of town as me and have had less travel time as well as ability to meet with me over a lunch period.
115. Mostly positive due to SW Kansas having limited access for LMSWs to receive supervision.
116. "Mostly positive"
117. MOSTLY POSITIVE. Being able to provide virtual clinical supervision allows a supervisee to find the right skilled professional to supervise when without a geographical limitation and improves the attendance weekly for supervision.
118. Mostly positive, allowing for more regular and impromptu supervision when needed. Also allowed for supervision in areas where clinical supervisors are generally unavailable geographically.
119. Mostly positive, better ability to meet needs in the moment, able to respond faster to clinical needs.
120. mostly positive, easier access, less travel time and expense

121. Mostly positive, especially for rural social workers. The savings in energy, fuel, travel, hours of windshield time, and exposure in some cases to pockets of influenza risk are a plus.
122. Mostly positive, gave access and convenience to the supervisee
123. Mostly positive, virtual meetings tend to cause a lack of participation because people try to multitask, and don't give their full attention. So, keeping participants engaged is key.
124. mostly positive. It allows for remote access to supervision since it doesn't require in-person attendance. Is as effective for the supervision to occur remotely as in-person
125. Mostly positive. Helps with busy schedules and distance. Bigger area of rural Kansas but as people move farther West in person could require 1-2 hours of travel, which may not be realistic.
126. Mostly positive. Increased capability.
127. Mostly positive. It allows flexibility and reduces the amount of time/money spent for travel.
128. Mostly positive. It has reduced the number of times an individual had to reschedule supervision because televideo allows more flexibility.
129. Mostly positive; In rural areas it's hard to find clinical therapists who provide supervision.
130. mostly positive-improved access to quality supervisors, decreased travel cost and supervisors don't have to factor the cost of the office space into the rate that they charge.
131. My experience is the supervision by televideo has not been negatively affected, does provide better access to supervision.
132. My experience was it being a hybrid supervision -- at times in person and at times by video. It worked well, in part because it parallels what is happening in the clinical realm.
133. "N/A re: clinical supervision. Very effective clinical telehealth therapy with private cts utilizing a range of modalities."
134. Neutral to positive
135. Not provided
136. Oh yes, very much so! It makes it easier accessible to supervisees! It's an added bonus when hiring staff.

137. Positive (9 Responses)

138. Positive allows for more flexibility in scheduling No different than meeting in person
139. Positive - flexibility.
140. Positive - has helped access supervision
141. Positive and yes it gave improved access
142. Positive as military spouse this allows me to keep providing supervision no matter where my spouse's job takes us.
143. Positive because it has resulted in more flexibility for the staff and thus is emphasizing self care. For example, it is still important for staff to stay home from work if they are sick. With covid, for example, sometimes your symptoms are mild and you're able to continue to work and prevent the spread to our vulnerable staff or clients. Telehealth is a necessity.
144. Positive change and allows more access to more qualified providers and ability for those working within the field to maintain work/financial ability to provide for family and ability to access supervision outside of traditional work schedules m-f 8-5 pm
145. Positive change, allows clinicians to better fit supervision in their schedule if they are providing virtual sessions to clients.

146. Positive change. Easier to schedule supervision. Televideo has been helpful for the practice of social work.

147. Positive changes (3 Responses)

148. Positive changes as being face to face for supervision is not necessary at all for learning, opened up opportunities for supervision of staff in rural or remote areas

149. Positive changes have included being more consistent with supervision times when done via video calls and more access to supervision for supervisees who may live/work far away from supervisors.

150. Positive changes including better access although I prefer face to face supervision

151. Positive changes when access to supervision was limited due to Covid lack of anyone who could provide supervision. In addition, driving time from location to location could be reduced or eliminated by TeleVideo supervision, a win-win situation.

152. "Positive changes, as someone who had supervision in person to begin with and then moved to remote, there was no change in the quality of the supervision and if remote hadn't been an option, I would have had to find a new supervisor in the middle of my hours.

153. As a clinical supervisor through my employment, the agency would not be able to meet the need for those looking for supervision. "

154. Positive changes, I work for an organization with several sites. It would be more challenging to complete clinical supervision without televideo options. Additionally, it allowed for my supervisee to outreach immediately when needed.

155. Positive changes, yes

156. Positive changes. Able to meet during normal business hours. Decrease on travel time and less stress finding locations. Some of my supervisees are over an hour away.

157. Positive changes. Definitely has made access easier for both me as supervisor and my supervisee. I appreciate being able to use televideo as needed for supervision.

158. Positive changes. Folks from across the state can more easily access clinical supervisors in other areas. This has been great.

159. Positive changes. It allows for greater flexibility in scheduling and is just as effective.

160. Positive changes. It allows supervisee to get supervision with less impact on their busy workday, so they can better care for clients and themselves.

161. Positive changes. It allows us to have more flexibility and opportunities to meet.

162. Positive changes. This has reduced barriers for access to supervision.

163. Positive due to flexibility in overcoming travel barriers (e.g., snow, prohibitive distance)

164. Positive experience and more accessible to all.

165. Positive experience. Allows supervisor and supervisees better access to supervision and the ability to be more flexible. I still do at least 1 time a month in person.

166. Positive- Helps in rural and frontier areas to be able to consistently see staff as required. Helps to be flexible to reschedule more easily if needed at times due to taking out the travel time.

167. Positive in regard to clients being able to attend sessions without hardship.

168. Positive! Yes, it has really helped Rural areas such as Hayes, Andover etc

169. Positive! It's absolutely helped individuals better access supervision and been very helpful to supervisees with limited transportation or childcare support.

170. Positive! We've got to keep up with technology! Allowing us to provide supervision despite physical proximity has been game changing. Allowing me to supervise more people and keep up with my work!
171. Positive, allows for flexibility so I can have the time to provide supervision in my workplace
172. Positive, much greater access and even more frequent support as needed.
173. positive, sometimes it is very difficult for clinicians to find local supervision, and, during the pandemic it was crucial for that to continue (clinical supervision).
174. Positive, yes, being able to access supervision due to distant location or more privacy allows for growth. (If my supervisor is not in my circle of people as sometimes happens in smaller communities, it can be easier to be vulnerable with the process.)
175. Positive. It requires less driving and allows supervisees to find a good fit for supervisor, even if that person is not geographically nearby.
176. Positive. Tele video is a flexible, efficient, and supportive practice.
177. Positive. Yes, it provides better access. I have met in person with everyone I provide televideo supervision to before we start to meet remotely.
178. Positive. Better access. Better overall. Continue to allow televideo!
179. Positive. It's great for providers that are far from the office, and it works just as well. Better attendance.
180. Positive. Removes barriers to weekly supervision as we mostly work remotely and in the community.
181. Positive. Weather, traffic and illness doesn't prevent SW from accessing supervision.
182. Positive. Yes. When distance or illness are an issue, virtual is a great option.
183. Positively impacted. Telehealth option is necessary in our mobile world we live in. Not allowing remote would be an unnecessary step backward.
184. Primarily positive experience.
185. Provided televideo supervision in 2020-21 related to the pandemic. Worked ok, though not as ideal as in person training, in my opinion. A hybrid model might be equally effective.
186. Provision of supervision via telehealth simply allows for flexibility of scheduling. This allows for improved consistency in attendance.
187. Remote supervision accommodated my physical disability and geographic barriers to meeting in person.
188. Televideo allows for more flexibility to complete supervision sessions consistently with less interruption from patient care
189. Televideo has been helpful for me. It helps to view materials when screen sharing. It saves on printing. It helps if individuals are at different locations and do need to commute. It helps when the weather is bad and when outbreaks occur that caused social distancing.
190. Televideo has increased the ability for LMSW's to access supervision, both in terms of availability of supervisors and time management (not having to drive long distances to the supervisor's location)
191. Televideo has resulted in positive changes, especially in rural Kansas where people might not have access to an LSCSW who is willing to provide supervision in their community or have

an extensive distance to drive for supervision. The only negative is when people do not have a solid internet connection.

192. Televideo helps to provide access to supervision especially in rural and frontier area. I do believe a combination of in person and televideo is most helpful.

