Virginia Department of Health Professions
Board of Social Work

Agenda
Full Board Meeting

September 21, 2018
Board Room 1
10:00 a.m.

Call to Order – John Salay, LCSW, Board Chair
- Welcome and Introductions
- Mission of the Board
- Roll Call
- Emergency Egress Procedures

Approval of Minutes
- Board Meeting – June 15, 2018

Ordering of Agenda

Public Comment

The Board will receive public comment related to agenda items at this time. The Board will not receive comment on any pending regulation process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.

Agency Report - David E. Brown, DC, Agency Director

Presentation
- 2018 Workforce Report – **Elizabeth Carter, PhD, Executive Director, Healthcare Workforce Data Center**

Staff Reports
- Executive Director's Report – **Jaime Hoyle, JD, Executive Director**
- Discipline Report – **Jennifer Lang, Deputy Executive Director**
- Licensing Manager's Report – **Latasha Austin, Licensing Manager**

Committee and Board Member Reports
- Board of Health Professions Report – None
- Legislative/Regulatory Committee – None

Legislation and Regulatory Actions – Elaine Yeatts, Senior Policy Analyst
- Board Action on Proposed Regulations *(additional hours in ethics for continuing education)*

Unfinished Business
- None

New Business

- **Review of Guidance Documents**
  - Guidance Dcoument 140-1 *(Guidance on Use of Confidentsil Consent Agreements)*
  - Guidance Document 140-3 *(Guidance on Technology-Assisted Therapy & the Use of Social Media)*
  - Guidance Document 140-4.2 *(Guidance on Possible Disciplinary or Alternative Actions in Response to Non-compliance with Continuing Education Requirements)*
- **Abuse of Complaint Process** – Jamie Clancey, LCSW

Next Meeting

- Agenda Items & Topics for Next Meeting
- Date of Next Meeting
- 2019 Meeting Dates

Meeting Adjournment

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the public body at the meeting and will be available to the public pursuant to Virginia Code Section 2.2-3708(D).

Virginia Department of
Health Professions
Board of Social Work

Approval of Quarterly Full Board Meeting Minutes June 15, 2018

THE VIRGINIA BOARD OF SOCIAL WORK
MINUTES
Friday, June 15, 2018

The Virginia Board of Social Work ("Board") meeting convened at 10:00 a.m. on Friday, June 15, 2018 at the Department of Health Professions, 9960 Mayland Drive, Henrico, Virginia. Yvonne Haynes, L.C.S.W., Board Chair called the meeting to order at 10:06 a.m.

BOARD MEMBERS PRESENT: Maria Eugenia del Villar, L.C.S.W.
Yvonne Haynes, L.C.S.W., Chair
Dolores Paulson, L.C.S.W., Ph.D.
John Salay, L.C.S.W., Vice- Chair
Joseph Walsh, L.C.S.W., Ph.D.

BOARD MEMBERS ABSENT: Canek Aguirre, Citizen Member
Angelia Allen, Citizen Member
Jamie Clancey, L.C.S.W.
Gloria Manns, L.C.S.W.

STAFF PRESENT: Latasha Austin, Licensing Manager
Christy Evans, Discipline Case Specialist
Jaime Hoyle, Executive Director
Jennifer Lang, Deputy Executive Director

OTHERS PRESENT: Elaine Yeatts, Senior Policy Analyst, Department of Health Professions
David E. Brown, D.C., Director, Department of Health Professions
Barbara Allison-Bryan, M.D., Deputy Director, Department of Health Professions

BOARD COUNSEL PRESENT: James E. Rutkowski, Assistant Attorney General

IN THE AUDIENCE: Sue Rowland, Virginia Society for Clinical Social Work

MISSION STATEMENT:
Ms. Haynes read the mission statement of the Department of Health Professions, which was also the mission statement of the Board.

ROLL CALL:
Ms. Haynes requested a roll call. Ms. Austin announced that five members of the Board were present; therefore, a quorum was established.

EMERGENCY EGRESS:
Ms. Haynes announced the Emergency Egress procedures.

APPROVAL OF MINUTES:
Ms. Haynes requested that a correction be made to the last sentence of the Chairman's report. Ms. Haynes requested that last sentence be corrected to read as follows: *Ms. Haynes explained the proposed Member board's contribution to the ASWB mobility strategy and the three bylaw amendments that were approved by the delegate assembly.*

Dr. Paulson inquired if the minutes should reflect the receipt of a letter from Psychology.

Upon a motion by Dr. Walsh, which was properly seconded by Ms. Del Villar, the meeting minutes from the Full Quarterly Board Meeting held on February 2, 2018 were approved with one correction, adding the Board's response to the Board of Psychology's Draft Joint Guidance Document on Assessment Titles and Signatures as an attachment. The motion passed with none abstaining.

PUBLIC COMMENT:
There was no public comment.

AGENCY REPORT:
Dr. Brown informed the Board of the new administrative changes appointments under Governor Northam. Dr. Brown informed the Board that the new Secretary of Health and Human Resources is Dr. Daniel Carey, M.D. and that the new Deputy Secretaries of Health and Human Resources are Gena Boyle Berger and Marvin Figueroa.

Dr. Brown announced and introduced the new Deputy Director for the Department of Health Professions, Dr. Barbara Allison-Bryan, M.D.

Dr. Brown also informed the Board on legislative bills related to the Department of Health Professions.

EXECUTIVE DIRECTOR'S REPORT:
Ms. Hoyle discussed the budget for the Board of Social Work. A copy of the report given was included in the agenda packet.

Ms. Hoyle announced and introduced Latasha Austin as the new Licensing Manager for the Board of Social Work. Ms. Austin came to the Board of Social Work having worked for the Board of Nursing as a Senior Licensing and Discipline Specialist.

Ms. Hoyle informed the Board that the Customer Satisfactory Rates for the last quarter was 92%.

Ms. Hoyle recognized Ms. Haynes for her service to the Board of Social Work as her 2nd term comes to an end. Ms. Hoyle acknowledged that Ms. Haynes has been on the Board since 2010 and recognized her for all her accomplishments since she has been on the Board with a plaque.

DEPUTY DIRECTOR'S REPORT:
Ms. Lang reported on the disciplinary statistics for the Board of Social Work. A copy of the report given was included in the agenda packet.

LICENSING MANAGER'S REPORT:
Ms. Austin reported on the licensing statistics for the Board of Social Work. A copy of the report given was included in the agenda packet.

BOARD COUNSEL'S REPORT:
No report

COMMITTEE REPORTS:
- Board of Health Professions Report: No report

- Legislative/Regulatory Committee Report: No report

LEGISLATION & REGULATORY ACTIONS:
Ms. Yeatts informed the Board that the regulatory actions regarding the hours of ethics required for Social Workers and the correction to the regulations regarding failing the examination twice were currently under review at the Governor's office. Ms. Yeatts also informed the Board that there is currently a backlog in the Governor's office, so she was unable to give a timeframe for when the actions would be complete.

Ms. Yeatts discussed House Bill 614, which changed Licensed Social Workers to Baccalaureate Social Workers and Masters of Social Work. This legislation passed the General Assembly and will become effective on July 1, 2018. The Board reviewed proposed draft exempt regulations that would reflect the changes to the Code as result of passage of House Bill 614, and conform the current regulations to the Code.

Upon a motion by Dr. Walsh, which was properly seconded by Mr. Salay, the motion to adopt the changes to Chapter 20 to conform to the changes in code as outlined in House Bill 614 was approved. The motion passed with none abstaining.

UNFINISHED BUSINESS:
No unfinished business was discussed.

NEW BUSINESS:

- **Guidance Document 140-3:**

Guidance Document 140-3 was reviewed and discussed by the Board. It was determined that Dr. Walsh would form a Committee to edit the document with draft changes to present to the Board as a recommendation.

- **Guidance Document 140-5:**

Guidance Document 140-5 was reviewed and discussed by the Board.

Upon a motion by Dr. Paulson, which was properly seconded by Mr. Salay, the Board voted unanimously to reaffirm Guidance Document 140-5.

- **Guidance Document 140-12:**

Guidance Document 140-12 was reviewed and discussed by the Board.

Upon a motion by Mr. Salay, which was properly seconded by Dr. Walsh, the Board voted unanimously to repeal Guidance Document 140-12.

- **Guidance Document 140-11:**

Guidance Document 140-11 was reviewed and discussed by the Board.

Upon a motion by Dr. Walsh, which was properly seconded by Mr. Salay, the Board voted unanimously to amend Guidance Document 140-11 by deleting the monetary penalty of $250.00 as a possible action for first offenses involving practice with an expired license; 90 days or less.

- **Virginia Board of Social Work By Laws:**

The Board reviewed the Bylaws revised June 15, 2018 that were provided in the agenda packet.

Upon a motion by Dr. Walsh, which was properly seconded by Dr. Paulson, the Board voted unanimously to accept the Bylaws.

Virginia Board of Social Work Elections:
As chair of the Nominations Committee, Dr. Paulson announced the nominations. The nomination for chair was John Salay. The nomination for Vice Chair was Dr. Dolores Paulson.

The Board voted unanimously to elect John Salay as the new Chair for the Board of Social Work.

The Board voted unanimously to elect Dr. Dolores Paulson as the new Vice Chair for the Board of Social Work.

NEXT MEETING:

Ms. Haynes announced that the next quarterly scheduled full Board meeting would occur on September 21, 2018.

ADJOURNMENT:

The meeting was adorned by Ms. Haynes at 11:25a.m.

_____
Yvonne Haynes, L.C.S.W., Chair

_____
Jaime Hoyle, Executive Director

Virginia Department of
Health Professions
Board of Social Work

Presentation
2018 Workforce Report

Virginia's Licensed Clinical Social Worker Workforce: 2018

Healthcare Workforce Data Center

August 2018

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-367-2115, 804-527-4466(fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from: ***https://www.dhp.virginia.gov/hwdc/findings.htm***

5,838 Licensed Clinical Social Workers voluntarily participated in this survey. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Social Work express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, DC
Director

Barbara Allison-Bryan, MD
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Elizabeth Carter, PhD	Yetty Shobo, PhD	Laura Jackson, MSHSA	Christopher Coyle
Director	*Deputy Director*	*Operations Manager*	*Research Assistant*

Virginia Board of Social Work

Chair

John Salay, LCSW
Midlothian

Vice-Chair

Dolores Paulson, PhD, LCSW
McLean

Members

Canek Aguirre
Alexandria

Angelia Allen
Portsmouth

Jamie Clancey, LCSW
Culpeper

Maria Eugenia del Villar, LCSW
Fairfax

Michael Hayter, LCSW, CSAC
Abingdon

Gloria Manns, LCSW
Roanoke

Joseph Walsh, PhD, LCSW
Richmond

Executive Director

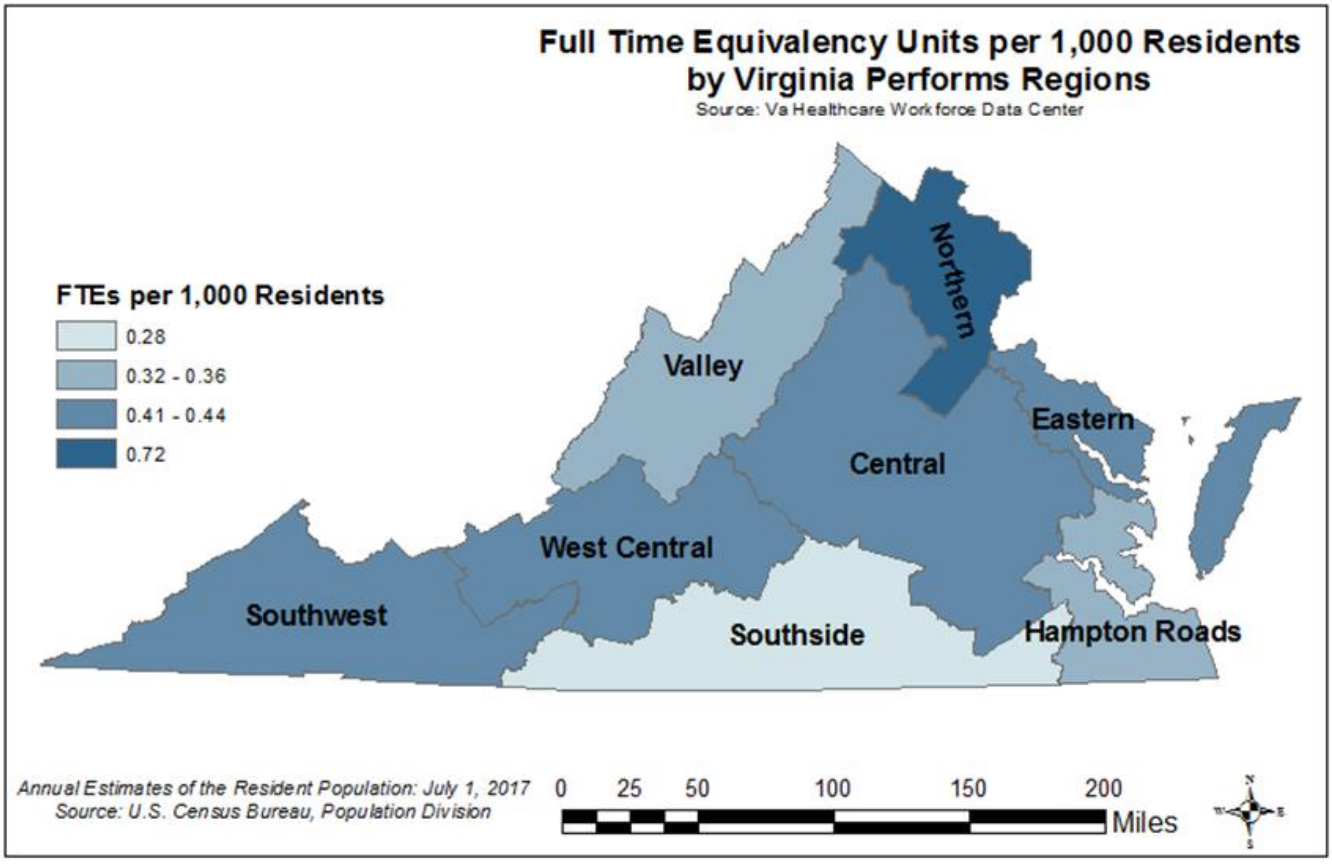
Jaime H. Hoyle, JD

Contents

The Licensed Clinical Social Worker Workforce: At a Glance:

The Workforce		Background		Current Employment	
Licensees:	6,984	Rural Childhood:	23%	Employed in Prof.:	90%
Virginia's Workforce:	5,787	HS Degree in VA:	45%	Hold 1 Full-time Job:	55%
FTEs:	4,690	Prof. Degree in VA:	54%	Satisfied?:	96%
Survey Response Rate		**Education**		**Job Turnover**	
All Licensees:	84%	Masters:	96%	Switched Jobs:	6%
Renewing Practitioners:	93%	Doctorate:	4%	Employed over 2 yrs:	71%
Demographics		**Finances**		**Time Allocation**	
Female:	86%	Median Income:	$60k-$70k	Patient Care:	70%-79%
Diversity Index:	34%	Health Benefits:	65%	Administration:	10%-19%
Median Age:	51	Under 40 w/ Ed debt:	64%	Patient Care Role:	62%

Source: Va. Healthcare Workforce Data Center



Results in Brief

An estimated 5,787 Licensed Clinical Social Workers (LCSWs) participated in Virginia's workforce, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work as an LCSW at some point in the future. Between July 2017 and June 2018, these LCSWs provided 4,690 "full-time equivalency units (FTE)", which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off). These data are from the LCSW Survey which the Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers during the license renewal process, which takes place every June for LCSWs.

Nearly all LCSWs have a Master's degree as their highest professional degree, while the remaining LCSWs have a doctoral degree. 55% of all LCSWs have a primary specialty in mental health, while another 8% specialize in issues related to children. 35% of all LCSWs currently carry educational debt and the median debt burden for those with educational debt is between $40,000 and $50,000. Median annual income is only slightly higher than the debt at between $60,000 and $70,000. In addition, 63% of all LCSWs receive at least one employer-sponsored benefit and 96% of LCSWs indicate they are satisfied with their current employment situation.

86% of all LCSWs are female, including 91% of those LCSWs who are under the age of 40. In a random encounter between two LCSWs, there is a 34% chance that they would be of different races or ethnicities, a measure known as the diversity index. Overall, just 6% of Virginia's LCSWs work in rural areas of the state. Nearly 40% of all LCSWs work in Northern Virginia, while another 28% work in Central Virginia. Two-thirds of all LCSWs work in the private sector, including 47% who work at a for-profit institution. Approximately a third of all LCSWs work in either a solo or group private practice at their primary work location, while another 14% work at an outpatient mental health facility. About 27% of all LCSWs expect to retire by the age of 65; 27% of the current workforce expect to retire in the next ten years.

Summary of Trends

The LCSW workforce has witnessed consistent and significant growth in many areas in the past four years. Both the total number of LCSWs and the number working in Virginia increased by 20% and 16%, respectively, when compared to 2013. FTE, however, increased by only 7% in the same period. The LCSW workforce has also witnessed increasing racial/ethnic diversity; the diversity index increased from 27% in 2013 to 34% in 2018. For the first time in 5 years, median age declined to 51 years from the 53-54 years where it had hovered in the previous 4 years. The percent under age 40 also increased from 18% in 2013 to 23% in 2018.

There has not been much change with regards to educational attainment and education debt. Most LCSWs have a Master's degree as their higher educational attainment. In 2013, 95% reported their highest educational attainment as a Master's degree and, in 2018, 96% did. The specialty reported by LCSWs has also barely changed; the top three specialties have been mental, children, and family – in the past 5 years and about the same percent reported each every year. The percent reporting education debt increased from 27% in 2013 to 35% in 2018. The percent under 40 with education debt increased from 68% in 2013 to 70% in 2015 and then was back down to 64% in 2018. After increasing from $30,000-$40,000 to $40,000-$50,000 in 2015, the median education debt has been stable. A higher proportion also hold higher debt as the percent with more than $90,000 in education debt increased from 2.3% to 7.5% in the period examined. The percent reporting more than $90,000 in income also increased from 9% in 2013 to 17% in 2018 even though the median income remained at $60,000-$70,000 since its last increase in 2017.

Close to half of all LCSWs are employed in the private sector consistently over the years. The establishments that LCSWs worked and the geographic distribution of LCSWs has barely changed over the past 5 years. LCSWs' location in non-metro areas of the state has also barely changed. The percent working in non-metro area has hovered around 5-6% in the past 5 years. The retirement expectations have also barely changed over the past five years for LCSWs; the percent planning to retire within a decade of the survey year declined only slightly from 29% in 2013 to 27% in 2018.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	5,985	86%
New Licensees	582	8%
Non-Renewals	417	6%
All Licensees	**6,984**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 93% of renewing LCSWs submitted a survey. These represent 84% of LCSWs who held a license at some point during the survey time period.

Definitions

1. **The Survey Period:** The survey was conducted in June 2018.
2. **Target Population:** All LCSWs who held a Virginia license at some point between July 2017 and June 2018.
3. **Survey Population:** The survey was available to LCSWs who renewed their licenses online. It was not available to those who did not renew, including LCSWs newly licensed in 2018.

Response Rates	
Completed Surveys	5,838
Response Rate, all licensees	84%
Response Rate, Renewals	93%

Source: Va. Healthcare Workforce Data Center

Response Rates			
Statistic	**Non Respondents**	**Respondent**	**Response Rate**
By Age			
Under 35	248	491	66%
35 to 39	129	639	83%
40 to 44	109	718	87%
45 to 49	109	787	88%
50 to 54	88	683	89%
55 to 59	88	718	89%
60 to 64	81	641	89%
65 and Over	294	1,161	80%
Total	**1,146**	**5,838**	**84%**
New Licenses			
Issued Since July 2017	321	261	45%
Metro Status			
Non-Metro	56	275	83%
Metro	762	4,630	86%
Not in Virginia	329	933	74%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed LCSWs

Number:	6,984
New:	8%
Not Renewed:	6%

Response Rates

All Licensees:	84%
Renewing Practitioners:	93%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

Virginia's LCSW Workforce:	5,787
FTEs:	4,690

Utilization Ratios

Licensees in VA Workforce:	83%
Licensees per FTE:	1.49
Workers per FTE:	1.23

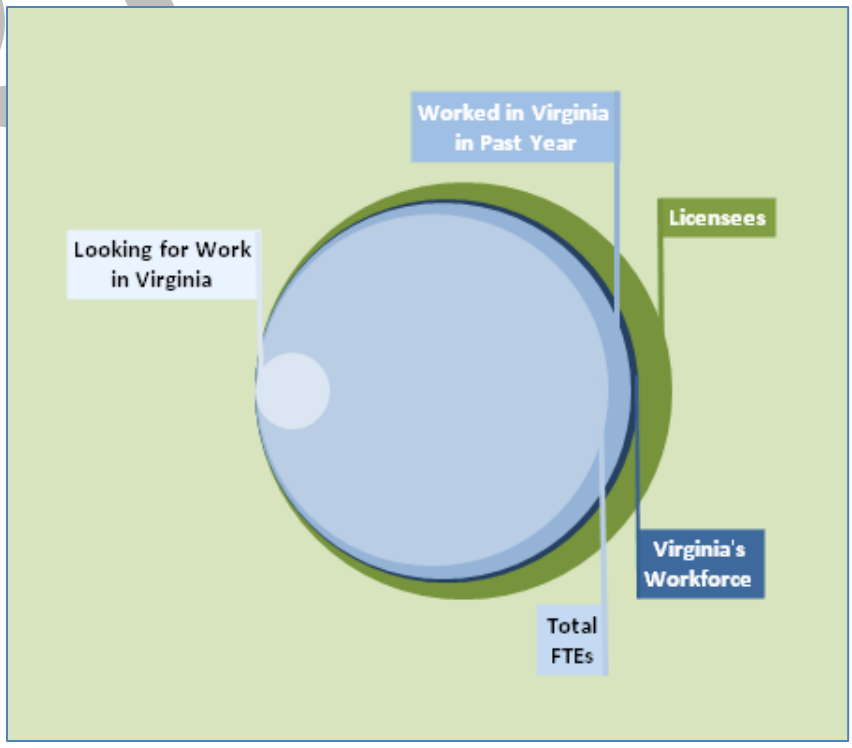
Source: Va. Healthcare Workforce Data Center

Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time during the survey timeframe or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's LCSW Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	5,578	96%
Looking for Work in Virginia	209	4%
Virginia's Workforce	**5,787**	**100%**
Total FTEs	**4,690**	
Licensees	**6,984**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

This report uses weighting to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on HWDC's methodology visit: www.dhp.virginia.gov/hwdc

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 35	41	7%	546	93%	587	12%
35 to 39	62	11%	516	89%	579	11%
40 to 44	46	8%	553	92%	599	12%
45 to 49	88	13%	571	87%	660	13%
50 to 54	77	13%	497	87%	573	11%
55 to 59	69	12%	498	88%	567	11%
60 to 64	91	18%	415	82%	506	10%
65 +	224	23%	749	77%	973	19%
Total	**698**	**14%**	**4,345**	**86%**	**5,044**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	86%
% Under 40 Female:	91%

Age

Median Age:	51
% Under 40:	23%
% 55+:	41%

Diversity

Diversity Index:	34%
Under 40 Div. Index:	43%

Source: Va. Healthcare Workforce Data Center

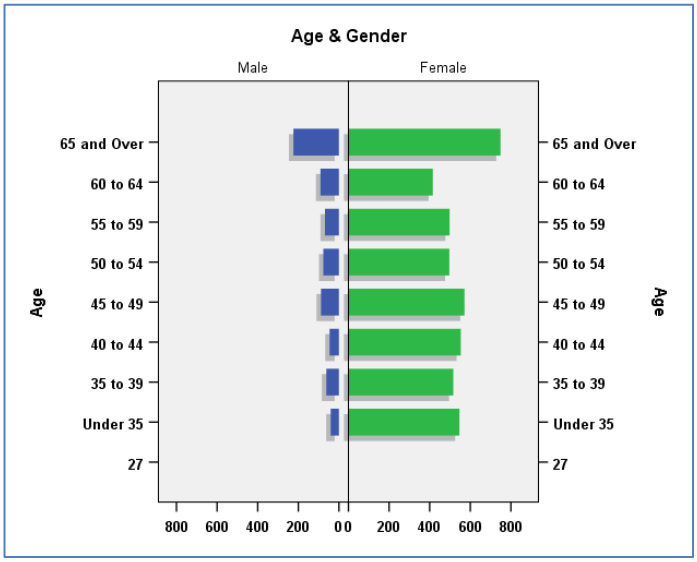
Race & Ethnicity					
Race/ Ethnicity	Virginia*	LCSWs		LCSWs under 40	
	%	#	%	#	%
White	62%	4,047	80%	844	73%
Black	19%	665	13%	218	19%
Asian	7%	78	2%	29	2%
Other Race	0%	28	1%	4	0%
Two or more races	3%	82	2%	23	2%
Hispanic	9%	144	3%	43	4%
Total	**100%**	**5,043**	**100%**	**1,160**	**100%**

*Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2017.

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two LCSWs, there is a 34% chance that they would be of a different race/ethnicity (a measure known as the Diversity Index).

23% of all LCSWs are under the age of 40, and 91% of these professionals are female. In addition, the diversity index among LCSWs who are under the age of 40 is 43%.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	16%
Rural Childhood:	23%

Virginia Background

HS in Virginia:	45%
Prof. Ed. in VA:	54%
HS or Prof. Ed. in VA:	63%

Location Choice

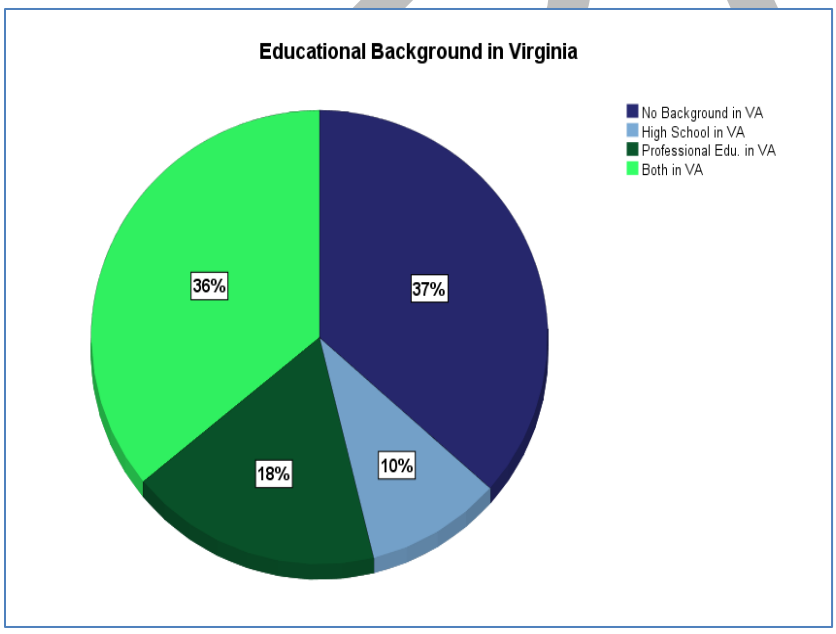
% Rural to Non-Metro:	14%
% Urban/Suburban to Non-Metro:	3%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	18%	65%	17%
2	Metro, 250,000 to 1 million	43%	42%	14%
3	Metro, 250,000 or less	34%	52%	14%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	46%	46%	8%
6	Urban pop, 2,500-19,999, Metro adj	55%	33%	12%
7	Urban pop, 2,500-19,999, nonadj	81%	13%	6%
8	Rural, Metro adj	43%	46%	11%
9	Rural, nonadj	45%	42%	12%
	Overall	**23%**	**60%**	**16%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

23% of LCSWs grew up in self-described rural areas, and 14% of these professionals currently work in non-Metro counties. Overall, just 6% of all LCSWs in the state currently work in non-Metro counties.

Top Ten States for Licensed Clinical Social Worker Recruitment

Rank	All LCSWs			
	High School	#	Init. Prof Degree	#
1	Virginia	2,277	Virginia	2,696
2	New York	412	Washington, D.C.	382
3	Maryland	297	New York	292
4	Pennsylvania	228	Maryland	233
5	New Jersey	179	Massachusetts	142
6	North Carolina	166	Pennsylvania	128
7	Ohio	101	North Carolina	125
8	California	97	Michigan	90
9	Outside U.S./Canada	95	Florida	85
10	Massachusetts	88	Illinois	77

Source: Va. Healthcare Workforce Data Center

45% of licensed LCSWs received their high school degree in Virginia, and 54% received their initial professional degree in the state.

Among LCSWs who received their initial license in the past five years, 47% received their high school degree in Virginia, while 52% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	Init. Prof Degree	#
1	Virginia	950	Virginia	1,037
2	New York	139	New York	138
3	Maryland	118	Washington, D.C.	101
4	North Carolina	82	Maryland	84
5	New Jersey	79	North Carolina	69
6	Pennsylvania	66	Pennsylvania	59
7	Outside U.S./Canada	47	Massachusetts	50
8	California	41	Florida	45
9	Florida	40	Illinois	38
10	Michigan	40	California	37

Source: Va. Healthcare Workforce Data Center

17% of Virginia's licensees did not participate in the state's LCSW workforce during the past year. 83% of these professionals worked at some point in the past year, including 73% who worked in a behavioral sciences-related job.

At a Glance:

Not in VA Workforce

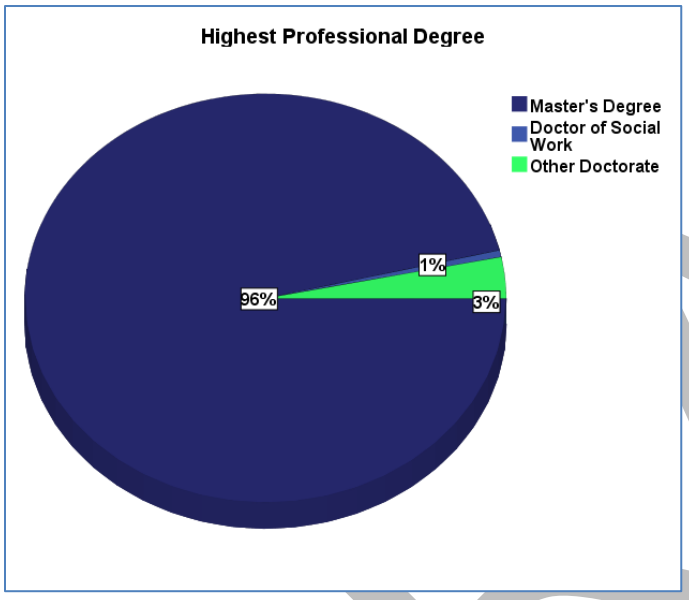
Total:	1,198
% of Licensees:	17%
Federal/Military:	22%
Va. Border State/DC:	26%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Degree		
Degree	#	%
Bachelor's Degree	0	0%
Master's Degree	4,770	96%
Doctor of Social Work	26	1%
Other Doctorate	161	3%
Total	**4,957**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

At a Glance:

Education

Master's Degree:	96%
Doctorate:	4%

Educational Debt

Carry debt:	35%
Under age 40 w/ debt:	64%
Median debt:	$40k-$50k

Source: Va. Healthcare Workforce Data Center

35% of LCSWs carry educational debt, including 64% of those under the age of 40. The median debt burden among LCSWs with educational debt is between $40,000 and $50,000.

Educational Debt				
Amount Carried	All LCSWs		LCSWs under 40	
	#	%	#	%
None	2,854	65%	371	36%
Less than $10,000	171	4%	61	6%
$10,000-$19,999	171	4%	57	5%
$20,000-$29,999	183	4%	65	6%
$30,000-$39,999	160	4%	64	6%
$40,000-$49,999	123	3%	58	6%
$50,000-$59,999	126	3%	59	6%
$60,000-$69,999	116	3%	61	6%
$70,000-$79,999	79	2%	44	4%
$80,000-$89,999	87	2%	48	5%
$90,000-$99,999	60	1%	25	2%
$100,000-$109,999	94	2%	57	5%
$110,000-$119,999	34	1%	13	1%
$120,000-$129,999	34	1%	14	1%
$130,000-$139,999	28	1%	10	1%
$140,000-$149,999	13	0%	7	1%
$150,000 or More	70	2%	28	3%
Total	**4,403**	**100%**	**1,042**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Primary Specialty

Mental Health:	55%
Child:	8%
Health/Medical:	6%

Secondary Specialty

Mental Health:	15%
Substance Abuse:	11%
Child:	11%

Source: Va. Healthcare Workforce Data Center

More than half of all LCSWs have a primary specialty in mental health. Another 8% have a primary specialty in children, while 6% have a health/medical specialty.

A Closer Look:

Specialties				
Specialty	Primary		Secondary	
	#	%	#	%
Mental Health	2,707	55%	652	15%
Child	417	8%	485	11%
Health/Medical	296	6%	228	5%
Behavioral Disorders	248	5%	456	11%
Family	199	4%	439	10%
School/Educational	176	4%	153	4%
Substance Abuse	166	3%	491	11%
Gerontologic	111	2%	108	3%
Marriage	59	1%	204	5%
Forensic	30	1%	44	1%
Sex Offender Treatment	24	0%	39	1%
Social	23	0%	35	1%
Vocational/Work Environment	9	0%	22	1%
Public Health	7	0%	24	1%
Industrial-Organizational	7	0%	15	0%
Rehabilitation	5	0%	10	0%
Neurology/Neuropsychology	2	0%	9	0%
Experimental or Research	1	0%	2	0%
Other Specialty Area	195	4%	287	7%
General Practice (Non-Specialty)	238	5%	611	14%
Total	**4,919**	**100%**	**4,315**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employment

Employed in Profession: 90%
Involuntarily Unemployed: <1%

Positions Held

1 Full-time: 55%
2 or More Positions: 21%

Weekly Hours:

40 to 49: 48%
60 or more: 4%
Less than 30: 19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	6	0%
Employed in a behavioral sciences-related capacity	4,468	90%
Employed, NOT in a behavioral sciences-related capacity	217	4%
Not working, reason unknown	1	0%
Involuntarily unemployed	14	0%
Voluntarily unemployed	158	3%
Retired	124	2%
Total	**4,987**	**100%**

Source: Va. Healthcare Workforce Data Center

90% of LCSWs are currently employed in their profession. 55% of LCSWs hold one full-time job, and nearly half work between 40 and 49 hours per week.