193. Televideo supervision has expanded availability to rural areas. In a time of high demand, this tool has been a real time-saver. More effective use of time plus better ability to overcome obstacles such as weather or exposure to illness of all communicable types.

194. televideo supervision in my experience has improved accessibility, scheduling conflicts, and all-around reduced barriers to getting/providing supervision weekly.

195. the content of supervision session remained unchanged in relation to the mode of supervision. It has kept my supervisee safe as she has not had to travel in icy weather.

196. The flexibility of televideo has significantly improved the availability of social work services, including supervision.

197. This allowed greater flexibility for scheduling when an agency has multiple locations and ability to work from home some days.

198. This allows a broader selection of practitioners. I find remote work very effective.

199. This depends on the supervisee. Some use it as a crutch and others as when they absolutely need it. I feel that I want to put requirements for my supervisees, but not sure if that can be done since it is my preference. The sessions are more in depth with information in person.

200. This has allowed consistent meetings for me and my supervisees. Our schedules don't always allow for drive time to offices.

201. This has allowed me to supervise SW in a more accommodating environment to ensure they can complete their goals

202. This has been positive and has allowed people more flexibility to achieve their clinical licenses

203. This has created positive changes. It would have been a time and location barrier to meet in person weekly for supervision. Televideo supervision has allowed me to meet my supervisee's weekly supervision needs.

204. This has had a very positive impact on my supervisees.

205. this is a great step forward. It has absolutely improved access for supervisees

206. This has been beneficial because it allowed for flexibility for both myself and the candidate. We were able to utilize technology to review things much easier as well.

207. This opportunity allowed my supervisee who lived in a different town to be able to avoid the travel expense along with cost of supervision. We did meet in person from time-to-time to review records on clinical cases on which I signed off.

208. This positive change has allowed for providing supervision when it would otherwise not be possible.

209. This type of supervision allows the Social Worker to be matched with specialists and people who match their clinical need. I believe this is highly beneficial.

210. Travel distance would have been a prohibitive factor for one of my supervisees.

211. very beneficial to being able to provide necessary supervision in rural areas. Particularly during COVID and bad weather.

212. Very positive and just as effective as in-person supervision. Here's a tip: stop allowing non-clinically licensed LMSW's or any non-clinical master's of any profession starting their own practices without on-site clinical supervision! This negatively affects clients and our profession.
213. Very positive changes. I have been able to provide supervision to clinicians working and living remotely even though I do not.
214. Very positive- has been extremely helpful in accessing supervision with minimal to no problems
215. Very positive. This has expanded the reach of supervision and allowed those in rural and frontier areas to receive this crucial support.
216. Virtual meetings are becoming a standard in all areas in a modern world. I use a combination of televideo and in person sessions throughout the extensive time supervision is required. I believe having completed training towards becoming a nationally certified telehealth provider was most beneficial.
217. with having telehealth providers, it is much more convenient
- 218. Yes (7 Responses)**
219. Yes - just as effective as face to face.
220. Yes because it not only improves access to a supervisor, it allows for more flexibility and scheduling
221. Yes because less travel time is involved, and one can see supervisees in a day. It is helpful to social workers who cannot find supervisors in a more rural area.
222. Yes, I do.
223. Yes it has helped especially if someone is ill or recovering from covid we can still meet
224. Yes it has made supervision easier for the supervisee and supervisor.
225. Yes- it makes Supervision much more accessible and practical.
226. Yes, its helped rural social workers receive supervision
227. Yes telehealth has made supervision much easier in rural areas
228. Yes, they were able to participate and be flexible and manage time better without having to try and get somewhere
229. Yes this affords both parties to be more flexible with time and overall availability
230. Yes this meets the needs with ever changing needs and allows for quality care for supervision
231. Yes to all of the above. It has been a mostly positive change and has helped significantly with access.
232. Yes! The counties in which myself and my supervisees work are all rural/frontier. Without telehealth, clinical supervision would not be possible for any of them as I am the only LSCSW currently in the organization. It also increases efficiency and maintains more time for clients as there is no additional travel time.
233. YES!! Only positive benefits that I have noted.
234. Yes, ability to meet remotely helps when supervision sessions need rescheduled or when weather is bad.
235. Yes, as is true for therapy sessions as well. My supervisee was able to continue during covid, during illness which was not debilitating but which was infectious.

236. Yes, being able to provide supervision via televideo was beneficial in my situation. It allowed me to provide supervision regularly while maintaining a busy schedule. I continued to meet in-person with the supervisee on a regular basis to maintain contact and relationship.

237. Yes, better flexibility, better access to resources and better time management.

238. Yes, by reducing travel time and having more options across the State.

239. Yes, can meet more regularly

240. Yes, during the height of pandemic was very valuable and in general worked well.

241. Yes, easier access and more flexibility has resulted in highly positive changes.

242. Yes, has allowed collaboration across state lines and enhanced overall quality of service.

243. Yes, I do believe the televideo option allowed for greater flexibility and gave those in rural areas working on their clinical license a more diverse choice of clinical supervisors.

244. Yes, I live in a r

245. Yes, I was able to provide supervision throughout the pandemic and the one who has completed their hours passed their exam and has had a clinical license since this past fall. I believe an effective supervisor offers a mixture of modalities including in-person and televideo and group (when able). I believe some sessions still need to be in-person but televideo if in-person is not accessible.

246. Yes, increased flexibility for many reasons.

247. Yes, it allows for flexibility

248. Yes, it allows you to provide supervision more easily and conveniently.

250. Yes, it had made it easier even with those near because of time demands and costs with travel.

251. yes, it has been effective. i would add it is best if you have some kind of prior relationship/knowledge of staff you are working with.

252. Yes, it has definitely been a positive for access to supervision.

253. Yes, positive it slows more flexibility

254. Yes, prior to providing any telehealth services, I was experiencing an abundance of reschedules or cancellations for transportation, weather, illness etc. Telehealth has afforded more flexibility and more consistency with all services across the board.

255. Yes, televised supervision has been a positive change and does not impact the ability to appropriately supervise.

256. Yes, the ability to provide supervision remotely has created greater access for those working on a clinical license to receive supervision from a clinical licensed social worker

257. yes, the results have been positive

258. Yes. Geographic distance is made irrelevant, which means persons in rural or frontier areas can choose from more options for supervision.

259. Yes. It allows for more scheduled supervision since it can be done from anywhere and at any time.

260. Yes. It is effective and very important in frontier counties.

261. Yes. Supervisee moved to another state. Zoom made it possible to continue meeting.

262. Yes. The option is needed and access to supervisors very helpful. I think it's still very effective just as teletherapy can be.

263. “Yes. The world has changed since Covid. Also, generational changes are occurring, and a lot of services take place online.”