Current Weekly Hours		
Hours	#	%
0 hours	296	6%
1 to 9 hours	135	3%
10 to 19 hours	332	7%
20 to 29 hours	459	9%
30 to 39 hours	673	14%
40 to 49 hours	2,369	48%
50 to 59 hours	473	10%
60 to 69 hours	140	3%
70 to 79 hours	27	1%
80 or more hours	15	0%
Total	**4,919**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	296	6%
One Part-Time Position	853	17%
Two Part-Time Positions	221	4%
One Full-Time Position	2,731	55%
One Full-Time Position & One Part-Time Position	734	15%
Two Full-Time Positions	17	0%
More than Two Positions	75	2%
Total	**4,928**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	59	1%
Less than $20,000	247	6%
$20,000-$29,999	199	5%
$30,000-$39,999	208	5%
$40,000-$49,999	373	9%
$50,000-$59,999	590	15%
$60,000-$69,999	680	17%
$70,000-$79,999	528	13%
$80,000-$89,999	420	11%
$90,000-$99,999	224	6%
$100,000-$109,999	182	5%
$110,000 or More	248	6%
Total	**3,958**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings

Median Income: $60k-$70k

Benefits

(Salary & Wage Employees only)

Health Insurance: 65%

Retirement: 62%

Satisfaction

Satisfied: 96%

Very Satisfied: 69%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	3,303	69%
Somewhat Satisfied	1,273	27%
Somewhat Dissatisfied	169	4%
Very Dissatisfied	46	1%
Total	**4,791**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical LCSW earned between $60,000 and $70,000 per year. Among LCSWs who received either a wage or salary as compensation at their primary work location, 65% received health insurance and 62% also had access to some form of a retirement plan.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Vacation	2,573	58%	73%
Paid Sick Leave	2,406	54%	68%
Health Insurance	2,338	52%	65%
Dental Insurance	2,239	50%	63%
Retirement	2,219	50%	62%
Group Life Insurance	1,869	42%	53%
Signing/Retention Bonus	148	3%	4%
Receive At Least One Benefit	**2,829**	**63%**	**78%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year		
In the past year did you . . .?	#	%
Experience Involuntary Unemployment?	41	1%
Experience Voluntary Unemployment?	299	5%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	110	2%
Work two or more positions at the same time?	1,232	21%
Switch employers or practices?	360	6%
Experienced at least one	**1,780**	**31%**

Source: Va. Healthcare Workforce Data Center

Only 1% of Virginia's LCSWs experienced involuntary unemployment at some point during the past year. By comparison, Virginia's average monthly unemployment rate was 3.4% during the past 12 months.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	90	2%	69	6%
Less than 6 Months	237	5%	117	10%
6 Months to 1 Year	344	7%	135	11%
1 to 2 Years	706	15%	237	19%
3 to 5 Years	1,067	23%	279	23%
6 to 10 Years	813	17%	152	12%
More than 10 Years	1,426	30%	234	19%
Subtotal	**4,681**	**100%**	**1,223**	**100%**
Did not have location	220		4,483	
Item Missing	886		80	
Total	**5,787**		**5,787**	

Source: Va. Healthcare Workforce Data Center

60% of LCSWs are salaried employees, while 17% receive income from their own business/practice.

At a Glance:

Unemployment Experience

Involuntarily Unemployed: 1%
Underemployed: 2%

Turnover & Tenure

Switched Jobs: 6%
New Location: 18%
Over 2 years: 71%
Over 2 yrs, 2nd location: 54%

Employment Type

Salary/Commission: 60%
Business/Practice Income: 17%

Source: Va. Healthcare Workforce Data Center

71% of LCSWs have worked at their primary location for more than two years, while 6% have switched jobs during the past 12 months.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	2,269	60%
Business/ Practice Income	639	17%
Hourly Wage	554	15%
By Contract	259	7%
Unpaid	34	1%
Subtotal	**3,755**	**100%**
Did not have location	220	
Item Missing	1,812	

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics. The non-seasonally adjusted monthly unemployment rate ranged from 2.8% in April 2018 to 3.9% in July 2017. The rate for June 2018, the last month used in this calculation, is preliminary.

At a Glance:

Concentration

Top Region:	38%
Top 3 Regions:	82%
Lowest Region:	1%

Locations

2 or more (Past Year):	27%
2 or more (Now*):	24%

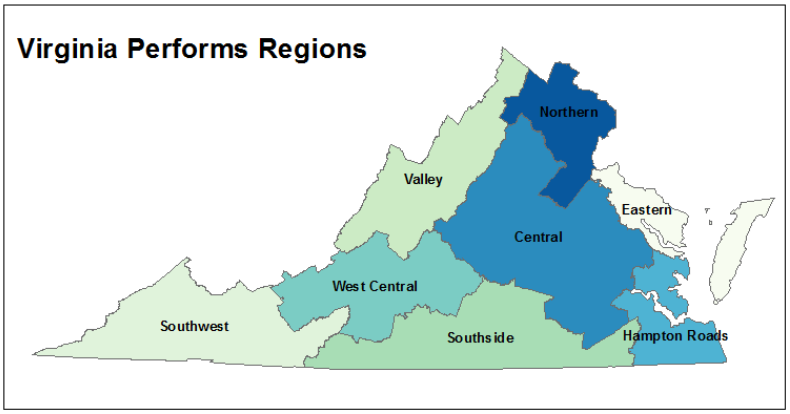
Source: Va. Healthcare Workforce Data Center

38% of LCSWs work in Northern Virginia, the most of any region in the state. In addition, another 28% of LCSWs work in Central Virginia.

A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	1,333	28%	322	25%
Eastern	41	1%	10	1%
Hampton Roads	731	16%	229	18%
Northern	1,761	38%	433	34%
Southside	94	2%	30	2%
Southwest	139	3%	37	3%
Valley	174	4%	38	3%
West Central	340	7%	86	7%
Virginia Border State/DC	27	1%	43	3%
Other US State	38	1%	47	4%
Outside of the US	4	0%	5	0%
Total	**4,682**	**100%**	**1,280**	**100%**
Item Missing	885		23	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	208	4%	286	6%
1	3,378	69%	3,427	70%
2	668	14%	631	13%
3	560	11%	504	10%
4	33	1%	20	0%
5	20	0%	13	0%
6 or More	21	0%	8	0%
Total	**4,888**	**100%**	**4,888**	**100%**

*At the time of survey completion, June 2017.

Source: Va. Healthcare Workforce Data Center

24% of all LCSWs currently have multiple work locations, while 27% had multiple work locations over the course of the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	2,049	47%	760	67%
Non-Profit	925	21%	221	20%
State/Local Government	995	23%	119	11%
Veterans Administration	198	5%	11	1%
U.S. Military	173	4%	14	1%
Other Federal Government	55	1%	8	1%
Total	**4,395**	**100%**	**1,133**	**100%**
Did not have location	220		4483	
Item Missing	1,172		171	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

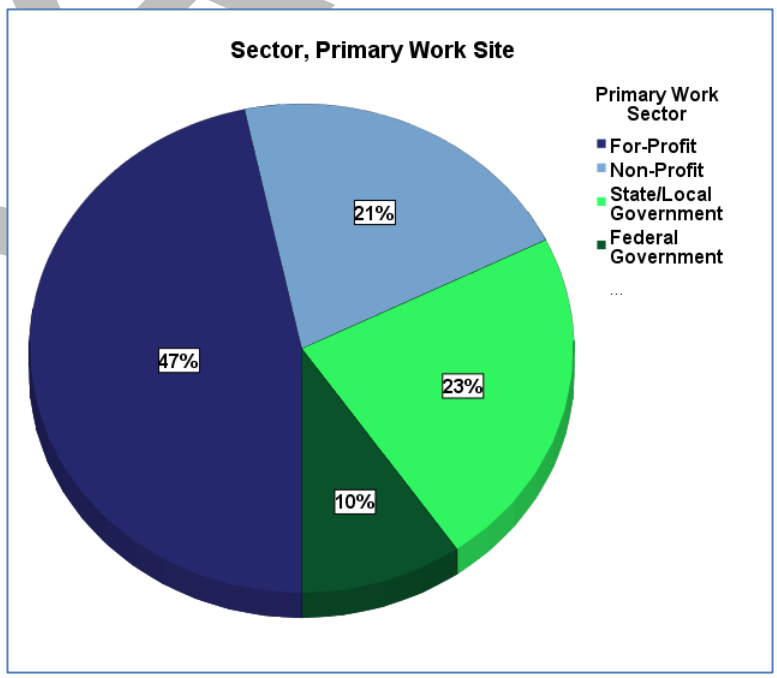
For Profit:	47%
Federal:	10%

Top Establishments

Private Practice, Solo:	16%
Mental Health Facility:	14%
Private Practice, Group:	12%

Source: Va. Healthcare Workforce Data Center

Two-thirds of LCSWs work in the private sector, including 47% who work at for-profit establishments. Meanwhile, 23% of LCSWs work for state or local governments, and 10% work for the federal government.



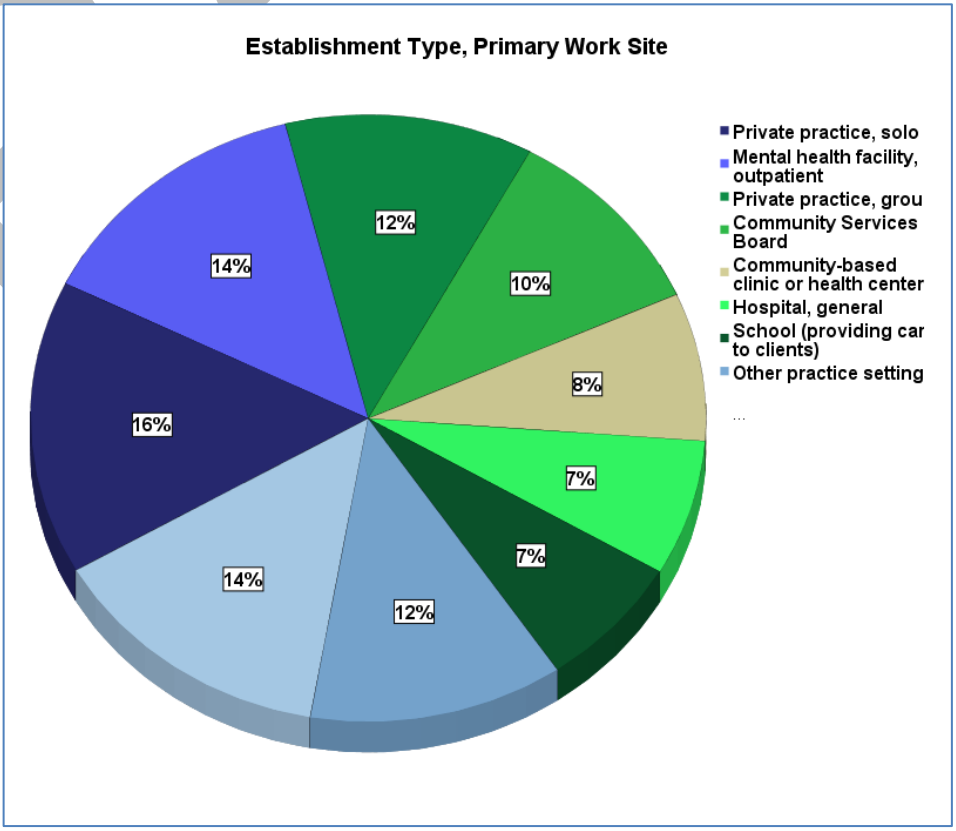
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Private Practice, Solo	647	16%	194	18%
Mental Health Facility, Outpatient	567	14%	174	16%
Private Practice, Group	491	12%	206	19%
Community Services Board	428	10%	53	5%
Community-Based Clinic or Health Center	325	8%	82	8%
Hospital, General	298	7%	49	5%
School (Providing Care to Clients)	294	7%	33	3%
Hospital, Psychiatric	142	3%	30	3%
Administrative or Regulatory	92	2%	12	1%
Residential Mental Health/Substance Abuse Facility	74	2%	16	1%
Academic Institution (Teaching Health Professions Students)	62	2%	53	5%
Other practice setting	709	17%	179	17%
Total	**4,129**	**100%**	**1,081**	**100%**
Did Not Have a Location	220		4,483	

Source: Va. Healthcare Workforce Data Center

28% of all LCSWs work at either a solo or group private practice, while another 14% work at an outpatient mental health facility.

Among those LCSWs who also have a secondary work location, 37% work at either a solo or group private practice, while 16% work at an outpatient mental health facility.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%

Roles

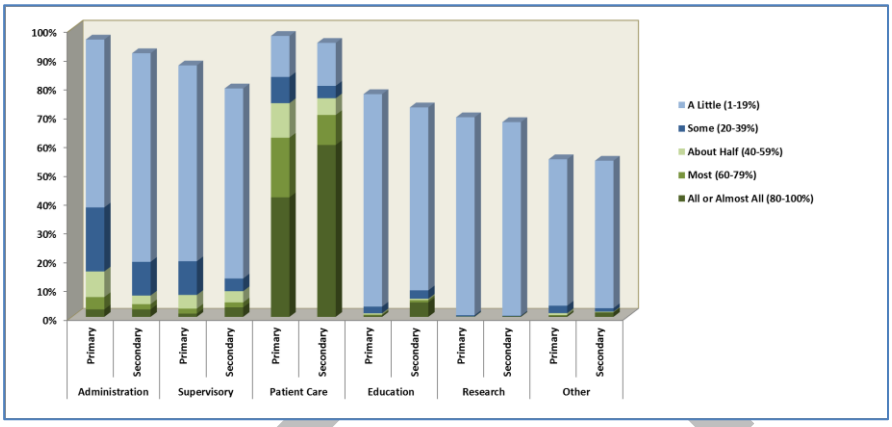
Patient Care:	62%
Administrative:	7%
Supervisory:	3%

Patient Care LCSWs

Median Admin Time:	1%-9%
Ave. Admin Time:	10%-19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



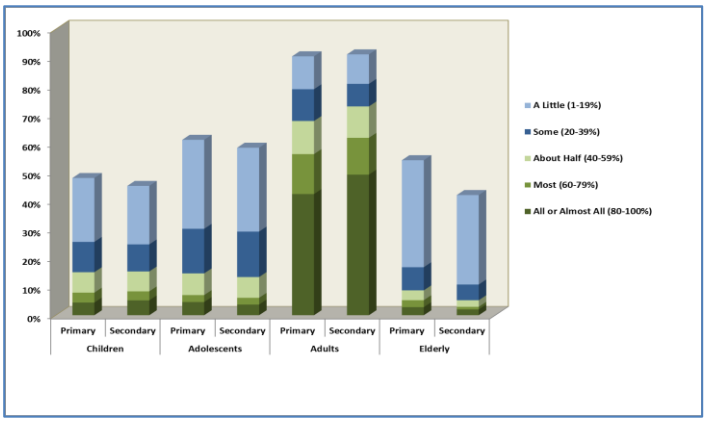
Source: Va. Healthcare Workforce Data Center

62% of all LCSWs fill a patient care role, defined as spending 60% or more of their time on patient care activities. Another 7% of LCSWs fill an administrative role, while 3% fill a supervisory role.

Time Allocation												
Time Spent	Admin.		Supervisory		Patient Care		Education		Research		Other	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	3%	3%	1%	3%	41%	60%	0%	5%	0%	0%	0%	2%
Most (60-79%)	4%	2%	2%	2%	21%	10%	0%	1%	0%	0%	0%	0%
About Half (40-59%)	9%	3%	5%	4%	12%	6%	0%	1%	0%	0%	1%	0%
Some (20-39%)	22%	12%	12%	4%	9%	4%	2%	3%	0%	0%	3%	1%
A Little (1-19%)	58%	72%	68%	66%	14%	15%	74%	64%	69%	67%	51%	51%
None (0%)	4%	9%	13%	21%	2%	5%	23%	27%	31%	32%	45%	46%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

Approximately three-quarters of all patients seen by a typical LCSW at her primary work location are adults. In addition, 56% of LCSWs serve an adult patient care role, meaning that at least 60% of their patients are adults.

At a Glance:
(Primary Locations)

Typical Patient Allocation

Children:	None
Adolescents:	1%-9%
Adults:	70%-79%
Elderly:	1%-9%

Roles

Children:	8%
Adolescents:	7%
Adults:	56%
Elderly:	5%

Source: Va. Healthcare Workforce Data Center

Patient Allocation								
Time Spent	Children		Adolescents		Adults		Elderly	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	4%	5%	5%	4%	42%	49%	3%	2%
Most (60-79%)	3%	3%	2%	2%	14%	13%	2%	1%
About Half (40-59%)	7%	7%	8%	7%	12%	11%	3%	2%
Some (20-39%)	11%	9%	16%	16%	11%	8%	8%	5%
A Little (1-19%)	22%	20%	31%	29%	11%	10%	37%	31%
None (0%)	52%	55%	39%	41%	10%	9%	46%	58%

Source: Va. Healthcare Workforce Data Center

At a Glance:

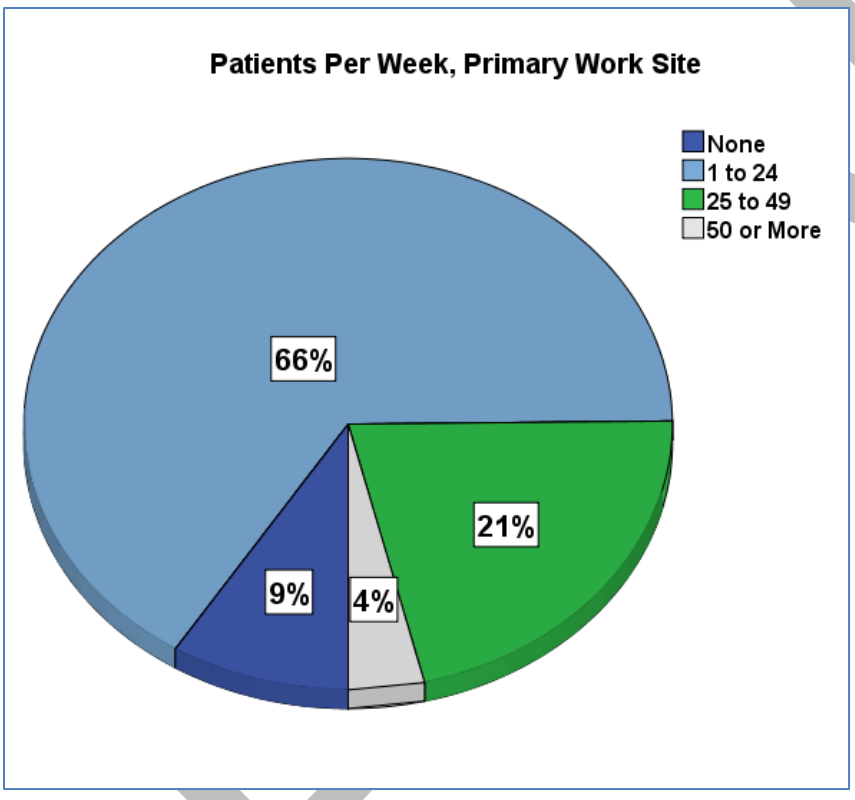
Patients Per Week

Primary Location: 1-24
Secondary Location: 1-24

Source: Va. Healthcare Workforce Data Center

Patients Per Week				
# of Patients	Primary Location		Secondary Location	
	#	%	#	%
None	408	9%	165	15%
1 to 24	2,792	64%	839	76%
25 to 49	983	23%	80	7%
50 to 74	93	2%	11	1%
75 or More	71	2%	9	1%
Total	**4,345**	**100%**	**1,103**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Close to two-thirds of all LCSWs treat between 1 and 24 patients per week at their primary work location. Among those LCSWs who also have a secondary work location, 76% treat between 1 and 24 patients per week.

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All LCSWs		LCSWs over 50	
	#	%	#	%
Under age 50	46	1%	0	0%
50 to 54	94	2%	4	0%
55 to 59	238	6%	57	3%
60 to 64	752	18%	259	12%
65 to 69	1,456	34%	705	32%
70 to 74	842	20%	586	27%
75 to 79	293	7%	227	10%
80 or over	118	3%	97	4%
I do not intend to retire	385	9%	252	12%
Total	**4,224**	**100%**	**2,188**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All LCSWs

Under 65:	27%
Under 60:	9%

LCSWs 50 and over

Under 65:	15%
Under 60:	3%

Time until Retirement

Within 2 years:	8%
Within 10 years:	27%
Half the workforce:	By 2038

Source: Va. Healthcare Workforce Data Center

Although 27% of LCSWs expect to retire by the age of 65, this percentage falls to 15% for those LCSWs who are already at least 50 years old. Meanwhile, 39% of all LCSWs expect to work until at least age 70, including 9% who do not plan on retiring at all.

Within the next two years, only 2% of Virginia's LCSWs plan on leaving the state and another 1% plan on leaving the profession entirely. Meanwhile, 11% plan on increasing patient care hours, and 10% expect to pursue additional educational opportunities.

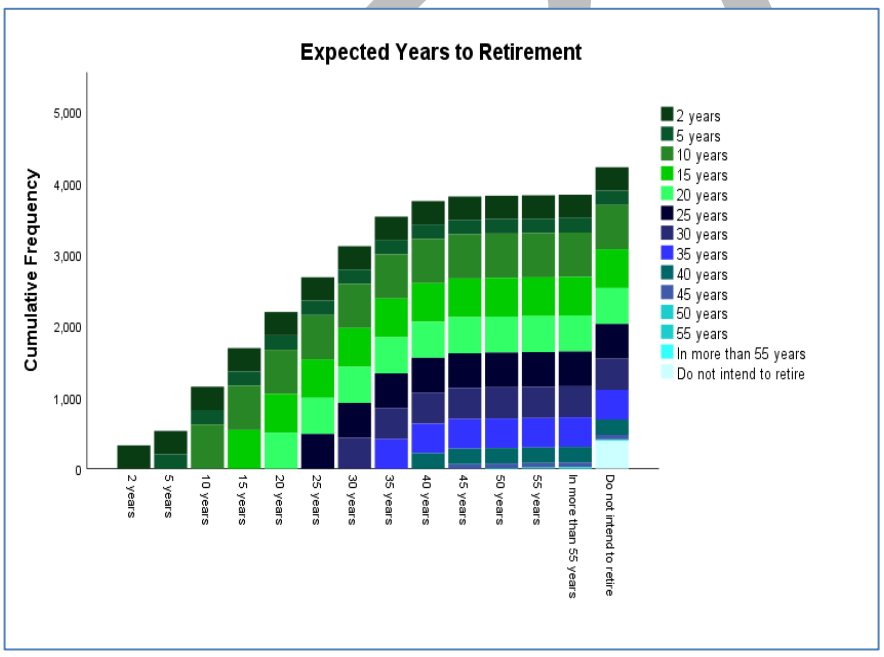
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	67	1%
Leave Virginia	127	2%
Decrease Patient Care Hours	461	8%
Decrease Teaching Hours	37	1%
Increase Participation		
Increase Patient Care Hours	648	11%
Increase Teaching Hours	324	6%
Pursue Additional Education	564	10%
Return to Virginia's Workforce	84	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for LCSWs. 8% of LCSWs expect to retire in the next two years, while just over a quarter plan on retiring in the next ten years. More than half of the current LCSW workforce expects to retire by 2038.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	327	8%	8%
5 years	203	5%	13%
10 years	620	15%	27%
15 years	542	13%	40%
20 years	505	12%	52%
25 years	487	12%	64%
30 years	436	10%	74%
35 years	415	10%	84%
40 years	216	5%	89%
45 years	65	2%	90%
50 years	10	0%	91%
55 years	6	0%	91%
In more than 55 years	9	0%	91%
Do not intend to retire	385	9%	100%
Total	**4,224**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirements will begin to reach over 10% of the current workforce every five years by 2028. Retirements will peak at 16% of the current workforce around the same time period before declining to under 10% of the current workforce again around 2053.

At a Glance:

FTEs

Total:	4,690
FTEs/1,000 Residents[2]:	0.553
Average:	0.84

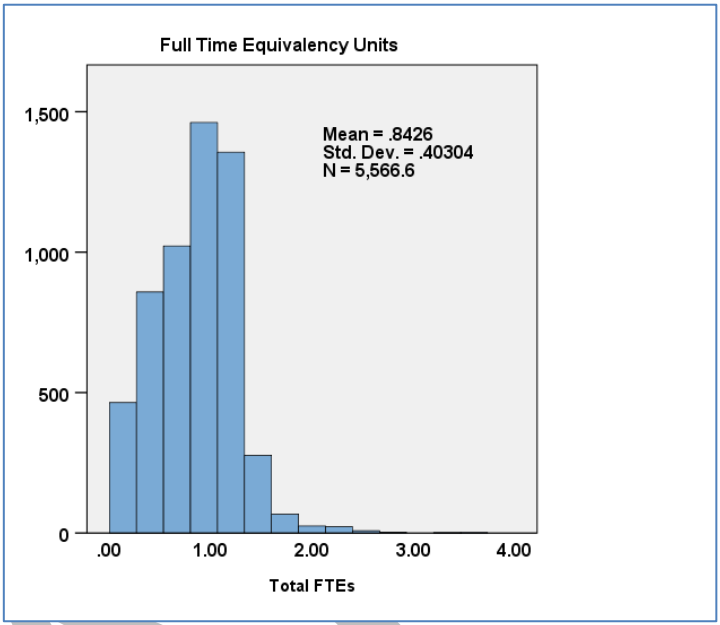
Age & Gender Effect

Age, Partial Eta[3]:	Small
Gender, Partial Eta[3]:	Small

Partial Eta[3] Explained:
Partial Eta[3] is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

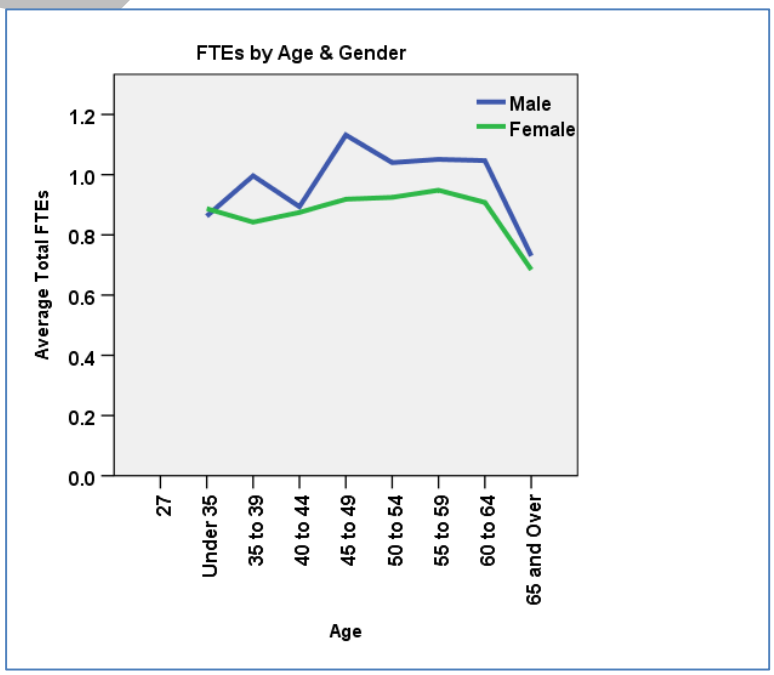


Source: Va. Healthcare Workforce Data Center

The typical (median) LCSW provided 0.90 FTEs, or approximately 36 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify a difference exists.[3]

Full-Time Equivalency Units		
Age	**Average**	**Median**
Age		
Under 35	0.85	1.01
35 to 39	0.82	0.91
40 to 44	0.87	0.84
45 to 49	0.97	1.05
50 to 54	0.92	0.99
55 to 59	0.95	0.95
60 to 64	0.90	0.91
65 and Over	0.61	0.51
Gender		
Male	0.93	1.03
Female	0.87	0.95

Source: Va. Healthcare Workforce Data Center



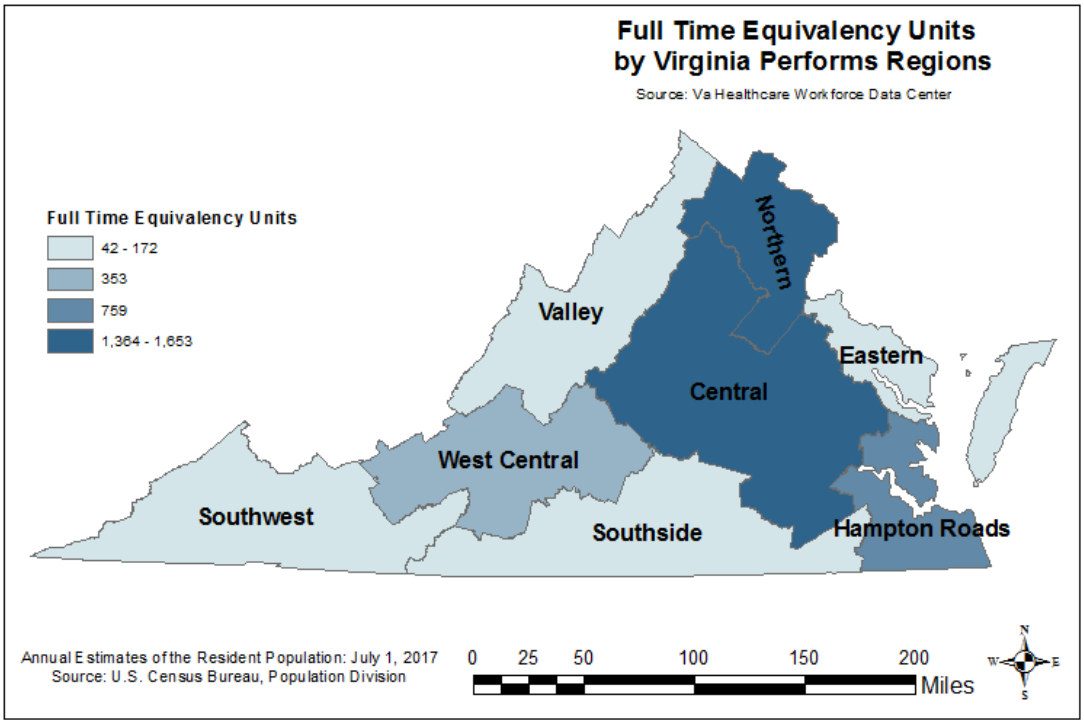
Source: Va. Healthcare Workforce Data Center

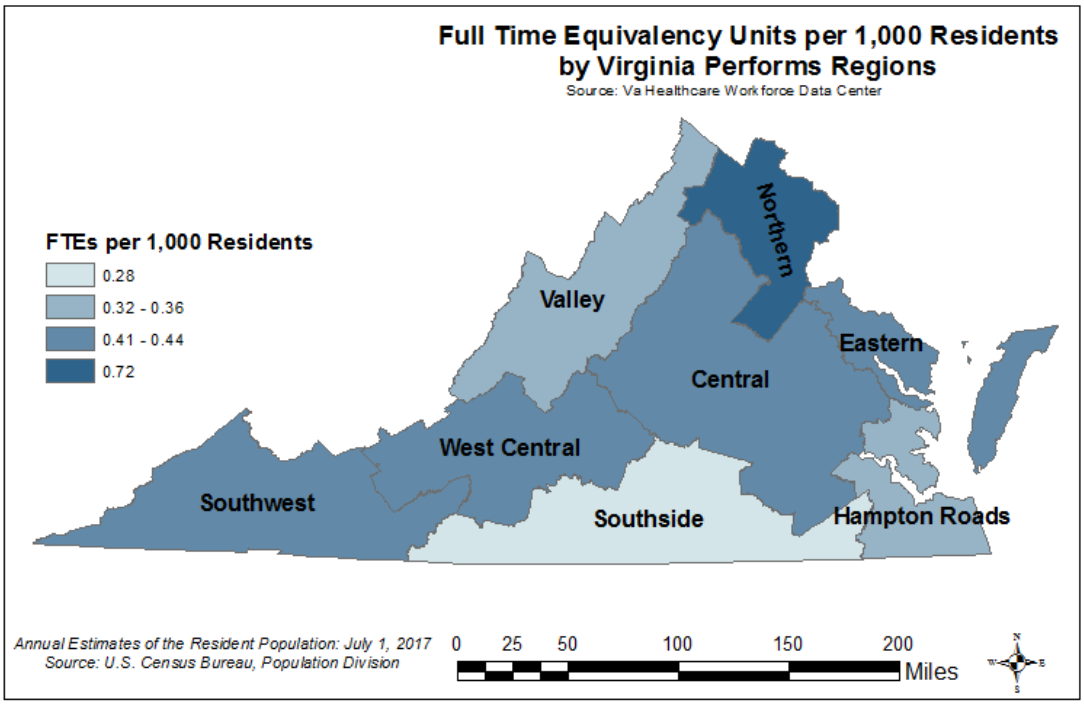
[2] Number of residents in 2017 was used as the denominator.

[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test is significant)

Maps

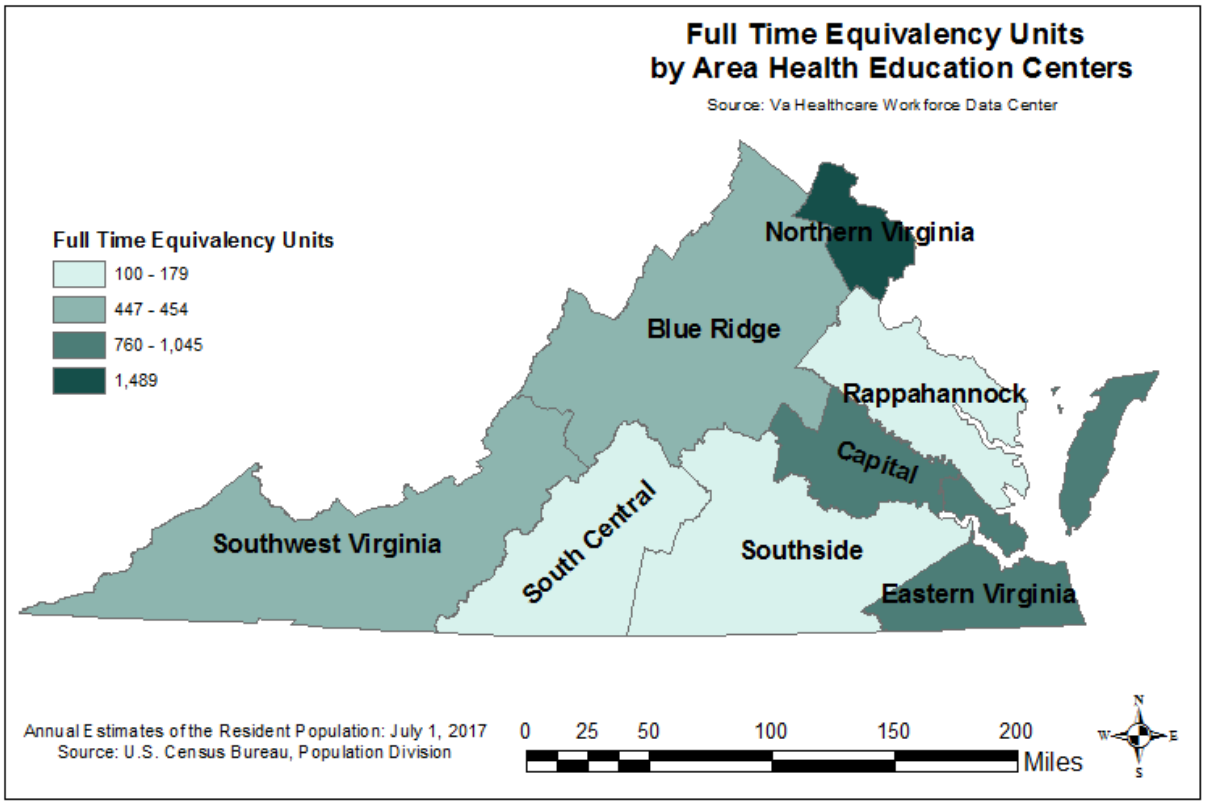
Virginia Performs Regions[3]