264. Yes. Easier access and less time constraints

265. Yes. Good alternative when weather strikes or possible illness/exposure.

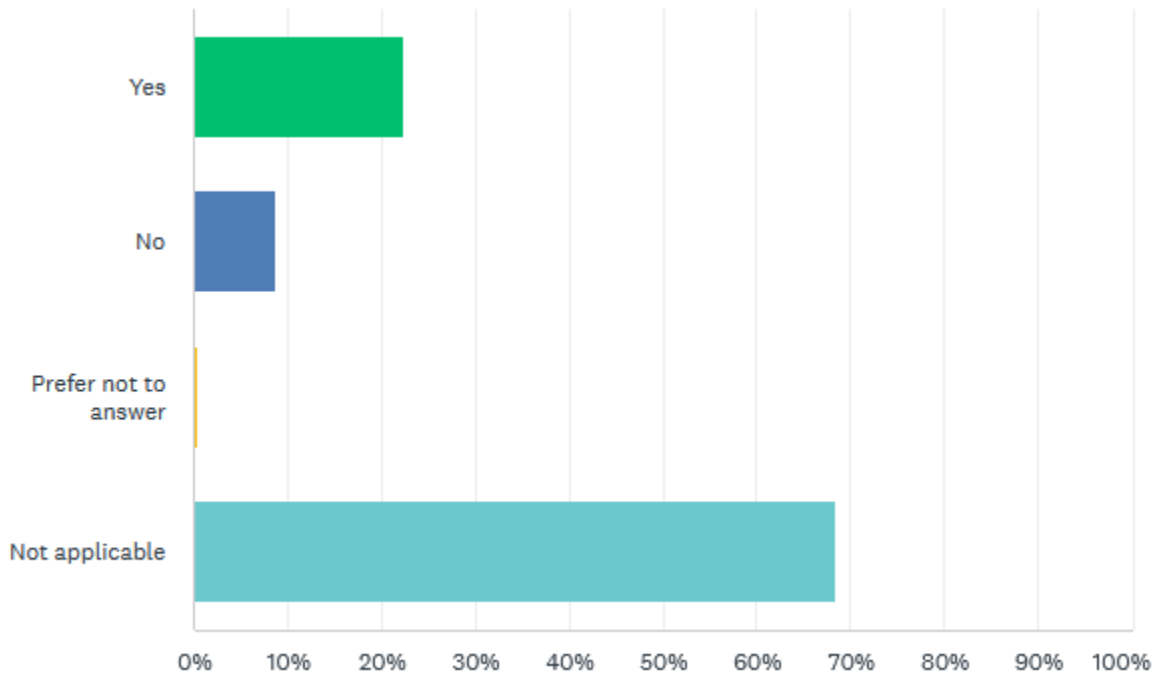
266. Yes. I am in a large community, and I have multiple office locations as do my supervisees. We rarely are at the same location, and while we try to meet in person as often as possible, having this flexibility to change to televideo on occasions has been extremely helpful to maintain the consistency of our scheduled sessions.

267. Yes. It should be an option to do in person and video supervision.

268. Yes. Yes. Yes! The option for tele health improves access to clinical supervision at times that are needed beyond scheduled weekly supervision when the supervisee is in a different office or location. It improves access if the supervisor or supervisee is sick (contagious) but able to ask work or function. It opens a variety of options for supervisees to identify a social worker that might work somewhere else in the state who has a specific specialty.

269. Yes...it helps with the ability to coordinate schedules, is more flexible, provides access to Social Workers in rural areas, is less time consuming when removing transportation requirement.

Question 12. If you received clinical-level supervision over the past two years, have you received any supervision by televideo, rather than in person?



ANSWER CHOICES	RESPONSES	
▼ Yes	22.42%	444
▼ No	8.69%	172
▼ Prefer not to answer	0.35%	7
▼ Not applicable	68.54%	1,357
TOTAL		1,980

Question 13. If you received clinical-level supervision by televideo over the past two years, do you believe the quality of supervision provided remotely has been mostly positive, mostly negative, or something else? Has the ability to receive supervision remotely helped with accessing supervisors? Please explain: (Note: Individual text responses were provided by survey responders, which are included below (answers with the same response were grouped together and are bolded):

1. 100% positive
2. A majority of my supervision has been in person. I am indifferent to in-person or tele-video.
3. Absolutely helped the availability, consistency and quality of supervision received.
4. Absolutely! It is helpful to be able to schedule when it's convenient for all involved.
5. Accessibility has been easier. I have never had in person supervision so I cannot compare.
6. Accessing supervision via televideo has provided a flexibility assuring meetings can happen as frequent as needed, reduces travel time, and allows more options for when supervision can occur.
7. All positive.
8. All positive. It's easier and less barriers to in person (schedules, travel, etc.)
9. Almost identical to in person supervision. Better in that we have more ability to meet and flexibility around scheduling.
10. Attending supervision via telehealth is still very effective and as allowed a great flexibility change for my schedule. It allows me to have more time to see clients as well
11. Being able to access supervision remotely increased access and provided extremely positive results in my experience.
12. Being able to receive supervision remotely has been a wonderful experience because the quality (in my opinion) is the same in person but more accessible for my supervisor who is incredibly busy and allowed me to spend the I would have to drive being able to see clients.
13. Being in the same facility but different locations has made meeting in person difficult at times of high work volume. Being able to reach out virtually has increased accessibility
14. By being able to access supervision via televideo, it has greatly improved my experience. Since I am in a more rural area, I am very limited as to who in my town would be able to provide clinical supervision. By engaging in supervision via televideo, I have been able to connect with a supervisor from a different town who has been an amazing and positive support. It's the best supervision I've ever had hands down and I wouldn't have been able to travel to her otherwise.
15. Comparable to in-person
16. Completely positive and absolutely!!
17. Completely positive, I prefer meeting on television for ease of scheduling with my clinical supervisor.
18. Definitely positive. I am currently in clinical consultation (supervision) with a clinician from New York City who is a professor in a certificate program I'm enrolled in. Without televideo, I would be unable to further my clinical education in this way and would be unable to benefit from the greater experience and expertise of clinicians outside my geographic area.
19. Did not change quality, made it easier to access
20. differs
21. Essential given geographical constraints
22. Extremely positive

23. Generally, I've had a positive experience and remote supervision has been especially helpful given the length of travel from working in such remote communities to accessing my supervisor.
24. Good
25. Having televideo options for supervision has been extremely helpful and a positive experience!
26. Helped
27. Helpful. I have mostly done group supervision by telehealth. I find it helpful to access supervision and peer support.
28. High quality, particularly helpful during the pandemic.
29. I believe it definitely is better in person but due to weather or location might not be possible for some.
30. I believe it has been mostly positive. I enjoyed supervision via video and is easier to schedule supervision times via video.
31. I believe my clinical supervision was equally beneficial when in person and via televideo. I didn't feel there were any barriers to quality. While both clinical supervisors I worked with were based in my work setting, my work setting has continued to allow us to have a limited hybrid schedule (3 days in office and up to 2 days working from home). This enabled my clinical supervisor and I to meet on our desired day and time even though there were times that our in office/ WFH schedules didn't match up.
32. I believe televideo supervision is a fantastic option! Many times both my supervisor and I were in between client appointments. Being able to televideo was a great convenience.
33. I believe that it was positive and quite beneficial. Conversations were not as time limited as face to face due to a more flexible, slightly more casual and comfortable interaction.
34. I believe that Telehealth and video conferencing are effective and efficient and definitely relatable to client work
35. "I believe the quality of supervision has been positive, and that receiving remote/telehealth supervision has not in any way diminished the quality and effectiveness of supervision.
36. Due to a physical condition (complex connective tissue disorder) and my need to work from home (I would be physically unable to work outside of my home), remote/telehealth clinical practice and supervision have made it possible for me to contribute and provide services to people in need. I am, though, still under supervision since I don't yet have my LSCSW). "
37. I can now see my supervisor for my 1099 via zoom without traveling 200 miles.
38. I currently receive mostly remote supervision, but the last year I received in person supervision. My supervision experience with my remote supervisor is a much more positive one than my previous supervisor. I believe this is because I was able to find one in a more populated area, so I had more quality options for supervision.
39. I didn't receive clinical level supervision over the past two years.
40. I do not believe televideo has offered anything different than in person would have offered. It does offer most availability to supervisors.
41. I do not think the telehealth aspect of the supervision was what negatively impacted the quality of supervision received. I think a quality supervisor can provide quality supervision via telehealth. I like that supervision can be available via telehealth but do prefer to attend in person whenever possible.