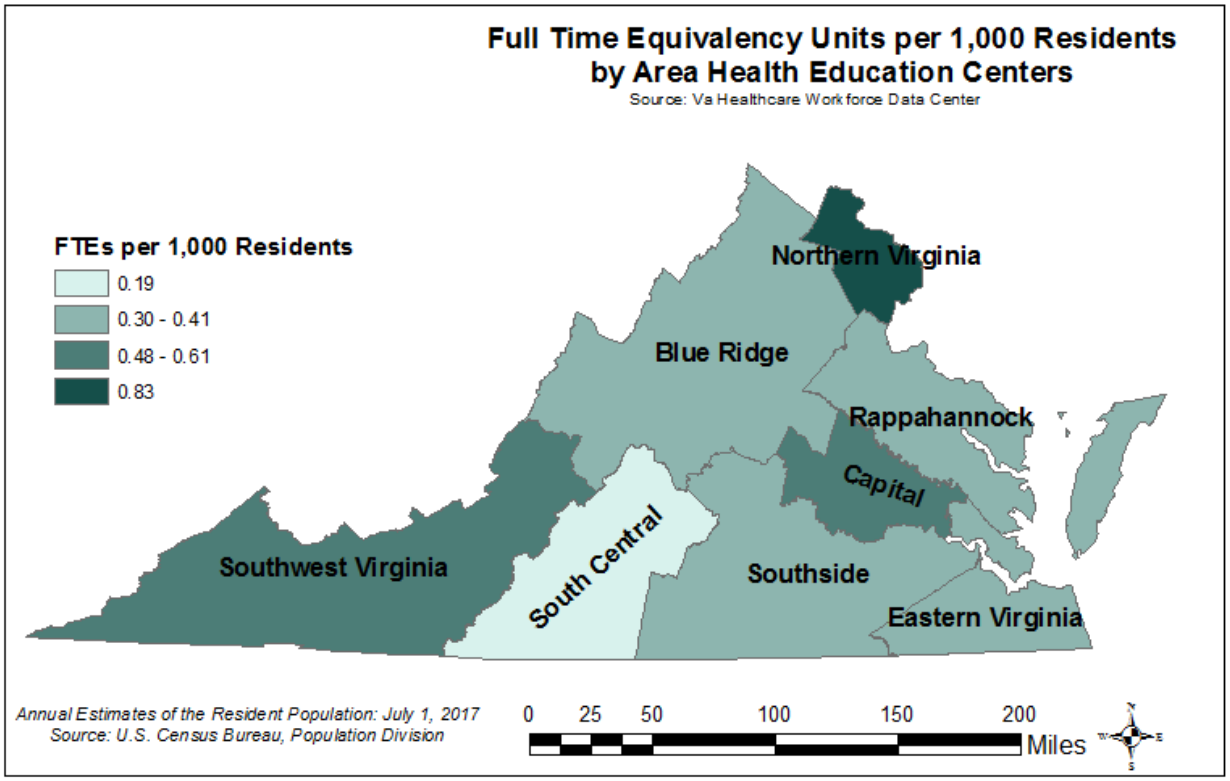




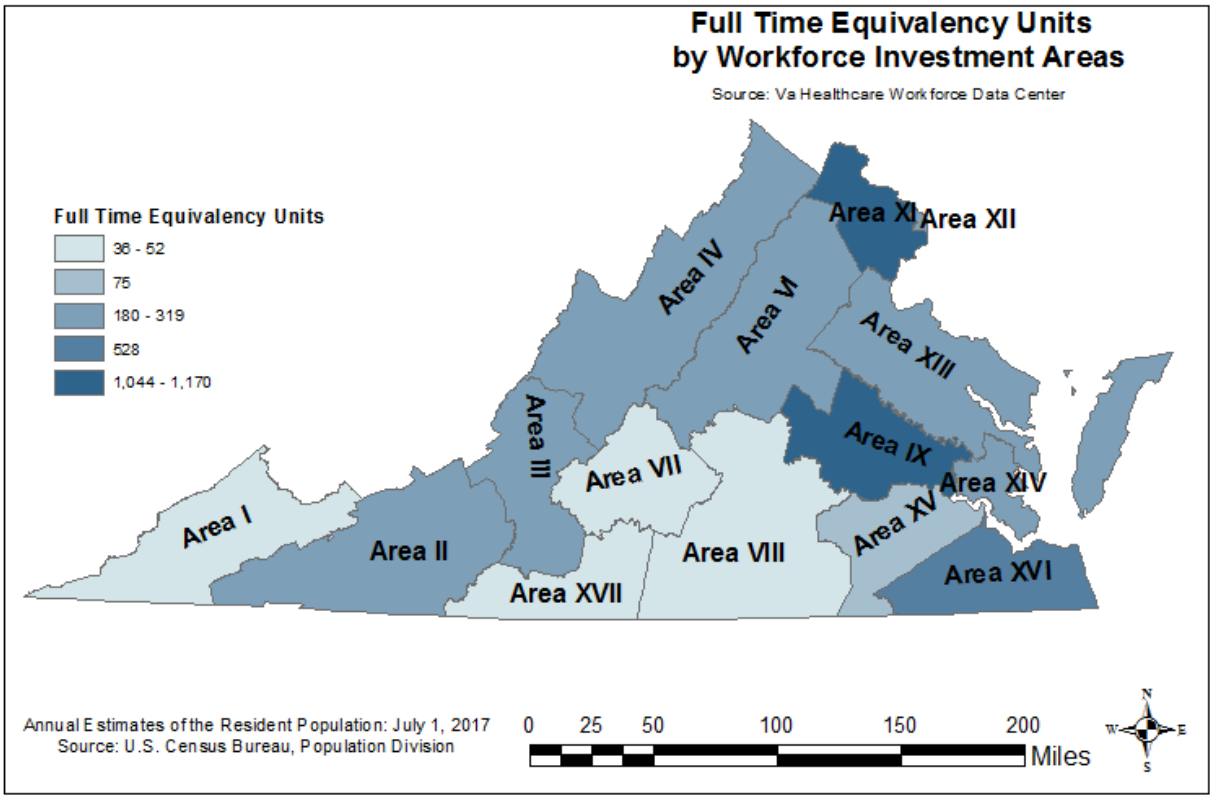
[3] These are now referred to as VA Perform's regions: http://vaperforms.virginia.gov/Regions/regionalScorecards.php

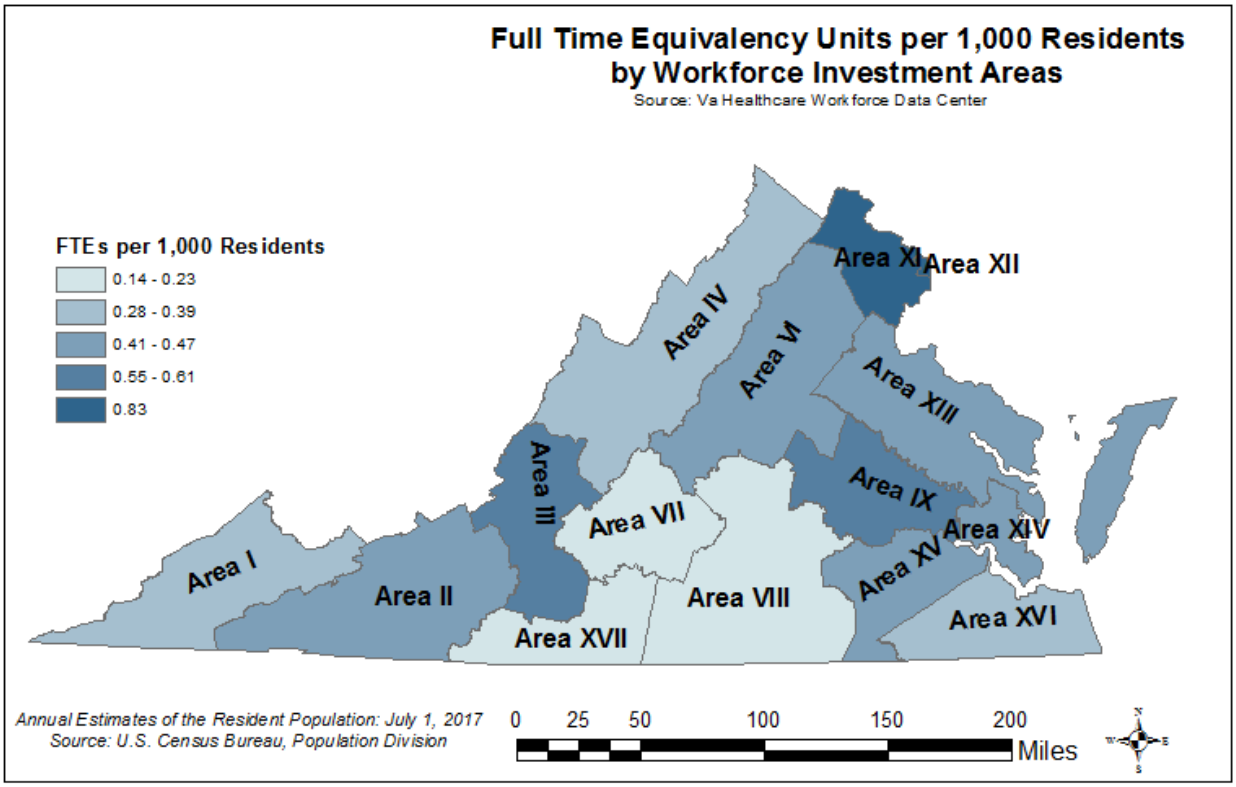
Area Health Education Center Regions

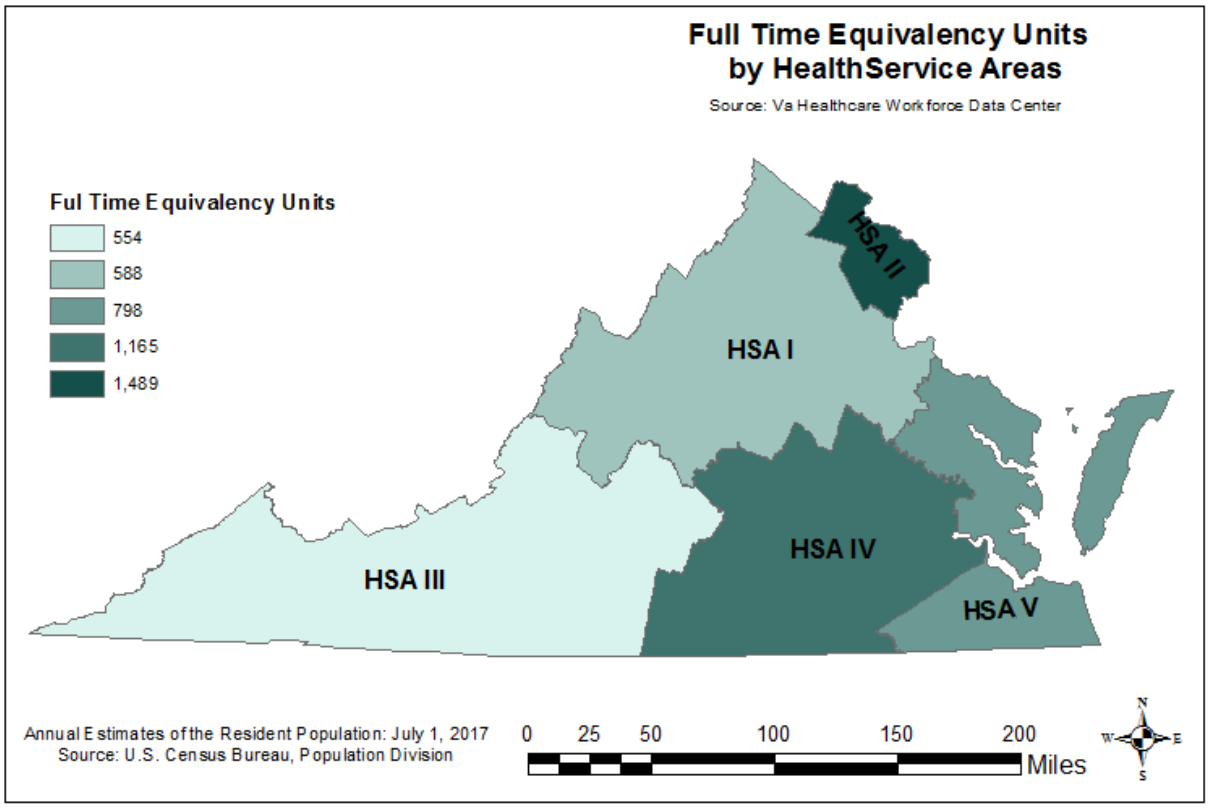


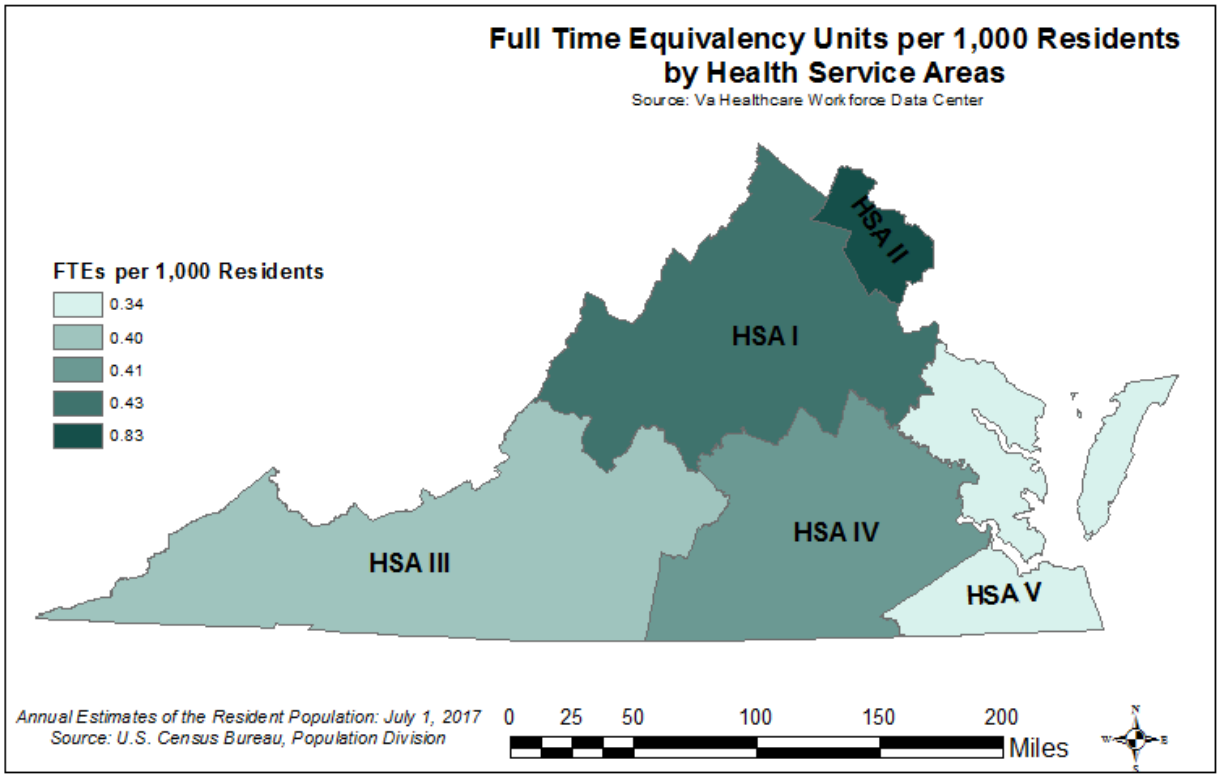


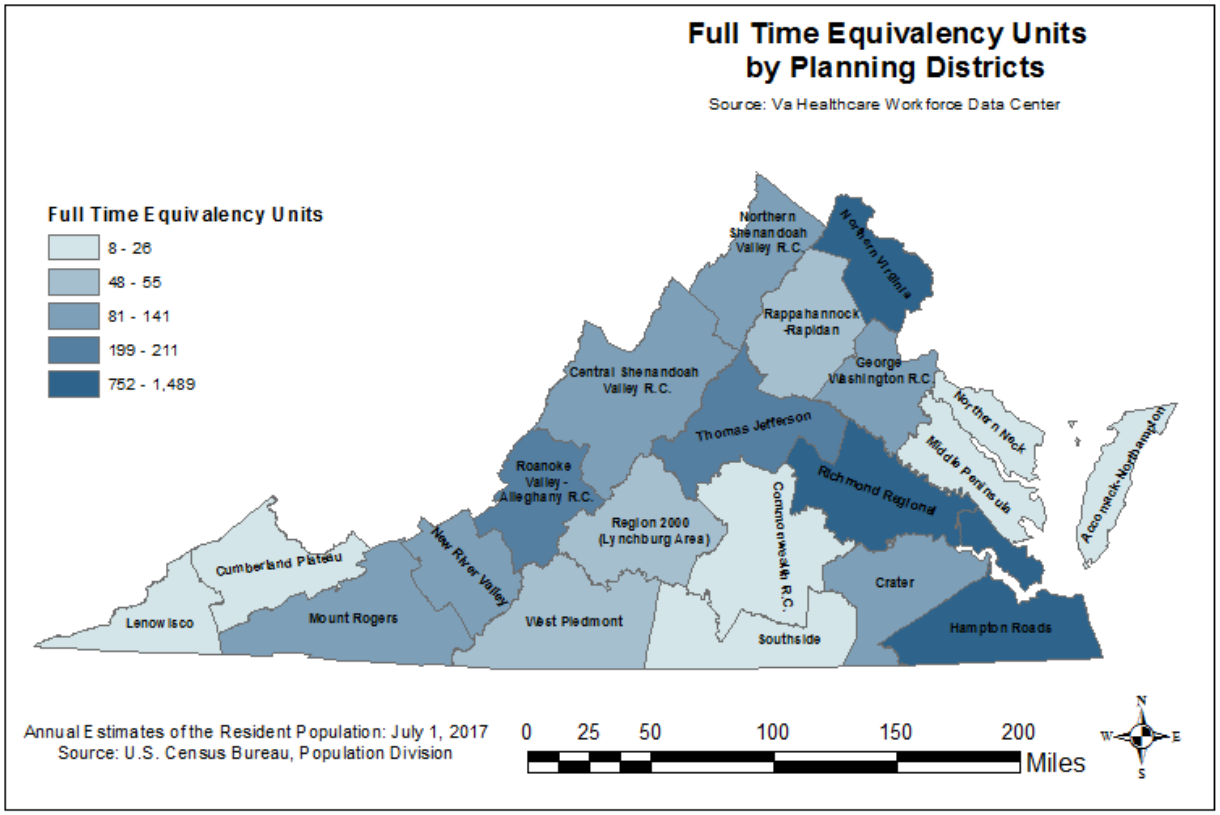
Workforce Investment Areas

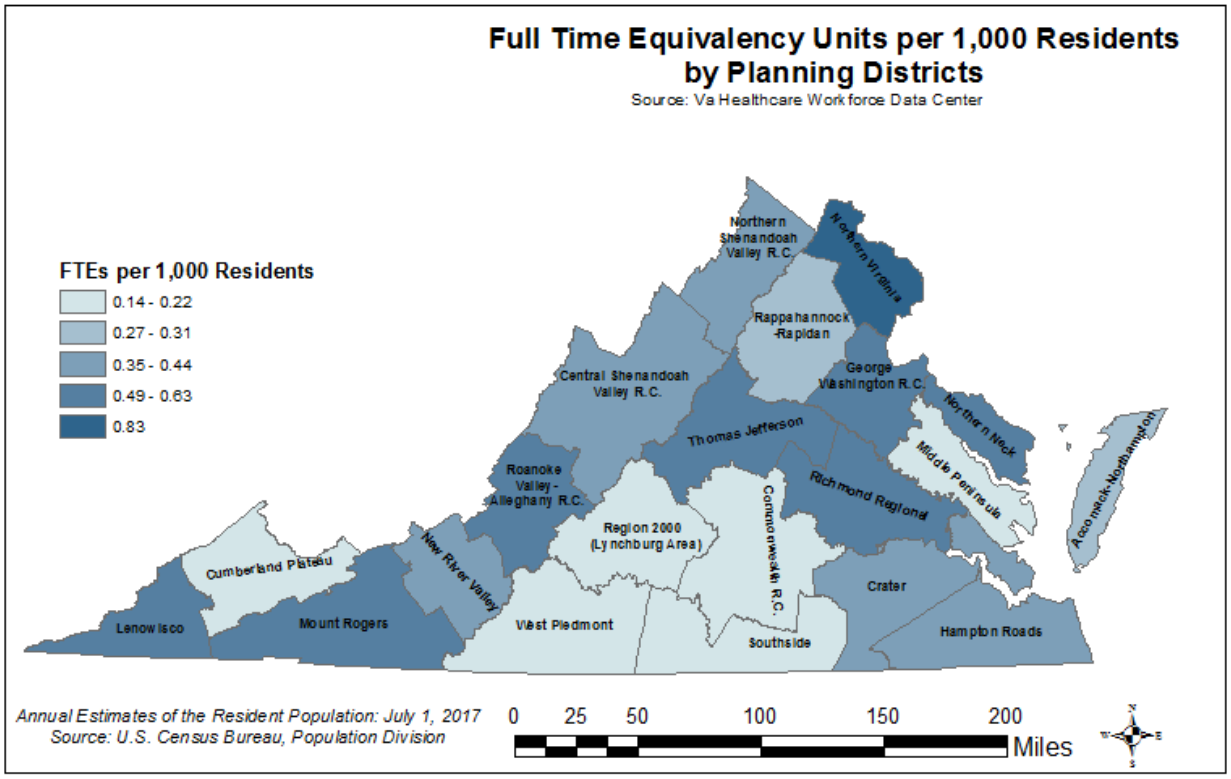





Full Time Equivalency Units
by HealthService Areas
Source: Va Healthcare Workforce Data Center
Ful Time Equivalency Units
554
588
798
1,165
1,489
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2017
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Health Service Areas
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.34
0.40
0.41
0.43
0.83
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2017
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units
by Planning Districts
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
8 - 26
48 - 55
81 - 141
199 - 211
752 - 1,489
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock -Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley - Alleghany R.C.
Region 2000 (Lynchburg Area)
Richmond Regional
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2017
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Planning Districts
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.14 - 0.22
0.27 - 0.31
0.35 - 0.44
0.49 - 0.63
0.83
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock -Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley - Alleghany R.C.
Region 2000 (Lynchburg Area)
Richmond Regional
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2017
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	4483	85.97%	1.1632071	1.09135315	1.463247043
Metro, 250,000 to 1 million	363	85.12%	1.1747573	1.102189891	1.477776555
Metro, 250,000 or less	546	85.53%	1.1691649	1.096942946	1.470741641
Urban pop 20,000+, Metro adj	33	69.70%	1.4347826	1.346152871	1.804873342
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	113	83.19%	1.2021277	1.127869539	1.512206903
Urban pop, 2,500-19,999, nonadj	81	91.36%	1.0945946	1.026979033	1.376936542
Rural, Metro adj	78	76.92%	1.3000000	1.219696086	1.635324634
Rural, nonadj	26	92.31%	1.0833333	1.016413405	1.362770528
Virginia border state/DC	798	74.31%	1.3456998	1.262572936	1.692812372
Other US State	464	73.28%	1.3647059	1.280404941	1.716720882

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 35	739	66.44%	1.50509165	1.362770528	1.804873342
35 to 39	768	83.20%	1.201877934	1.088228632	1.441266014
40 to 44	827	86.82%	1.151810585	1.053736551	1.381226332
45 to 49	896	87.83%	1.138500635	1.030844276	1.365265329
50 to 54	771	88.59%	1.128843338	1.022100171	1.287568722
55 to 59	806	89.08%	1.122562674	1.016413405	1.346152871
60 to 64	722	88.78%	1.126365055	1.019856233	1.350712603
65 and Over	1455	79.79%	1.253229974	1.134724835	1.50284627

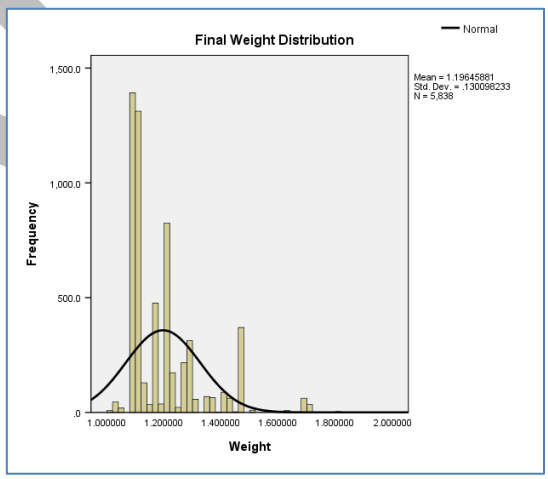
Source: Va. Healthcare Workforce Data Center

See the Methods section on the HWDC website for details on HWDC Methods: www.dhp.virginia.gov/hwdc/

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: 0.8359



Source: Va. Healthcare Workforce Data Center

Virginia Department of
Health Professions
Board of Social Work

Executive Director's Report

Virginia Department of Health Professions
Cash Balance
As of June 30, 2018

	110- Social Work
Board Cash Balance as June 30, 2017	$ 401,802
YTD FY18 Revenue	756,485
Less: YTD FY18 Direct and Allocated Expenditures	516,698
Board Cash Balance as June 30, 2018	641,588

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11000 - Social Work

For the Period Beginning July 1, 2017 and Ending June 30, 2018

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	181,485.00	100,300.00	(81,185.00)	180.94%
4002406	License & Renewal Fee	558,694.50	602,865.00	44,170.50	92.67%
4002407	Dup. License Certificate Fee	1,555.00	850.00	(705.00)	182.94%
4002409	Board Endorsement - Out	5,795.00	2,750.00	(3,045.00)	210.73%
4002421	Monetary Penalty & Late Fees	8,955.00	1,100.00	(7,855.00)	814.09%
4002432	Misc. Fee (Bad Check Fee)	-	35.00	35.00	0.00%
	Total Fee Revenue	756,484.50	707,900.00	(48,584.50)	106.86%
	Total Revenue	756,484.50	707,900.00	(48,584.50)	106.86%
5011110	Employer Retirement Contrib.	5,063.47	6,580.00	1,516.53	76.95%
5011120	Fed Old-Age Ins- Sal St Emp	3,061.14	4,361.00	1,299.86	70.19%
5011140	Group Insurance	491.77	639.00	147.23	76.96%
5011150	Medical/Hospitalization Ins.	323.50	-	(323.50)	0.00%
5011160	Retiree Medical/Hospitalizatn	442.92	576.00	133.08	76.90%
5011170	Long term Disability Ins	247.66	322.00	74.34	76.91%
	Total Employee Benefits	9,630.46	12,478.00	2,847.54	77.18%
5011200	Salaries				
5011230	Salaries, Classified	37,684.36	48,772.00	11,087.64	77.27%
5011250	Salaries, Overtime	2,705.44	8,220.00	5,514.56	32.91%
	Total Salaries	40,389.80	56,992.00	16,602.20	70.87%
5011300	Special Payments				
5011340	Specified Per Diem Payment	1,750.00	2,800.00	1,050.00	62.50%
5011380	Deferred Compnstn Match Pmts	10.00	480.00	470.00	2.08%
	Total Special Payments	1,760.00	3,280.00	1,520.00	53.66%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	51,780.26	72,750.00	20,969.74	71.18%
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	-	537.00	537.00	0.00%
5012140	Postal Services	8,402.83	4,411.00	(3,991.83)	190.50%
5012150	Printing Services	128.65	67.00	(61.65)	192.01%
5012160	Telecommunications Svcs (VITA)	269.57	550.00	280.43	49.01%
5012190	Inbound Freight Services	0.69	-	(0.69)	0.00%
	Total Communication Services	8,801.74	5,565.00	(3,236.74)	158.16%
5012200	Employee Development Services				
5012210	Organization Memberships	-	1,500.00	1,500.00	0.00%
5012250	Employee Tuition Reimbursement	1,560.00	-	(1,560.00)	0.00%
	Total Employee Development Services	1,560.00	1,500.00	(60.00)	104.00%
5012400	Mgmnt and Informational Svcs	-			

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11000 - Social Work

For the Period Beginning July 1, 2017 and Ending June 30, 2018

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012420	Fiscal Services	9,772.16	5,500.00	(4,272.16)	177.68%
5012440	Management Services	65.61	212.00	146.39	30.95%
5012460	Public Infrmtnl & Relatn Svcs	16.00	-	(16.00)	0.00%
5012470	Legal Services	345.00	-	(345.00)	0.00%
	Total Mgmnt and Informational Svcs	10,198.77	5,712.00	(4,486.77)	178.55%
5012500	Repair and Maintenance Svcs				
5012530	Equipment Repair & Maint Srvc	1,585.34	-	(1,585.34)	0.00%
	Total Repair and Maintenance Svcs	1,585.34	-	(1,585.34)	0.00%
5012600	Support Services				
5012630	Clerical Services	24,103.14	66,208.00	42,104.86	36.41%
5012640	Food & Dietary Services	862.95	480.00	(382.95)	179.78%
5012650	Laundry and Linen Services	16.23	-	(16.23)	0.00%
5012660	Manual Labor Services	242.86	2,188.00	1,945.14	11.10%
5012670	Production Services	1,262.85	2,405.00	1,142.15	52.51%
5012680	Skilled Services	14,455.28	24,297.00	9,841.72	59.49%
	Total Support Services	40,943.31	95,578.00	54,634.69	42.84%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	3,141.13	2,809.00	(332.13)	111.82%
5012850	Travel, Subsistence & Lodging	213.24	1,607.00	1,393.76	13.27%
5012880	Trvl, Meal Reimb- Not Rprtble	186.00	917.00	731.00	20.28%
	Total Transportation Services	3,540.37	5,333.00	1,792.63	66.39%
	Total Contractual Svs	66,629.53	113,688.00	47,058.47	58.61%
5013000	Supplies And Materials				
5013100	Administrative Supplies				
5013120	Office Supplies	555.62	276.00	(279.62)	201.31%
5013130	Stationery and Forms	17.35	41.00	23.65	42.32%
	Total Administrative Supplies	572.97	317.00	(255.97)	180.75%
5013500	Repair and Maint. Supplies				
5013520	Custodial Repair & Maint Matrl	0.21	-	(0.21)	0.00%
	Total Repair and Maint. Supplies	0.21	-	(0.21)	0.00%
5013600	Residential Supplies				
5013620	Food and Dietary Supplies	-	21.00	21.00	0.00%
5013630	Food Service Supplies	-	82.00	82.00	0.00%
	Total Residential Supplies	-	103.00	103.00	0.00%
	Total Supplies And Materials	573.18	420.00	(153.18)	136.47%
5014000	Transfer Payments				
5014100	Awards, Contrib., and Claims				
5014130	Premiums	65.00	-	(65.00)	0.00%
	Total Awards, Contrib., and Claims	65.00	-	(65.00)	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11000 - Social Work

For the Period Beginning July 1, 2017 and Ending June 30, 2018

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Transfer Payments	65.00	-	(65.00)	0.00%
5015000	**Continuous Charges**				
5015100	**Insurance-Fixed Assets**				
5015160	**Property Insurance**	-	26.00	26.00	0.00%
	Total Insurance-Fixed Assets	-	26.00	26.00	0.00%
5015300	**Operating Lease Payments**				
5015340	**Equipment Rentals**	519.48	540.00	20.52	96.20%
5015350	**Building Rentals**	14.29	-	(14.29)	0.00%
5015390	**Building Rentals - Non State**	10,000.77	11,584.00	1,583.23	86.33%
	Total Operating Lease Payments	10,534.54	12,124.00	1,589.46	86.89%
5015500	**Insurance-Operations**				
5015510	**General Liability Insurance**	-	97.00	97.00	0.00%
5015540	**Surety Bonds**	-	6.00	6.00	0.00%
	Total Insurance-Operations	-	103.00	103.00	0.00%
	Total Continuous Charges	10,534.54	12,253.00	1,718.46	85.98%
5022000	**Equipment**				
5022100	**Computer Hrdware & Sftware**				
5022170	**Other Computer Equipment**	186.00	-	(186.00)	0.00%
5022180	**Computer Software Purchases**	256.90	-	(256.90)	0.00%
	Total Computer Hrdware & Sftware	442.90	-	(442.90)	0.00%
5022200	**Educational & Cultural Equip**				
5022240	**Reference Equipment**	-	43.00	43.00	0.00%
	Total Educational & Cultural Equip	-	43.00	43.00	0.00%
5022600	**Office Equipment**				
5022610	**Office Appurtenances**	-	21.00	21.00	0.00%
5022620	**Office Furniture**	631.23	-	(631.23)	0.00%
	Total Office Equipment	631.23	21.00	(610.23)	3005.86%
5022700	**Specific Use Equipment**				
5022710	**Household Equipment**	5.90	-	(5.90)	0.00%
	Total Specific Use Equipment	5.90	-	(5.90)	0.00%
	Total Equipment	1,080.03	64.00	(1,016.03)	1687.55%
	Total Expenditures	130,662.54	199,175.00	68,512.46	65.60%
	Allocated Expenditures				
20100	**Behavioral Science Exec**	74,520.70	84,132.40	9,611.70	88.58%
30100	**Data Center**	76,672.03	67,531.59	(9,140.44)	113.54%
30200	**Human Resources**	19,561.49	10,704.19	(8,857.30)	182.75%
30300	**Finance**	37,815.38	35,392.61	(2,422.76)	106.85%
30400	**Director's Office**	18,436.97	18,783.97	347.00	98.15%
30500	**Enforcement**	97,440.94	133,854.73	36,413.79	72.80%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11000 - Social Work

For the Period Beginning July 1, 2017 and Ending June 30, 2018

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
30600	Administrative Proceedings	30,768.37	25,914.67	(4,853.70)	118.73%
30700	Impaired Practitioners	1,143.83	913.01	(230.82)	125.28%
30800	Attorney General	2,708.05	2,708.17	0.12	100.00%
30900	Board of Health Professions	10,167.56	10,670.72	503.16	95.28%
31100	Maintenance and Repairs	-	417.32	417.32	0.00%
31300	Emp. Recognition Program	825.01	171.56	(653.45)	480.89%
31400	Conference Center	5,554.64	5,819.28	264.65	95.45%
31500	Pgm Devlpmnt & Implmentn	10,420.96	10,576.53	155.57	98.53%
	Total Allocated Expenditures	386,035.92	407,590.75	21,554.83	94.71%
	Net Revenue in Excess (Shortfall) of Expenditures	$ 239,786.04	$ 101,134.25	$ (138,651.79)	237.10%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11000 - Social Work