42. I don't think it's as good of an experience as in person, however most social workers have busy schedules therefore video is the most convenient.
43. I feel it is very positive. The number of LSCSW's willing to offer supervision is limited; therefore, access to well qualified, reliable LSCSW's increases with the use of televideo meetings.
44. I feel like this level of supervision has been mostly positive as it has aided in accessibility for both me and my supervisor. We are able to meet on a flexible basis if necessary, which we would not be able to do without meeting over televideo.
45. I feel the interactions with my supervisor are the same quality via telehealth as in person. This is huge for ease of scheduling supervision!
46. I find it easier to get on and talk and get things accomplished.
47. I graduated in 2020 so I had to do a lot of supervision through Telehealth. I also currently receive play therapy supervision via Telehealth. I find that I am able to receive the same level of supervision in person as through Telehealth.
48. I had a mostly positive experience with clinical supervision via tele-video. It assisted in continuing supervision during the COVID crisis.
49. I have completed clinical supervision years ago, but I meet with my Director via this method effectively. Access is improved across multiple offices and locations.
50. I have had a positive experience with televideo. It allows for more flexibility.
51. I have had less than a couple months of clinical supervision mostly remote and my experience has been very positive. Having the option to do remote allows more time in my already hectic schedule. It has definitely made it much easier in accessing clinical supervisors.
52. I have not provided I am being supervised and it has been wonderful and quick access.
53. I have not used televideo yet but appreciate this option
54. I have only received in person supervision
55. I have received post clinical supervision for additional certification and televises has been key to getting great quality supervision. Getting good supervision may mean you need access to someone who doesn't live close enough to easily see them. But also, there are circumstances where televideo is very helpful even when they are close by because life happens!
56. I have utilized zoom for supervision, and it has helped with connecting supervisors and other therapists. It is effective.
57. I offer televideo and it has been all positive feedback from supervisees.
58. I only received supervision via virtual methods if my supervisor or I was unable to be there in person, which was fairly limited overall. I thought it was fine because I already had an established relationship with my supervisor at the time.
59. I oversee clinical programs at the agency in which I am employed. Others in the programs I oversee do receive clinical supervision virtually. With shortage of eligible therapist in Kansas, the ability to connect virtually has been beneficial and mostly positive.
60. I prefer in-person interaction, but I do not feel that televideo supervision was negative in any way. It allowed me to continue supervision when my supervisor and I were not in the same place.
61. I think it was beneficial. I wish there was more structure to the supervision though. Like what exactly the expectations are.

62. I think it would have been about the same or maybe even easier. It is easier to coordinate schedules via phone than in person.
63. I was fortunate to receive supervision in person AND remotely which promoted convenience and quality.
64. I would say mostly positive, with a young child, a private practice and second employment, the flexibility of remote supervision has been extremely important in assisting with completing my hours!
65. I'd like to comment on the exam issue but there's no place to do that. I would like the KS law to still require an exam for every level of licensure, but it would be helpful to re-word it so that KS could provide an alternate exam if that's warranted. I know ASWB is making some changes, and hopefully they'll be good, but I don't wish for us to be locked into their exam only. Also, I don't think that lowering the CE requirement to 30 hours would negatively affect practice, but I am loathe to lower the requirements. I still remember when it used to be 60 hrs.
66. I'm a doctoral student at Smith College School for Social Work. I met my current clinical supervisor participating in a (previous) certificate program at this SW School. This was conducted in person and through ZOOM meetings. When I started doctoral training this summer, I met her in person a second time to determine if we were going to work together. All clinical supervision that's occurred by ZOOM occurred after the working relationship was decided on. Televideo sessions since this time have been very positive.
67. In my experience it has been positive. It allows me to ensure I get my weekly supervision while at the same time it doesn't take too much away from my other responsibilities (ex. work, family, etc). Even if it saves 20-30 minutes of travel time, it is helpful if necessary.
68. It allowed for being able to meet when physically it would have presented too many challenges to name to meet consistently
69. It allowed us to meet, even when one of us was out of town.
70. It has absolutely helped with getting supervision. The quality has been the same as in person meetings and at times made discussing challenging cases almost immediate compared to scheduling in person meetings.
71. It has been a very positive experience, and my access to a supervisor widened tremendously!
72. It has been beneficial at times due to schedule, weather or other factors but I prefer in person. I do think it makes it easier to find a supervisor though.
73. It has been incredibly positive. It has vastly increased accessibility of supervisors and time that we can meet and also makes our time better able to be focused on clinical work.
74. It has been most sufficient and positive experience.
75. It has been mostly positive as it allowed me to still have supervision even if I was feeling unwell, had a client schedule right after, or needed to go out of town on the scheduled day. There was no significant change in the supervision quality.
76. It has been mostly positive. Receiving supervision remotely was absolutely necessary to accessing a supervisor.
77. It has been mostly positive. It has helped my ability to access supervisors.
78. It has been positive and helpful.
79. It has been positive because it has allowed my supervisor to be more accessible to me. We have been able to find supervision times more easily than if we had to do in-person

80. It has been positive. It is incredibly helpful to have televideo supervision as all people involved are busy and maintain their office in different locations. This makes it easy to join in without getting to a conference room.
81. It has been very helpful and a positive experience for me. It has also saved me a lot of time not having to commute to elsewhere to see someone in person.
82. It has been very positive and absolutely helped in terms of access!
83. It has been very positive and convenient.
84. It has been very positive.
85. It has definitely been more positive. Not being able to do televideo supervision would have significantly impacted my ability to work toward my clinical license. I have done both in person and televideo and do not believe I am missing out on anything by doing mostly televideo. Group supervision has been more easily accessible as well which adds positively to the learning experience.
86. It has helped maintain the supervision requirements with the added flexibility with the option to participate remotely.
87. It has helped me in many moments as it reduces the pressure to coordinate schedules so tightly and allows for different experiences and timing of meetings to be available.
88. It has helped me so much because I have 3 children at home. Telehealth has been positive!
89. It has helped my peers pursuing clinical licensure significantly.
90. it has helped with accessibility / flexibility of scheduling supervision meetings
91. It has increased my ability to participate regularly in supervision. Remote supervision has greatly increase access for me personally and removed a dig barrier for me.
92. It has still been just as beneficial as when i did it in person.
93. It helps to access at times, but I feel there is more richness to in person supervision
94. It isn't a common practice to receive supervision this way. Mainly I have received it when one of us needed that as an option to stay in compliance. It is an extremely beneficial option when needed.
95. It was a little over two years ago. I completed 1 or two sessions over televideo. It was convenient and no different than in person.
96. It was a positive experience and it absolutely helped me access supervision.
97. It was a positive experience to meet by televideo. We are all busy and being able to adapt and meet in person and by televideo is important.
98. It was a positive experience. It provided flexibility when I couldn't attend in person.
99. It was during 2020-2022 due to concerns related to covid and masking/social distance mandates for those facilities/environment
100. It was fine and allowed me to obtain clinical license.
101. It was helpful in maintaining consistency when weather/health would have prevented meeting.
102. It was just as helpful as in person
103. It was more convenient than meeting in person with work schedules, traffic ect
104. It was positive and helpful that I didn't have to miss work to have to drive to her office
105. It was positive, and this is very beneficial for people who would otherwise have difficulty accessing supervision.

106. It was positive, but I did not continue it.
107. It was very helpful and instances when one of us was working out of state or temporarily attending a conference. This way I had no break in supervision and my supervisor was consistent
108. It was very positive and more easily accessible to receive supervision with telehealth as an option! I'm so grateful for the change.
109. It was very positive as this happened seldom but was effective
110. It's been positive and allowed for flexibility with the supervisor so that they can provide supervision as well as pursue their other endeavors, I.e. their own clients, etc. As a supervisee, it opens up more opportunities to gain supervision.
111. It's been positive and it helped to be remote
112. It's made it a lot easier to schedule appointments that work with my schedule and my supervisor's schedule.
113. Most of my supervision sessions are remote, and they have all been positive and effective. I am in Salina and my supervisor is in Wichita. She is quality and trustworthy, and I don't think I'd be able to find anyone like her in Salina. So, televideo has been crucial for my ability to access my supervisor!
114. Mostly helpful
- 115. Mostly positive (25 Responses)**
116. Mostly positive - it has allowed me to access a great supervisor with a schedule similar to mine.
117. Mostly positive - it is convenient and takes away barriers of the time and resources required for a commute, and it does not take away from supervision quality. I did appreciate meeting in person every so often, but televideo was extremely helpful.
118. Mostly positive - the ability to receive supervision remotely has helped tremendously in accessing supervision. It has allowed continued supervision despite busy, conflicting schedules and when one of us has been out of town. It has also allowed for meetings when one of us has been ill or recently exposed to COVID-19 or other contagious viruses. At times there have been connectivity issues however I feel the benefits of receiving supervision remotely has far outweighed any positives.
119. Mostly positive - we're able to staff cases sufficiently via televideo.
120. Mostly positive allowing greater flexibility and access to supervisors, and limiting time commuting for supervision services (i.e. I can fit supervision between other appointments). Only negative is difficulty reviewing paperwork/documentation together is more difficult.
121. Mostly positive and allowed me to get more supervisions without worrying about transportation.
121. Mostly positive and allows meetings to happen with less stress.
122. Mostly positive and definitely made supervision more accessible and affordable
123. Mostly positive and extremely helpful in accessing supervisors
124. Mostly positive and has helped with accessing supervisor.
125. Mostly Positive and it has help with access
126. Mostly positive and it has made it easier to access supervision without giving up time for clients.
127. Mostly positive and made availability to di supervision easier as well.

128. Mostly positive and made supervision immensely more accessible.
129. Mostly positive and makes access easy and effective reducing time barriers
130. Mostly positive and remote access helped accessing supervisors
131. Mostly positive and yes, I would say it has helped me to access supervision i otherwise would either have to travel for or not receive.
132. Mostly positive as it opens up more opportunities to meet during busy schedule times.
133. mostly positive- has worked better with schedules and still being able to have the full supervision session
134. Mostly positive- more flexible, can still meet if ill, etc.
135. Mostly positive- Yes, in person is challenging at times with the daily demand of our jobs.
136. Mostly positive, absolutely helps with access and loss of time traveling to meet in person.
137. Mostly positive, allowed me to have supervisor in my clinical specialty even though we were ~1 hour apart. No difference in quality of interaction over video.
138. Mostly positive, allows me to speak with my clinical supervisor in real time while still at work.
139. Mostly positive, increased accessibility
140. Mostly positive, increased flexibility for many of my colleagues.
141. Mostly positive, it allowed for more group supervision and flexibility in scheduling time.
142. Mostly positive, it has ensured that my supervisor was more available and could easily fit supervision into both schedules, in addition it did not hinder the learning process
143. Mostly Positive, it has helped with accessing supervisors. I was able to interview for supervisors across state lines so my "pool" for potential supervisors was bigger. And it helps with my work schedule in that I don't have to take time out to travel to meet with my supervisor, I get to do it online and then get back to work.
144. Mostly positive, it has significantly helped me be able to reach my clinical license sooner.
145. Mostly positive, made seeking supervision more accessible
146. Mostly positive, more access to shared resources, and handouts in real time.
147. Mostly positive, my supervisor lived an hour away so being able to meet by televideo enabled us to continue to meet regularly even when weather was bad, or we had other scheduling conflicts.
148. Mostly positive, no concerns. Has helped tremendously with competing schedules.
149. "Mostly positive, no noticeable difference in format, really.
150. Yes, the ability to receive supervision remotely HAS helped with accessing supervisors!"
151. Mostly positive, same quality as in person.
152. Mostly positive, the level of supervision is equal to in person and allows for accessibility
153. Mostly positive, tremendously helped access regular consistent supervision
154. Mostly positive. Allowed some flexibility to meet needs.
155. Mostly positive. I think it has been much more convenient and probably allowed me to participate at a higher level than I might have otherwise. I probably would have missed more sessions and it would have taken longer.
156. Mostly positive. It has definitely helped with accessing supervisors.
157. Mostly positive. It was much more accessible and relevant.

158. mostly positive. Quality is dependent on the people not the format. Saves money and time in travel weekly. Time saved allows me to provide another hour seeing clients.

159. Mostly positive. Supervisors are not always available locally, however their insight, guidance, and knowledge do not require them to be in person to share.

160. Mostly positive. Without remote access to supervision, it would have been unavailable or significantly more expensive for me to receive. Without the remote option I am not sure it would have been an option. I would have either not pursued my license or chosen to practice in a more urban setting rather than the rural setting that I'm providing services in.

161. Mostly positive. Accessibility has been so helpful in managing two people's schedules.

162. Mostly positive. Allowed me to maintain more of a work life balance and my supervisor was more easily accessible given both of our schedules.

163. Mostly positive. I am able to access my supervisor more easily and group supervisions are made possible that would otherwise not be.

164. Mostly positive. I am the spouse of a military member; moving every couple of years is a given. Being able to access my supervisor remotely has taken a huge burden off my shoulders. Additionally, receiving supervision remotely has allowed me to maintain continuity while attaining the required supervision hours.

165. Mostly positive. I can still see my supervisor on the video and I feel my supervision both in person and virtually greatly impact my clinical skills for the better. There is not a difference in my opinion. I also would not always be available to leave my work building to get to supervision so the virtual option has made attaining my hours much more accessible.

166. Mostly positive. I have been receiving supervision in my current state of Arizona and attending online has helped me access services as I do not currently have an LMSW at my work site.

167. Mostly Positive. I prefer in-person engagement, but it allowed me to get my needed supervision times in in spite of both my supervisor and mines often hectic schedules.

168. Mostly positive. I recently relocated from Alaska to Kansas. There were no clinical supervisors where I lived due to the lack of resources in this remote village. If not for remote access, I would not have been able to have a clinical supervisor.

169. Mostly positive. I think meeting in person would have been much more difficult to accomplish.

170. Mostly positive. It allows flexibility and accommodates bad weather.

171. Mostly positive. It allows great flexibility for a profession that can be unpredictable and hard to get away to commute for supervision.

172. Mostly positive. It definitely made it easier to access my supervisor.

173. Mostly positive. It has allowed flexibility for both myself and my supervisor that would otherwise be impossible due to single mother status.

174. Mostly positive. It has allowed me more access to my clinical supervisor without sacrificing quality.

175. Mostly positive. It has allowed me to schedule clinical supervision more easily in my work schedule. I am unsure I would be able to schedule supervision at this time due to travel time/ scheduling conflicts otherwise without it.

176. Mostly positive. It has enhanced my ability to seek supervision from people outside of my organization and it has been more convenient.
177. Mostly positive. It has helped significantly.
178. Mostly positive. It helps to access supervision on a more flexible schedule.
179. Mostly positive. It made supervision more accessible.
180. Mostly positive. It makes supervision more assessable. Traveling to and from supervision takes 30 minutes in itself.
181. Mostly positive. It offers improved accessibility for travel and scheduling logistics, with more minimal interference to regular work / client hours before and after supervision. No notable drawbacks in communication or quality of supervision when done remotely. Allows for easy visual sharing of resources / information.
182. Mostly positive. It was more convenient. I feel it was just as effective as in-person.
183. Mostly positive. It was only done a couple of times, but it was a way to ensure supervision was completed. Televideo didn't take away from what was being discussed.
184. Mostly positive. It's really helped me access it with limited childcare support.
185. Mostly positive. It's been very helpful for me to stay in track and receive excellent supervision even through bad weather busy schedules.
186. Mostly positive. My supervisor has made extra effort to understand my practice, visiting my office and scheduling in-person time but it is primarily online. Remote supervision would be the only way I could received supervision. I live in a rural community and would have to travel at least 1 hour (round trip) to receive supervision. That would take 2 hours out of my work day every week and is far less reasonable for me to manage.
187. Mostly positive. Rarely but occasionally my supervisor is traveling for work, but we are still able to do supervision during the week due to the availability of televideo.
188. Mostly positive. Remotely helped tremendously with a busy lifestyle!
189. Mostly positive. Stays on-subject, more organized, better overall experience.
190. Mostly positive. Televideo has allowed me and my supervisor flexibility in our schedules to see one another. The commute to each other is lengthy so we can have supervision with greater ease.
191. Mostly positive. Television did not affect supervision access for me.
192. Mostly positive. The quality of the supervision does not seem to change when it's in person vs when it's by televideo. It has helped access supervision when one of us is ill/not in the office.
193. Mostly positive. There is a shortage in QUALITY supervisors and televideo is the only way to meet with my clinical supervisor.
194. Mostly positive. There is no change to the quality of supervision via video versus in person. The ability to receive supervision remotely helps immensely.
195. Mostly positive. This method has allowed for greater ease in meeting times and fitting clinical supervision sessions into a busy schedule.
196. Mostly positive. We were easily able to share education materials via the platform, and were able to avoid cancelling due to childcare issues, transportation concerns etc.
197. Mostly positive. With the pandemic I would have had to pause on obtaining my clinical hours for my LSCSW.
198. Mostly positive. Yes, has helped with access.