For the Period Beginning July 1, 2017 and Ending June 30, 2018

Account Number	Account Description	July	August	September	October	November	December	January	February	March	April	May	June	Total
4002400	Fee Revenue													
4002401	Application Fee	13,950.00	16,350.00	15,565.00	15,645.00	12,625.00	10,345.00	15,870.00	14,430.00	17,470.00	15,560.00	18,715.00	14,960.00	**181,485.00**
4002406	License & Renewal Fee	11,247.00	2,105.00	605.00	785.00	515.00	155.00	315.00	360.00	400.00	515.00	204,602.50	337,090.00	**558,694.50**
4002407	Dup. License Certificate Fee	140.00	200.00	120.00	185.00	70.00	115.00	115.00	75.00	100.00	115.00	90.00	230.00	**1,555.00**
4002409	Board Endorsement - Out	650.00	510.00	590.00	750.00	375.00	500.00	475.00	225.00	570.00	325.00	450.00	375.00	**5,795.00**
4002421	Monetary Penalty & Late Fees	4,000.00	905.00	395.00	455.00	560.00	245.00	90.00	315.00	550.00	50.00	265.00	1,125.00	**8,955.00**
	Total Fee Revenue	29,987.00	20,070.00	17,275.00	17,820.00	14,145.00	11,360.00	16,865.00	15,405.00	19,090.00	16,565.00	224,122.50	353,780.00	**756,484.50**
	Total Revenue	29,987.00	20,070.00	17,275.00	17,820.00	14,145.00	11,360.00	16,865.00	15,405.00	19,090.00	16,565.00	224,122.50	353,780.00	**756,484.50**
5011000	Personal Services													
5011100	Employee Benefits													
5011110	Employer Retirement Contrib.	800.40	549.60	549.60	549.60	549.60	549.60	618.30	618.30	618.30	(1,854.90)	-	1,515.07	**5,063.47**
5011120	Fed Old-Age Ins- Sal St Emp	478.37	337.59	316.01	333.55	341.63	355.93	350.99	351.00	350.98	(1,052.97)	-	898.06	**3,061.14**
5011140	Group Insurance	77.73	53.38	53.38	53.38	53.38	53.38	60.04	60.04	60.04	(180.12)	-	147.14	**491.77**
5011150	Medical/Hospitalization Ins.	-	-	-	-	-	-	-	-	-	-	-	323.50	**323.50**
5011160	Retiree Medical/Hospitalizatn	70.02	48.08	48.08	48.08	48.08	48.08	54.08	54.08	54.08	(162.24)	-	132.50	**442.92**
5011170	Long term Disability Ins	39.15	26.88	26.88	26.88	26.88	26.88	30.26	30.26	30.26	(90.78)	-	74.11	**247.66**
	Total Employee Benefits	1,465.67	1,015.53	993.95	1,011.49	1,019.57	1,033.87	1,113.67	1,113.68	1,113.66	(3,341.01)	-	3,090.38	**9,630.46**
5011200	Salaries													
5011230	Salaries, Classified	5,992.58	4,074.16	4,074.16	4,074.16	4,074.16	4,074.16	4,583.34	4,583.34	2,291.67	(11,458.35)	-	11,320.98	**37,684.36**
5011250	Salaries, Overtime	256.73	334.93	52.88	282.04	387.81	574.67	-	-	-	-	-	816.38	**2,705.44**
	Total Salaries	6,249.31	4,409.09	4,127.04	4,356.20	4,461.97	4,648.83	4,583.34	4,583.34	2,291.67	(11,458.35)	-	12,137.36	**40,389.80**
5011340	Specified Per Diem Payment	-	-	100.00	-	500.00	-	-	450.00	450.00	50.00	-	200.00	**1,750.00**
5011380	Deferred Compnstn Match Pmts	-	-	-	-	-	-	-	-	-	-	-	10.00	**10.00**
5011500	Disability Benefits													
5011530	Short-trm Disability Benefits	-	-	-	-	-	-	-	-	2,291.67	(2,291.67)	-	-	**-**
	Total Disability Benefits	-	-	-	-	-	-	-	-	2,291.67	(2,291.67)	-	-	**-**
	Total Personal Services	7,714.98	5,424.62	5,220.99	5,367.69	5,981.54	5,682.70	5,697.01	6,147.02	6,147.00	(17,041.03)	-	15,437.74	**51,780.26**
5012000	Contractual Svs													**-**
5012100	Communication Services													**-**
5012140	Postal Services	4,617.68	1,749.19	373.39	373.30	64.31	231.40	71.11	153.02	356.71	189.57	41.84	181.31	**8,402.83**
5012150	Printing Services	-	-	76.73	-	-	-	-	-	-	34.57	17.35	-	**128.65**
5012160	Telecommunications Svcs (VITA)	17.28	17.97	-	-	24.78	-	24.78	49.56	49.56	24.78	27.32	33.54	**269.57**
5012190	Inbound Freight Services	-	-	-	-	-	-	-	-	-	-	0.69	-	**0.69**
	Total Communication Services	4,634.96	1,767.16	450.12	373.30	89.09	231.40	95.89	202.58	406.27	248.92	87.20	214.85	**8,801.74**
5012200	Employee Development Services													
5012250	Employee Tuition Reimbursement	-	-	600.00	-	930.00	-	-	-	-	-	-	30.00	**1,560.00**
	Total Employee Development Services	-	-	600.00	-	930.00	-	-	-	-	-	-	30.00	**1,560.00**
5012400	Mgmnt and Informational Svcs													
5012420	Fiscal Services	4,756.93	4,622.31	277.40	57.35	14.77	-	6.19	6.47	9.99	10.99	-	9.76	**9,772.16**
5012440	Management Services	-	47.84	-	(0.84)	-	4.37	-	3.11	-	5.02	-	6.11	**65.61**
5012460	Public Infrmtnl & Relatn Svcs	-	-	-	-	2.00	2.00	-	6.00	6.00	-	-	-	**16.00**
5012470	Legal Services	-	-	-	-	-	195.00	-	-	-	150.00	-	-	**345.00**
	Total Mgmnt and Informational Svcs	4,756.93	4,670.15	277.40	56.51	16.77	201.37	6.19	15.58	15.99	166.01	-	15.87	**10,198.77**
5012500	Repair and Maintenance Svcs													
5012530	Equipment Repair & Maint Srvc	-	-	-	-	-	-	-	-	1,585.34	-	-	-	**1,585.34**
	Total Repair and Maintenance Svcs	-	-	-	-	-	-	-	-	1,585.34	-	-	-	**1,585.34**
5012600	Support Services													

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11000 - Social Work

For the Period Beginning July 1, 2017 and Ending June 30, 2018

Account Number	Account Description	July	August	September	October	November	December	January	February	March	April	May	June	Total
5012630	Clerical Services	-	2,250.00	3,332.81	1,739.06	-	-	600.00	2,179.70	2,573.44	5,371.88	2,700.00	3,356.25	**24,103.14**
5012640	Food & Dietary Services	-	55.75	-	-	58.75	211.09	-	-	296.15	185.46	-	55.75	**862.95**
5012650	Laundry and Linen Services	-	-	-	-	-	-	-	16.23	-	-	-	-	**16.23**
5012660	Manual Labor Services	15.59	-	71.88	-	2.14	16.40	58.35	12.57	57.52	2.39	6.02	-	**242.86**
5012670	Production Services	91.10	62.20	439.35	-	13.15	114.75	177.30	87.90	230.70	13.20	33.20	-	**1,262.85**
5012680	Skilled Services	1,290.65	1,290.65	1,290.65	1,290.65	1,290.65	1,290.65	1,290.65	1,290.65	1,032.52	1,032.52	1,032.52	1,032.52	**14,455.28**
	Total Support Services	1,397.34	3,658.60	5,134.69	3,029.71	1,364.69	1,632.89	2,126.30	3,587.05	4,190.33	6,605.45	3,771.74	4,444.52	**40,943.31**
5012800	Transportation Services													
5012820	Travel, Personal Vehicle	-	-	150.87	-	854.40	-	-	685.07	913.48	52.32	169.97	315.02	**3,141.13**
5012850	Travel, Subsistence & Lodging	-	-	-	-	105.37	-	-	-	105.37	-	2.50	-	**213.24**
5012880	Trvl, Meal Reimb- Not Rprtble	-	-	-	-	59.25	-	-	67.50	59.25	-	-	-	**186.00**
	Total Transportation Services	-	-	150.87	-	1,019.02	-	-	752.57	1,078.10	52.32	172.47	315.02	**3,540.37**
	Total Contractual Svs	10,789.23	10,095.91	6,613.08	3,459.52	3,419.57	2,065.66	2,228.38	4,557.78	7,276.03	7,072.70	4,031.41	5,020.26	**66,629.53**
5013000	Supplies And Materials													
5013100	Administrative Supplies													**-**
5013120	Office Supplies	-	109.77	17.05	12.47	67.03	32.67	15.72	15.99	69.22	74.18	109.41	32.11	**555.62**
5013130	Stationery and Forms	-	-	-	-	-	-	-	-	-	-	17.35	-	**17.35**
	Total Administrative Supplies	-	109.77	17.05	12.47	67.03	32.67	15.72	15.99	69.22	74.18	126.76	32.11	**572.97**
5013500	Repair and Maint. Supplies													
5013520	Custodial Repair & Maint Matrl	-	-	-	-	-	-	-	-	-	0.21	-	-	**0.21**
	Total Repair and Maint. Supplies	-	-	-	-	-	-	-	-	-	0.21	-	-	**0.21**
	Total Supplies And Materials	-	109.77	17.05	12.47	67.03	32.67	15.72	15.99	69.22	74.39	126.76	32.11	**573.18**
5014000	Transfer Payments													
5014100	Awards, Contrib., and Claims													
5014130	Premiums	-	-	-	-	-	-	-	-	-	-	-	65.00	**65.00**
	Total Awards, Contrib., and Claims	-	-	-	-	-	-	-	-	-	-	-	65.00	**65.00**
	Total Transfer Payments	-	-	-	-	-	-	-	-	-	-	-	65.00	**65.00**
5015000	Continuous Charges													
5015300	Operating Lease Payments													
5015340	Equipment Rentals	-	44.09	44.09	44.09	45.58	44.09	44.09	41.87	41.87	85.97	41.87	41.87	**519.48**
5015350	Building Rentals	-	1.89	-	-	4.40	-	-	4.80	-	3.20	-	-	**14.29**
5015390	Building Rentals - Non State	775.85	908.18	794.19	775.85	864.74	775.85	775.85	834.43	776.28	878.05	963.45	878.05	**10,000.77**
	Total Operating Lease Payments	775.85	954.16	838.28	819.94	914.72	819.94	819.94	881.10	818.15	967.22	1,005.32	919.92	**10,534.54**
	Total Continuous Charges	775.85	954.16	838.28	819.94	914.72	819.94	819.94	881.10	818.15	967.22	1,005.32	919.92	**10,534.54**
5022000	Equipment													
5022170	Other Computer Equipment	-	-	-	-	186.00	-	-	-	-	-	-	-	**186.00**
5022180	Computer Software Purchases	-	-	-	-	-	-	-	-	-	-	-	256.90	**256.90**
	Total Computer Hrdware & Sftware	-	-	-	-	186.00	-	-	-	-	-	-	256.90	**442.90**
5022620	Office Furniture	-	-	-	-	-	-	-	-	631.23	-	-	-	**631.23**
	Total Office Equipment	-	-	-	-	-	-	-	-	631.23	-	-	-	**631.23**
5022710	Household Equipment	-	-	-	-	-	-	-	-	-	5.90	-	-	**5.90**
	Total Specific Use Equipment	-	-	-	-	-	-	-	-	-	5.90	-	-	**5.90**
	Total Equipment	-	-	-	-	186.00	-	-	-	631.23	5.90	-	256.90	**1,080.03**

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 11000 - Social Work
For the Period Beginning July 1, 2017 and Ending June 30, 2018

Account Number	Account Description	July	August	September	October	November	December	January	February	March	April	May	June	Total
	Total Plant and Improvements	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Expenditures	19,280.06	16,584.46	12,689.40	9,659.62	10,568.86	8,600.97	8,761.05	11,601.89	14,941.63	(8,920.82)	5,163.49	21,731.93	**130,662.54**
	Allocated Expenditures													
20100	Behavioral Science Exec	8,922.38	6,332.96	5,891.84	5,895.71	6,069.99	5,900.99	6,231.23	6,011.10	6,084.74	6,213.87	6,802.73	4,163.15	**74,520.70**
20200	Opt\Vet-Med\ASLP Executive Dir	-	-	-	-	-	-	-	-	-	-	-	-	**-**
20400	Nursing / Nurse Aid	-	-	-	-	-	-	-	-	-	-	-	-	**-**
20600	Funeral\LTCA\PT	-	-	-	-	-	-	-	-	-	-	-	-	**-**
30100	Data Center	9,274.03	2,929.28	7,304.34	7,337.48	2,535.80	9,199.75	6,693.21	6,434.50	13,644.13	3,064.85	7,318.79	935.88	**76,672.03**
30200	Human Resources	31.31	40.01	31.19	35.68	4,886.22	75.06	35.89	36.62	30.68	(63.81)	26.52	14,396.14	**19,561.49**
30300	Finance	6,362.33	3,317.43	3,234.60	1,728.10	4,115.92	3,263.30	2,265.89	4,861.28	1,602.77	129.40	2,684.78	4,249.57	**37,815.38**
30400	Director's Office	2,056.96	1,635.11	1,504.82	1,532.97	1,466.83	1,578.06	1,670.48	1,583.01	1,596.78	705.13	1,515.37	1,591.46	**18,436.97**
30500	Enforcement	11,712.05	9,525.95	9,119.18	9,216.20	8,266.53	8,132.10	6,042.47	6,302.47	8,312.42	8,037.72	8,551.82	4,222.02	**97,440.94**
30600	Administrative Proceedings	6,894.83	239.25	912.87	733.29	701.53	4,804.87	6,946.58	2,471.18	4,762.66	-	1,158.30	1,142.99	**30,768.37**
30700	Impaired Practitioners	144.71	107.79	99.00	99.76	97.55	103.05	99.81	84.55	79.92	100.01	83.67	44.01	**1,143.83**
30800	Attorney General	-	-	677.01	677.01	-	-	677.01	-	-	677.01	-	-	**2,708.05**
30900	Board of Health Professions	1,193.05	849.55	761.60	831.84	842.55	773.36	901.20	953.51	888.07	247.50	913.36	1,011.98	**10,167.56**
31000	SRTA	-	-	-	-	-	-	-	-	-	-	-	-	**-**
31100	Maintenance and Repairs	-	-	-	-	-	-	-	-	-	-	-	-	**-**
31300	Emp. Recognition Program	-	-	-	-	-	-	43.90	-	1.67	(31.29)	5.46	805.27	**825.01**
31400	Conference Center	6.89	13.08	10,133.64	(1,196.81)	(3,527.22)	54.60	6.12	(6.80)	10.28	29.01	19.66	12.18	**5,554.64**
31500	Pgm Devlpmnt & Implmentn	930.86	820.39	755.18	773.82	875.11	821.29	796.56	804.42	1,229.23	358.02	1,109.92	1,146.16	**10,420.96**
98700	Cash Transfers	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	Total Allocated Expenditures	47,529.41	25,810.80	40,425.27	27,665.04	26,330.82	34,706.44	32,410.36	29,535.84	38,243.33	19,467.43	30,190.39	33,720.80	**386,035.92**
	Net Revenue in Excess (Shortfall) of Expenditures	$ (36,822.47)	$ (22,325.26)	$ (35,839.67)	$ (19,504.66)	$ (22,754.68)	$ (31,947.41)	$ (24,306.41)	$ (25,732.73)	$ (34,094.96)	$ 6,018.39	$ 188,768.62	$ 298,327.27	**239,786.04**

Virginia Department of
Health Professions
Board of Social Work

Deputy Executive Director's Discipline Report

Virginia Department of
Health Professions
Board of Social Work

Discipline Reports

April 6, 2018 - August 16, 2018

OPEN CASES AT BOARD LEVEL (as of August 16, 2018)				
Open Case Stage	Counseling	Psychology	Social Work	BSU Total
Probable Cause Review	59	33	47	***139***
Scheduled for Informal Conferences	5	1	0	***6***
Scheduled for Formal Hearings	1	0	0	***1***
Consent Orders (offered and pending)	1	0	0	***1***
Cases with APD for processing (IFC, FH, Consent Order)	5	4	3	***12***
TOTAL OPEN CASES	71	40	50	***161***

NEW CASES RECEIVED AND ACTIVE INVESTIGATIONS				
	Counseling	Psychology	Social Work	BSU Total
Cases Received for Board review	64	28	38	***130***
Open Investigations in Enforcement	46	21	36	***103***

SCHEDULED CONFERENCES AND HEARINGS			
	Counseling	Psychology	Social Work
Informal Conferences	September 14, 2018 October 19, 2018 November 30, 2018 January 25, 2019 March 1, 2019	September 18, 2018 December 4, 2018	November 16, 2018
Formal Hearings	November 2, 2018	October 30, 2018	December 7, 2018

Virginia Department of
Health Professions
Board of Social Work

Discipline Reports

April 6, 2018 - August 16, 2018

CASES CLOSED	
Closed – no violation	21
Closed – undetermined	2
Closed – violation	3
Credentials/Reinstatement – Denied	1
Credentials/Reinstatement – Approved	1
TOTAL CASES CLOSED	28

HEARINGS HELD AND CONSENT ORDERS ENTERED	
Consent Orders Entered	1
Informal Conferences Held - Special Conference Committee	3
Formal Hearings Held	0
Summary Suspension Hearings Held	0

AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	173
Avg. time in Enforcement (investigations)	70
Avg. time in APD (IFC/FH preparation)	156
Avg. time in Board (includes hearings, reviews, etc).	91

Virginia Department of
Health Professions
Board of Social Work

Licensing Manager's Report

Virginia Department of
Health Professions
Board of Social Work

Current Count of Licenses

Quarterly Summary

Quarter 4 - Fiscal Year 2018

*Current licenses by board and occupation as of the last day of the quarter

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

												CURRENT
	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q4 2018	Q4 2018
SOCIAL WORK TOTAL	6,544	6,690	6,828	7,057	8,900	9,144	9,340	9,559	9,089	9,326	9,468	**9,671**

Virginia Department of Health Professions
Board of Social Work

Current Count of Licenses

Quarterly Breakdown
Quarter 4 - Fiscal Year 2018

*Current licenses by board and occupation as of the last day of the quarter

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

Board	Occupation	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018
Social Work	Associate Social Worker	1	1	1	1	1	1	1	2	2	2	2	2
	Licensed Clinical Social Worker	5,948	6,060	6,170	6,358	6,458	6,558	6,684	6,817	6,514	6,680	6,843	6,985
	Licensed Social Worker	583	617	645	686	739	778	816	852	684	727	763	795
	Licensed Social Worker Supervision	-	-	-	-	-	-	-	7	6	6	4	4
	Registered Social Worker	12	12	12	12	12	12	12	13	11	11	11	12
	Registration of Supervision					1,690	1,795	1,827	1,868	1,872	1,900	1,845	1,878
	Total	6,544	6,690	6,828	7,057	8,900	9,144	9,340	9,559	9,089	9,326	9,468	9,671

Virginia Department of Health Professions
Board of Social Work

Current Count of Licenses

Fiscal Year Breakdown
Quarter 4 - Fiscal Year 2018

*Current licenses by board and occupation as of the last day of the quarter

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

Board	Occupation	FY 2014	Change Between FY15 & FY14	FY 2015	Change Between FY16 & FY15	FY 2016	Change Between FY16 & FY17	FY 2017	Change Between FY17 & FY18	FY 2018
Social Work	Associate Social Worker	1	-	0	--	1	100.0%	2	0.0%	2
	Licensed Clinical Social Worker	5,814	-0.6%	5,781	10.0%	6,358	7.2%	6,817	2.5%	6,985
	Licensed Social Worker	518	1.4%	525	30.7%	686	24.2%	852	-6.7%	795
	Licensed Social Worker Supervision	-	-	-	-	-	--	7	-42.9%	4
	Registered Social Worker	17	-	0	--	12	8.3%	13	-7.7%	12
	Registration of Supervision	17	-	0	--	12	15466.7%	1,868	0.3%	1,873
Total		6,350	-0.7%	6,306	11.9%	7,057	35.5%	9,559	1.2%	9,671

Virginia Department of
Health Professions
Board of Social Work

Board Action on Proposed Regulations

Agenda Item: Board action on Proposed Regulations

Included in your agenda package are:

Copy of Notice of Intended Regulatory Action background document

(There was no public comment on the NOIRA)

Copy of DRAFT proposed regulation

Board action:

The Board may adopt the proposed amendments as included in the agenda package without any change; or

The Board may amend the proposed regulation.