199. Mostly positive. Yes, having the ability to receive supervision remotely has helped with accessing supervisors.
200. Mostly positive. Yes, it's helped with the flexibility.
201. Mostly positive. Yes, because it is more convenient and there is no travel involved.
202. Mostly positive. Yes, it has allowed continuity of supervision.
203. Mostly positive. Yes, remote access helped provide me with access to a supervisor without having to spend additional time outside of work commuting to receive in-person supervision.
204. Mostly positive. Yes, the ability to receive supervision remotely has helped with accessing supervisors. When I initially started seeking supervision, finding one locally was challenging, however I was able to obtain a supervisor clinically licensed here in Kansas but residing in another. In that we are able to do our supervision remotely. Which is greatly appreciated!
205. Mostly positive. Yes. I live in Lenexa Ks and my supervisor is in Independence MO.
206. Mostly positive. Yes. Remote supervision allowed me to do my job more efficiently by only requiring one hour for supervision rather than requiring me to drive both ways to access it. Remote supervision also allowed me access to a broader skill set than only what was available through employment.
207. Mostly Positive. Yes, has helped with access, and was able to find clinical supervisor with similar professional interest outside of current working relationships, which helps with professional growth.
208. Mostly positive; increase accessibility to supervision has helped rural populations receive adequate and quality supervision
209. Mostly positive; it has made supervision more accessible and easier with a busier schedule
210. mostly positive; more accessible, more flexible, better for expenses/mental health
211. Mostly positive; remote availability of clinical supervision has been helpful (only use this media when unavoidable)
212. Mostly Positive; yes. There are times when my clinical supervisor is not able to be at my worksite or meet face to face, and it helps us to be able to meet and discuss things just as we would in person.
213. Mostly positive; Yes, this has helped in maximizing the amount of time for a supervision session (allowing the supervisor and supervisee to jump in right away, versus get situated when meeting at a secure location).
214. Mostly positive-it made supervision convenient and easy to fit in during my work day.
215. Mostly supportive
216. Much easier to access supervisors!
217. My clinical supervision conducted remotely has been immensely helpful and extremely convenient, given that we are able to connect remotely. If we had to meet in person, this would become a barrier to receiving clinical supervision and furthering my career.
218. "My clinical supervision has been a combination of televideo and in-person. The quality of my tele-supervision has been very positive. Having televideo as an available option improved both accessibility and flexibility (ex. weather)."
219. My experience has been mostly positive. And because of the lack of supervisors in my city of residence, it has definitely made accessing a supervisor much more attainable.

220. My experience has been positive with both in-person and the few televideo supervision sessions.
221. My experience has been very positive. It has allowed us more flexibility which allows my supervisor to be more available.
222. My experience with receiving supervision by televideo has been mostly positive. I ability to receive supervision remotely has helped immensely with accessing supervisors. I had a bigger pool of supervisors to choose from than I would have had if only in-person supervision was allowed.
223. My experience with televideo clinical-level supervision has been mostly positive. The ability to receive this service remotely has allowed me to serve more clients throughout multiple counties. I have been able to receive supervision from multiple people within my specific practice of clinical work, which I would not be able to attain in person.
224. My experience with televideo supervision has been a good one. My supervisor holds licenses in 3 states and lives primarily in another state. There are few LCSW's available in my area. Without the ability to complete televideo supervision I don't know that I would have been able to work toward my clinical license.
225. My supervision quality has not been impacted by virtual sessions. The most significant impact for me has been that my supervision time frame would be extended by 6 months to a year if I did not have that option. So I highly favor the virtual option.
226. My supervisor has been wonderful through remote
227. N/A (not currently under supervision, but I do feel like it would have been helpful during my supervision)
228. N/A I have become used to telehealth/televideo as an educator, trainer, therapist, manager working with staff 100% remote.
229. negatively effected
230. Neutral
231. No I don't believe it has been negatively impacted as we do not always rely on televideo, only hybrid.
232. No it worked well for me
233. No negative impact from remote supervision and yes, it's a huge help with accessing supervisors.
234. Not at all positive, I felt like my clinical supervision failed to provide any content of value. No oversight over the televideo option allows clinical supervisors to do little to no preparation for supervision.
235. Not provided
236. Oh yes, very much so! It makes it easier accessible to supervisees! It's an added bonus when hiring staff.
237. Personally, televideo was more favorable for me given my hectic schedule. I could jump on a Teams call rather than having to drive somewhere else. Also, depending on the day, there were immediate needs that I couldn't avoid, and it made moving supervision to a later time or different date a lot easier. It wouldn't have worked sometimes if my supervision was in-person because the person would have already been at the meeting site. My supervisor works within the same company as me, but we work at two different locations so televideo was more beneficial for us.

238. Positive (21 Responses)

239. Positive - and yes, it has helped with access as it requires less time away from patient care for both supervisor and supervisee.
240. Positive yes it has helped to access supervisors
241. positive (I am referring to ongoing supervision not for the level of obtaining licensure); it still feels effective despite some challenges like for sharing handouts.
242. Positive. Helps with supervision in a rural area.
243. Positive and accessible
244. Positive and has been a great asset! I was able to find a great supervisor who via telehealth
245. Positive and has helped with access
246. Positive and helped with accessing my supervisor. She was unable to leave her home due to a fall but it did not prevent us from meeting and the quality of supervision felt the same.
247. Positive and increased availability of both myself and the supervisor to receive adequate supervision time.
248. Positive and very helpful in accommodating my unusual schedule.
249. Positive and very helpful!
250. Positive and yes it has helped to access my supervisor
251. Positive and yes, helped with accessibility especially during the pandemic
252. Positive because having an option for more supervisors in rural areas is great.
253. Positive due to the amount of time and accessibility for both me and my supervisor. I appreciate the flexibility.
254. Positive experience and was helpful to have the flexibility during work schedules.
255. Positive experience w/ televideo, and yes, it is helpful to access my supervisor much more easily.
256. Positive experience with additional in-person training
257. Positive experience. As someone who lived in MO during my clinical supervision, the televideo option made it possible to have supervision with a well-known and highly regarded supervisor who was over an hour from my home.
258. positive experience. helps with time management and was able to stay with someone i trusted when i moved cities for work.
259. Positive if there is an agenda and talking points
260. Positive in being able to access supervisors.
261. Positive--- in person is preferable
262. Positive it has helped me get the correct amount and not have to have travel time
263. Positive. Yes, I wouldn't be able to receive clinical supervision with my agency without the remote option.
264. Positive, and yes the convenience and flexibility was important
265. Positive, and yes the time spent I feel is focused and can be convenient
266. Positive, as a school social worker sometimes I am unable to leave the building. This has made it possible to still access my supervision.
267. Positive, definitely helps with locating a supervisor.
268. Positive, has increased access to supervisor, especially during inclement weather

269. Positive, it has allowed for increased flexibility and more consistent supervision meetings. It also facilitates real time review of tools, resources and information to better inform our discussion.
270. Positive, it helped to meet the needs of both of our schedules and I still got quality supervision.
271. Positive, saves drive time and allows me more flexibility
272. Positive, when combined also with in-person supervision also provided on a regular basis.
273. Positive, yes in terms of access
- 274. Positive (2 Responses)**
275. Positive. I live in a rural area and access to meet for clinical supervision would be challenging for in person. We do a combination of remote and in person and I don't feel any negative impact of the remote access.
276. positive. No challenges whatsoever.
277. Positive. Accessible and convenient
278. Positive. All of my clinical supervision was in person, however I have been working on EMDR certification and that has been remote and has been amazing.
279. Positive. Having access to televideo has improved access to my supervisor!
280. Positive. Helped with limiting travel and reducing time conflicts.
281. Positive. Helps access supervisors, more flexibility in scheduling with high caseloads, etc.
282. Positive. I believe access to televideo supervision is beneficial in helping with access to supervisors.
283. Positive. I believe this allows for both supervisor and supervised to reduce travel time and have more time in their day.
284. Positive. I was able to both in person and televideo. It does offer access for areas limited
285. Positive. It allowed me to continue supervision when complicated circumstances arose such as childcare, illness and highly urgent issues.
286. Positive. It depends on quality of the supervisor, as well as level of commitment by both parties.
287. Positive. It gives me better availability to meet with my supervisor
288. Positive. It has had no impact on the supervision I have received.
289. Positive. It has made it more accessible due to scheduling and conflicts or illness.
290. Positive. It provides much more flexibility, coordination of schedules, and helps to connect supervisors with supervisees who are not local to one another or within the same agency.
291. Positive. It was more conducive to my schedule.
292. Positive. It was only one time while my supervisor was sick.
293. Positive. It's the primary thing that made it possible
294. Positive. Televideo makes connections possible with far less barriers.
295. Positive. This has helped my ability to access clinical supervision.
296. Positive. We were able to screen share and review documents with ease. It was very professional and productive.
297. Positive. Yes I was able to have a supervisor across the state the offered great advise and help and wouldn't of got that if I wasn't able to get if I wasn't allowed telehealth
298. Positive. Yes, it helps.

299. Positive; Allowed for flexibility in adhering to supervision requirements during periods of unpredictability.

300. Positive; helped

301. Positive; yes

302. Positively

303. Positively influenced by removing barriers to in-person attendance and coordination

304. Positives it's not my preference but has been nice to have an alternative when needed for things like scheduling changes or inclement weather.

305. Primarily positive. It certainly helps accessing supervisors, even within my own organization due to how spread out the organization is.

306. Quality has been positive. Ability to receive supervision via televideo has been beneficial and increases time available to provide direct services to individuals (reduction in drive time = more time with clients)

307. Receiving clinical supervision via televideo has been very helpful, it provides with me flexibility to meet with my clinical supervisor as often as needed and allows for concerns to be addressed more promptly as I do not have to drive to meet with her.

308. Remote access to my clinical supervisor has been paramount, as we live three hours away from one another. I believe that my clinical supervision with this individual has been extremely positive. I have had other supervisors in the past (in person) that have not worked out as well for me. So, allowing remote/televideo clinical supervision has helped me access the RIGHT supervisor.

309. Remote clinical supervision was extremely positive. It allowed flexibility and less costly overall.

310. Remote is sufficient for supervision. More time and access to meet with supervisors due to everyone's busy schedules.

311. Remote supervision as a back up to in person has been a great option and mostly positive

312. Remote supervision has been 100% a positive experience. It provides me more access to my supervisor when needed and more times available to meet because I don't have to go to an actual building/location to meet/commute times.

313. Remote supervision has been very positive and an important way to help get weekly supervision in

314. Remote supervision was no different than in person; in regard to quality. The accessibility of a remote option was very helpful in certain situations (ex. Supervisor or myself was sick).

315. Remote, I believe is a great option for various reasons rather transportation, Weather, accessibility. I personally am able to obtain positive experiences through this form and believe it is helpful overall.

316. Supervision is typically conducted in-person and was only moved to be virtual on 2 occasions when one of us was sick. It didn't impact the quality of supervision and did help with accessibility.

317. Supervision provided via televideo was a completely positive experience. I was able to get supervision from someone who specialized in the area of expertise I am most interested in. It allowed me to spend less time commuting and more time on focusing what was important.

318. Supervision via telehealth has been positive. I prefer in person supervision, but it has been really great to have the option in inclement weather, if not feeling well, etc.

319. Televideo and virtual modalities are not the same quality as in-person. It is almost absurd to dispute that point.

320. Televideo has been very helpful. I encourage we continue to all for this option. It opens the door to qualified supervision by opening the door to supervision options.

321. Televideo has made supervision more accessible because my supervisor is in a different county, however I would say the quality of supervision over televideo is mostly negative because I can see my supervisor scrolling Facebook in her glasses.

322. Televideo supervision allowed me and my clinical supervisor to review the clinical record at the same time while remaining face to face on video. For social workers in a rural area, allowing televideo increases the quality of supervision, as it would be more difficult to have a supervisor without a dual relationship or other conflict of interest in a small community.

323. Televideo supervision has allowed for group supervision. With this, I have been able to learn from other supervisees and guidance from our supervisor that I would not obtain due to schedule conflicts for in person supervision. Televideo supervision has been highly beneficial.

324. Televideo supervision has been positive. It increases access to supervisors as we work in multiple locations and have different schedules.

325. Televideo supervision is a positive change that helps people access needed supervision. It does not have any negative impact on supervision quality.

326. Televideo supervision was efficient and positive. It allowed for more efficient use of my time by not having to travel to my supervisor's office. I was able to find a supervisor that was in my interest area with greater ease because of televideo.

327. The ability to do televideo supervision has been helpful if weather or other factors deter me from attending in person. The quality of the televideo supervision is hit and miss but that is more so on the supervisor than on any other factors.

328. The ability to have supervision over televideo was a positive experience. My supervisor was not always in my local area, so the ability to do supervision remotely was important. Also, the ability to have remote supervision allows the opportunity for those in rural areas to have the opportunity to have supervision.

329. The ability to move supervision in person to televideo as need arises has given me to opportunity to continue gaining supervision and see as many clients as possible.

330. The ability to use remote options for supervision was very important to me for accessing clinical supervision during and after the pandemic. I feel the quality was similar to in person supervision and at times better. It was easier to share materials and discuss using screen share and this allowed for me to gather more resources and tools.

331. The quality of my supervision has been positive.

332. "The quality of televideo supervision is overall positive.

333. Televideo supervision is not of as high quality as is in-person supervision.

334. Receiving supervision remotely does help in accessing supervision (self-explanatory, such as in context of physical illness sxs or transportation or other logistical challenges)."

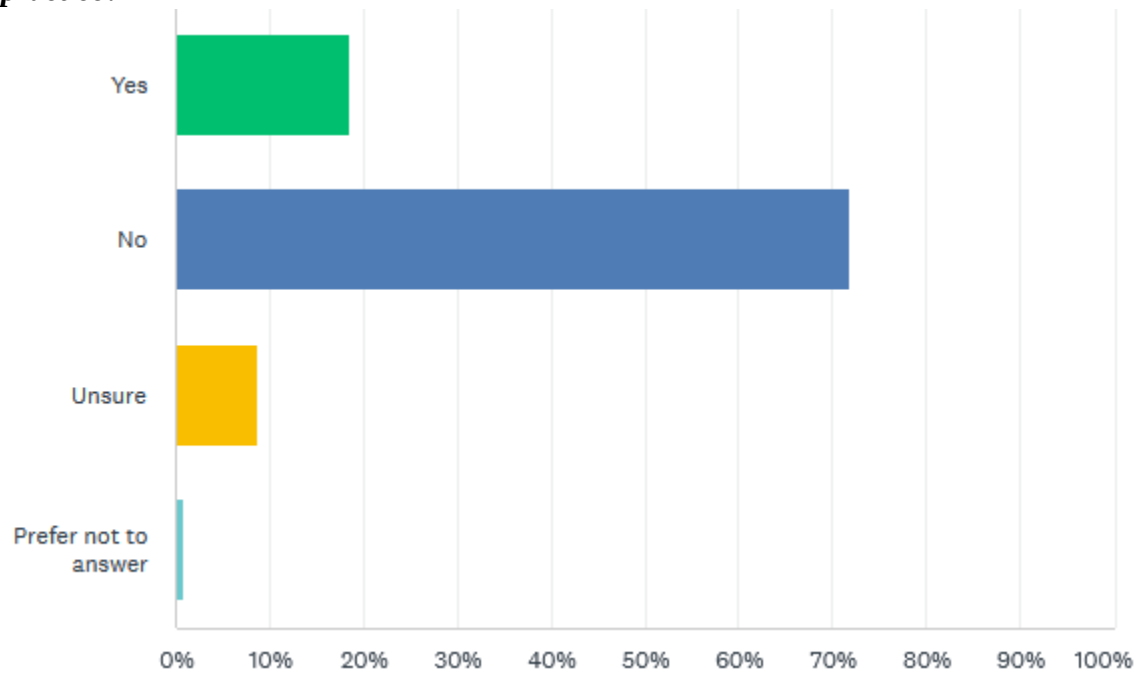
335. The remote option has been positive. It has allowed me to pick supervisors that are in alignment with my population and therapeutic approaches.

336. There have been no supervisors available to me, in person or not.
337. There were only a couple of times that we had to do supervision remotely. It did not affect the quality of supervision. Mainly my supervision is in person.
338. This allowed more options for supervisors.
339. This has allowed me to meet with supervisors who are not only LSCWS, but also RPTS and helped me in both learning more about my clinical skills, as well as my play therapy skills at the same time.
340. This has been a mostly positive experience. I have been able to meet with my supervisor more regularly and it has helped in scheduling around their and my other meetings/appointments.
341. This has been a positive change to increase accessibility, ensure clinical oversight, and improve client care.
342. This has been a positive experience
343. This has been all positive. It helps with scheduling.
344. This has been essential!!
345. This has only been positive. I was living in a rural area and could receive supervision from my supervisor who lived in an urban setting. It also allowed for greater time flexibility. Lastly, I was able to have more options for supervisors.
346. This is not about this question per se, but there was nowhere to put additional comments...but I wanted to bring up the LSCSW exam. I took it and missed by 1 point. It was so stressful, and my mental health suffered from the anxiety. I have been a sw for over 23 years and have passed both the LBSW and LMSW exams. Would BSRB be willing to consider taking a second look at sw's that missed by such a small margin on the exam? It's 1 point, but I cannot take it again due to the stress.
347. This type of supervision allows the Social Worker to be matched with specialists and people who match their clinical need. I believe this is highly beneficial.
348. Though I prefer in-person because I would always rather meet with someone in person vs online in any situation, I did find tele-supervision to be as effective as in-person supervision.
- 349. Very positive (3 Responses)**
350. Very positive and allowed for some flexibility considering how much I have to work to afford paying for my own clinical supervision.
351. Very positive and beneficial
352. Very positive and realistic as traveling to and from takes away from my daily duties.
353. Very positive and very thankful for the opportunity to be able to do that!
354. Very positive because of my strong bond with the individual. The tele aspect did not diminish.
355. Very positive, it's easier to fit into my schedule when completed over televideo.
356. Very positive. It allowed more freedom and time for my supervisor and I when arranging our appointment times.
357. Very positive. Virtual supervision has allowed us to meet when weather is bad, children are sick, etc. I find value in both in person and virtual supervision. I tend to be more open on virtual sessions.
- 358. Yes (11 Responses)**
359. Yes especially with scheduling conflicts

360. Yes- I feel with technology televideo supervision is no different than in person supervision
361. Yes, I felt my supervisor and meetings were high quality and fine
362. Yes, I have never felt like there was an issue with televideo supervision. My supervisor handled it very effectively.
363. Yes, I have received positive results. It has allowed me to save gas going out of town as well as remain available for my clients. I've also had some car trouble which would have otherwise made traveling for supervision very difficult as well as more expensive due to gas reasons.
364. Yes it has all been positive no downside at all.
365. Yes it has helped when my supervisor was busy and it would have resulted in a cancelled session otherwise.
366. Yes, it is helpful to have multiple options
367. Yes it was a positive experience and helped to make supervision more accessible.
368. Yes it was mostly positive, being able to meet for supervision by televideo was very helpful for access, it increased the times available for us to schedule and meet, cut down on travel time and expense, and seemed very beneficial to have as an option for both supervisor and supervisee!
369. Yes, it's been mostly positive. It's allowed for ability to keep supervision appointments when other weather, scheduling, or transportation issues they have gotten in the way otherwise.
370. Yes more convenient and just as helpful
371. Yes more flexibility
372. Yes most of my supervision was remote and good quality and It significantly reduced what would have been barriers for in person supervision.
373. Yes mostly positive
374. Yes remote is conducive to work schedule
375. Yes this has helped immensely in accessing quality supervision.
376. Yes! It removes barriers and allows the supervision to continue when life brings challenges.
377. Yes! It was easily accessible & I could see resources quickly. I was providing a lot of Telehealth & supervision in the way was helpful to be able to model & transfer skills practiced.
378. Yes! My clinical supervisor was always available and supportive.
379. Yes! Perfect all the way around for flexibility with schedules.
380. Yes! This has been so helpful, as when someone is sick or traveling, meeting can still occur.
381. Yes, all positive. Accessibility has been positively affected as well.
382. Yes, definitely positive. Remote supervision allowed me to continue my clinical supervision during the pandemic when it was necessary if I was sick, my children were sick, or my supervisor was sick. Without it, I'm not sure if I would've been able to complete the clinical licensing process.
383. Yes, I loved my video supervision. It was great to add it into my workday instead of taking off time to drive and meet someone. It was very high quality.
384. Yes, I'm blessed with the best without this it would Not be possible
385. yes, it has been positive and necessary in my circumstances given some life events with family health issues making office visits difficult.
386. Yes, it has been very positive.
387. Yes, it has made supervision attainable and should remain an option.

388. Yes, it was quality supervision that was received.
389. Yes, there are times my clinical supervisor is working at a different location than me so it is very convenient to do televideo instead.
390. Yes, when I was working in a rural area, access via televideo saved me multiple hours of drive time and helped me to maximize my patient/client contact.
391. Yes. Makes it much easier to receive supervision when both are busy professionals who sometimes don't have time to be in the same space.
392. Yes. I believe being remote added so much flexibility and removed a lot of barriers. My supervisor experience was mostly positive.
393. Yes. It was a positive experience and helps with access.
394. Yes. My supervisor would not be able to meet every week in person only.
395. Yes. Super helpful to have the option of virtual. Saves time.

Question 14. *Kansas currently requires 40 hours of continuing education every two-year license period for each level of permanent social work license. **Do you believe lowering the required number of hours from 40 hours to 30 hours would negatively affect professionalism and safe practice?***



ANSWER CHOICES	RESPONSES	
▼ Yes	18.62%	483
▼ No	71.78%	1,862
▼ Unsure	8.71%	226
▼ Prefer not to answer	0.89%	23
TOTAL		2,594

Additional Comments

The Behavioral Sciences Regulatory Board thanks all social workers who completed the 2024 Survey of Social Workers. In addition to the feedback that was provided through the survey, a handful of individuals sent messages to the BSRB with additional comments, so those comments have been summarized below:

- One individual stated they loved this approach;
- One individual noted they had been licensed as a bachelor's level social worker for several decades and expressed discouragement with the lack of jobs available for social workers at the bachelor's and master's levels of licensure. This individual expressed a request for a way to be able to advance to a higher level of license based on years of practice, noting that it would not be feasible to return to school and incur student loans;
- One individual asked if it would be permitted to share information for the survey on a social media group site (*note: the BSRB informed this individual that it would be appropriate to share news about the survey, but not to share the individual message, as that was sent to his personal e-mail with a specific link for him to take the survey.*);
- Two individuals noted being unable to receive the survey (*note: the BSRB followed up with both individuals and offered to work with these individuals to obtain their responses. One individual agreed and the results from this individual were entered manually into the survey results and are reflected in the combined report. Several other e-mail "bounce-back" notices were received by the agency, so the BSRB followed up to update contact information and to send the survey to individuals who did not receive it originally.*)
- One individual noted difficulty answering the demographic question on the survey, as he holds two different employment positions, and one job involves work in an urban setting while another job involves work throughout the entire state;
- One individual expressed concern that the survey questions may be written in a misleading way and noted that they might have answered some questions differently if they did not read the questions closely. This individual also expressed concerns with being asked to provide feedback on topics, such as a proposed multi-state compact, without more details being made clear, such as whether a person would need to pay a fee for a multi-state license if someone is already licensed in Kansas;
- One individual stated interest in learning the outcomes from the survey, specifically concerning the question on a potential decrease in continuing education hours. This individual expressed support for decreasing the required hours from 40 hours to 30 hours and noted that workshops can be costly, given social worker salaries. (*Note: the BSRB informed this individual that the survey responses would be included in a report and a link to the report would be sent to all social workers when the report was available.*); and
- One individual expressed concern regarding a possible decrease in professional standards, such as discontinuing a national examination and lowering continuing education hours from 40 hours to 30 hours. This individual noted the social work community should be working to strengthen professional standards to better serve clients, given the need for ethics, advanced critical thinking, and communication skills.