VIRGINIA
REGULATORY TOWN HALL

townhall.virginia.gov

Notice of Intended Regulatory Action (NOIRA)
Agency Background Document

Agency name	Board of Social Work, Department of Health Professions
Virginia Administrative Code (VAC) citation(s)	18VAC140-20-10 et seq.
Regulation title(s)	Regulations Governing the Practice of Social Work
Action title	Additional hours of ethics
Date this document prepared	3/6/18

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Subject matter and intent

Please describe briefly the subject matter, intent, and goals of the planned regulatory action.

The Board intends to amend the requirements for continuing education in section 105 to increase the hours pertaining to ethics or the standards of practice for behavioral health professions from a minimum of two to six hours every two years.

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and(2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400, which provides the Board of Social Work the authority to promulgate regulations to administer the regulatory system:

§ 54.1-2400 -General powers and duties of health regulatory boards
The general powers and duties of health regulatory boards shall be:
...6. To promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title.

The Board has a specific mandate to promulgate regulations requiring continuing education:

§ 54.1-3708. Continuing education requirements.
The Board shall establish in regulations requirements for the continuing education of licensed social workers.
The Board may approve persons who provide continuing education or accredit continuing education programs in order to accomplish the purposes of this section.

Purpose

Please describe the specific reasons why the agency has determined that the proposed regulatory action is essential to protect the health, safety, or welfare of citizens. In addition, please explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of adding hours in ethics or standards of practice is to address a concern about complaints against social workers, almost all of which stem from an ethical issue or a failure to adhere to professional standards of practice. While the rate of complaints against clinical social workers is similar to or lower than other behavioral health professions (13.52 per 1,000 licensees for LCSWs; 15.75 per 1,000 for licensed professional counselors; 16.45 per 1,000 for licensed clinical psychologists in the 2014-2016 biennium), the nature of the complaints indicates a lack of understanding of ethics or standards of practice. Therefore, the Board believes a higher percentage of the total hours of continuing education should be devoted to those topics in order to protect the health, welfare and safety of clients receiving social work services.

Substance

Please briefly identify and explain the new substantive provisions that are being considered, the substantive changes to existing sections that are being considered, or both.

Currently, section 105 specifies that 30 hours of continuing education are required for renewal of a licensed clinical social work license and 15 hours for a licensed social worker every two years. A minimum of two of those hours must pertain to ethics or the standards of practice for the

behavioral health professions or to laws governing the practice of social work in Virginia. The proposed amendment would increase the ethics/standards requirement from two to six hours; there would be no change in the total hours required.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

There are no viable alternatives that are less burdensome or intrusive.

Public participation

The agency is seeking comments on this regulatory action, including but not limited to: ideas to be considered in the development of this proposal, the costs and benefits of the alternatives stated in this background document or other alternatives, and the potential impacts of the regulation.

The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: projected reporting, recordkeeping, and other administrative costs; the probable effect of the regulation on affected small businesses; and the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Town Hall website (**http://www.townhall.virginia.gov**), or by mail, email, or fax to Elaine Yeatts at Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233 or elaine.yeatts@dhp.virginia.gov or by fax to (804) 527-4434. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by midnight on the last day of the public comment period.

A public hearing will be held following the publication of the proposed stage of this regulatory action and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (**http://www.townhall.virginia.gov**) and on the Commonwealth Calendar website (https://www.virginia.gov/connect/commonwealth-calendar). Both oral and written comments may be submitted at that time.

BOARD OF SOCIAL WORK

Hours of ethics for continuing education

18VAC140-20-105. Continued competency requirements for renewal of an active license.

A. Licensed clinical social workers shall be required to have completed a minimum of 30 contact hours of continuing education and licensed social workers shall be required to have completed a minimum of 15 contact hours of continuing education prior to licensure renewal in even years. Courses or activities shall be directly related to the practice of social work or another behavioral health field. A minimum of ~~two~~ six of those hours must pertain to ethics or the standards of practice for the behavioral health professions or to laws governing the practice of social work in Virginia. Up to two continuing education hours required for renewal may be satisfied through delivery of social work services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services, as verified by the department or clinic. Three hours of volunteer service is required for one hour of continuing education credit.

1. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing education requirement.

2. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee such as temporary disability, mandatory military service, or officially declared disasters upon written request from the licensee prior to the renewal date.

B. Hours may be obtained from a combination of board-approved activities in the following two categories:

1. Category I. Formally Organized Learning Activities. A minimum of 20 hours for licensed clinical social workers or 10 hours for licensed social workers shall be documented in this category, which shall include one or more of the following:

a. Regionally accredited university or college academic courses in a behavioral health discipline. A maximum of 15 hours will be accepted for each academic course.

b. Continuing education programs offered by universities or colleges accredited by the Council on Social Work Education.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state or local social service agencies, public school systems or licensed health facilities and licensed hospitals.

d. Workshops, seminars, conferences or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The Child Welfare League of America and its state and local affiliates.

(2) The National Association of Social Workers and its state and local affiliates.

(3) The National Association of Black Social Workers and its state and local affiliates.

(4) The Family Service Association of America and its state and local affiliates.

(5) The Clinical Social Work Association and its state and local affiliates.

(6) The Association of Social Work Boards.

(7) Any state social work board.

2. Category II. Individual Professional Activities. A maximum of 10 of the required 30 hours for licensed clinical social workers or a maximum of five of the required 15 hours for licensed social workers may be earned in this category, which shall include one or more of the following:

a. Participation in an Association of Social Work Boards item writing workshop. (Activity will count for a maximum of two hours.)

b. Publication of a professional social work-related book or initial preparation/presentation of a social work-related course. (Activity will count for a maximum of 10 hours.)

c. Publication of a professional social work-related article or chapter of a book, or initial preparation/presentation of a social work-related in-service training, seminar, or workshop. (Activity will count for a maximum of five hours.)

d. Provision of a continuing education program sponsored or approved by an organization listed under Category I. (Activity will count for a maximum of two hours and will only be accepted one time for any specific program.)

e. Field instruction of graduate students in a Council on Social Work Education-accredited school. (Activity will count for a maximum of two hours.)

f. Serving as an officer or committee member of one of the national professional social work associations listed under subdivision B 1 d of this section or as a member of a state social work licensing board. (Activity will count for a maximum of two hours.)

g. Attendance at formal staffings at federal, state, or local social service agencies, public school systems, or licensed health facilities and licensed hospitals. (Activity will count for a maximum of five hours.)

h. Individual or group study including listening to audio tapes, viewing video tapes, reading, professional books or articles. (Activity will count for a maximum of five hours.)

Virginia Department of
Health Professions
Board of Social Work

Guidance Document Review

- 140-3 *(Board Guidance on Use of Confidential Consent Agreements)*
- 140-3 *(Guidance on Technology-Assisted Therapy & the Use of Social Media)*
- 140-4.2 *(Guidance on Possible Disciplinary or Alternative Actions in Response to Non-Compliance w/ Continuing Education Requirments)*

***Board of Psychology GD 125-5.1 & Board of Counseling GD 115-1.1 enclosed for reference*

Agenda Item: Review of Guidance Documents

Included in your agenda package:

Current guidance documents for the Board that have not been reviewed, revised or readopted in the past four years

Board Action:

Review of guidance documents for revision, deletion or retention without change

BOARD OF SOCIAL WORK

Copies of the following documents may be viewed during regular work days from 8:15 a.m. until 5 p.m. at the offices of the Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, VA 23233. Copies may also be downloaded from the board's webpage at http://www.dhp.virginia.gov/social or the Regulatory Town Hall at http://www.townhall.virginia.gov or requested by email at socialwork@dhp.virginia.gov. Questions regarding interpretation or implementation of these documents or requests for copies may be directed to Jaime Hoyle, Executive Director of the Board, at the address above or by telephone at (804) 367-4441. Copies are free of charge.

Guidance Documents:

http://www.dhp.virginia.gov/social/social_guidelines.htm

140-1, Board guidance on use of confidential consent agreements, revised December 5, 2014

140-2, Impact of criminal convictions, impairment, and past history on social work licensure or registration in Virginia, revised February 2, 2018

140-3, Guidance on technology-assisted therapy and the use of social media, adopted October 25, 2013

140-4.2, Board guidance on possible disciplinary or alternative actions in response to non-compliance with continuing education requirements, revised December 5, 2014

140-5, Board guidance for process of delegation of informal fact-finding to an agency subordinate, re-adopted June 15, 2018

140-7, By-Laws of the Board of Social Work, revised June 15, 2018

140-8, Sanction Reference Points Instruction Manual, revised July 1, 2016

140-9, Supervisor training, re-affirmed February 2, 2018

140-10, Guidance on supervised experience for clinical social work licensure, revised February 2, 2018

140-11, Disposition of disciplinary cases involving practicing with an expired license, revised June 15, 2018

Virginia Board of Social Work

Confidential Consent Agreements

Legislation enacted in 2003 authorizes the health regulatory boards to resolve certain allegations of practitioner misconduct by means of a *Confidential Consent Agreement ("CCA")*. This agreement may be used by a board in lieu of public discipline, but only in cases involving minor misconduct, where there is little or no injury to a patient or the public, and little likelihood of repetition by the practitioner.

A CCA shall not be used if the board determines there is probable cause to believe the practitioner has (i) demonstrated gross negligence or intentional misconduct in the care of patients, or (ii) conducted his/her practice in a manner as to be a danger to patients or the public.

A CCA shall be considered neither a notice nor an order of a health regulatory board, both of which are public documents. The acceptance and content of a CCA shall not be disclosed by either the board or the practitioner who is the subject of the agreement.

A CCA may be offered and accepted any time prior to the issuance of a notice of informal conference by the board. By law, the agreement document must include findings of fact and may include an admission or a finding of a violation. The entry of a CCA in the past may be considered by a board in future disciplinary proceedings. A practitioner may only enter into only two confidential consent agreements involving a standard of care violation within a 10-year period. The practitioner shall receive public discipline for any subsequent violation within the 10-year period, unless the board finds there are sufficient facts and circumstances to rebut the presumption that such further disciplinary action should be made public.

Confidential Consent Agreements
Board of Social Work

The **Board of Social Work** adopted the following list of violations of Regulation or Statute that may qualify for resolution by a Confidential Consent Agreement:

1. Advertising

Example: A licensee or certificate holder using the title "Dr." without specifying "Ph.D.," "Ed.D.," or such similar designation after his or her name.

2. Continuing education

Example: Insufficient or improper coursework to meet the requirements. Confidential Consent Agreements will not, however, be used in instances where a licensee is found to have untruthfully reported compliance.

3. Record keeping

Example: To include such infractions as failure to record in a timely fashion; omission or inaccurate recording of dates, names, or times; and illegibility to the point of reasonably being unreadable.

4. Inadvertent breach of confidentiality

Example: Providing information about a client to another person without authorization, such as responding to, "what time is my wife's appointment?" By acknowledging the appointment the licensee has verified that he or she is treating someone.

5. Failure to report a known violation

Example: A licensee working at an agency is "instructed" by a supervisor (non-licensee) not to report a violation. As a result, the licensee does not report the violation under fear of action from his or her employer.

6. Fees and billing issues

Example: The licensee charges more than originally agreed upon. This would also apply in situations of unintentionally billing for the wrong date(s).

7. Practicing on an expired license for 90 days or less

Example: The licensee has failed to renew his license but has continued to practice for 90 days or less (see Guidance document 140-11)

VIRGINIA BOARD OF SOCIAL WORK

Guidance on Technology-Assisted Therapy and the Use of Social Media

BACKGROUND

Social workers are currently engaged in a variety of online contact methods with clients. The use of social media, telecommunication therapy and other electronic communication is increasing exponentially with growing numbers of social media outlets, platforms and applications, including blogs, social networking sites, video sites, and online chat rooms and forums. Some social workers often use electronic media both personally and professionally.

Social media and technology-assisted therapy can benefit health care in a variety of ways, including fostering professional connections, promoting timely communication with clients and family members, and educating and informing consumers and health care professionals.

Social workers are increasingly using blogs, forums and social networking sites to share workplace experiences particularly events that have been challenging or emotionally charged. These outlets provide a venue for the practitioner to express his or her feelings, and reflect or seek support from friends, colleagues, peers or virtually anyone on the Internet. Journaling and reflective practice have been identified as effective tools in health care practice. The Internet provides an alternative media for practitioners to engage in these helpful activities. Without a sense of caution, however, these understandable needs and potential benefits may result in the practitioner disclosing too much information and violating client privacy and confidentiality.

This document is intended to provide guidance to practitioners using electronic therapy or media in a manner that maintains client privacy and confidentiality. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. ***Therefore, the standards of practice set forth in section 18VAC140-20-150 of the regulations and in the Code of Virginia apply regardless of the method of delivery.***

RECOMMENDATIONS BY THE BOARD

The Board of Social Work recommends the following when a licensee uses technology-assisted services as the delivery method:

- *A Social worker providing services to a client located in Virginia through technology-assisted therapy must be licensed by the Virginia Board of Social Work.*
- *The service is deemed to take place where the client is located*. Therefore, the social worker should make every effort to verify the client's geographic location.
- Social workers shall strive to become and remain knowledgeable about the dynamics of online relationships, the advantages and drawbacks of non-face-to-face interactions, and the ways in which technology-assisted social work practice can be safely and

appropriately conducted. Traditional, face-to-face, in-person contact remains the preferred service delivery modality.

- *The social worker must take steps to ensure* client confidentiality and the security of client information in accordance with state and federal law.
- The social worker *should seek training or otherwise demonstrate* expertise in the use of technology-assisted devices, especially in the matter of protecting confidentiality and the security of client information.
- *When working with a client who is not in Virginia*, social workers are advised to check the regulations of the state board in which the client is located. It is important to be mindful that certain states prohibit social work services to a client in the state by an individual who is unlicensed by that state.
- Social workers must follow the same code of ethics for technology-assisted therapy as they do in a traditional social work setting.

ETHICS AND VALUES

Social workers providing technology-assisted therapy shall act ethically, ensure professional competence, protect client confidentiality, and uphold the values of the profession.

TECHNICAL COMPETENCIES

Social workers shall be responsible for becoming proficient in the technological skills and tools required for competent and ethical practice and for seeking appropriate training and consultation to stay current with emerging technologies.

CONFIDENTIALITY AND PRIVACY

Social workers shall protect client privacy when using technology in their practice and document all services, taking special safeguards to protect client information in the electronic record.

During the initial session, social workers should provide clients with information on the use of technology in service delivery. Social workers should assure that the client has received notice of privacy practices and should obtain any authorization for information disclosure and consent for treatment or services, as documented in the client record. Social workers should be aware of privacy risks involved when using wireless devices and other future technological innovations and take proper steps to protect client privacy.

Social workers should adhere to the privacy and security standards of applicable federal and state laws when performing services with the use of technology.

Social workers should give special attention to documenting services performed via the Internet and other technologies. They should be familiar with applicable laws that may dictate documentation standards in addition to licensure boards, third-party payers, and accreditation bodies. All practice activities should be documented and maintained in a safe, secure file with safeguards for electronic records.

BOARD OF SOCIAL WORK IMPLICATIONS

Instances of inappropriate use of social/electronic media or technology-assisted therapy may be reported to the Board, and it may investigate such reports, including reports of inappropriate disclosures on social media by a social worker, on the grounds of:

- Unprofessional conduct;
- Unethical conduct;
- Moral turpitude;
- Mismanagement of client records;
- Revealing a privileged communication; and
- Breach of confidentiality.

If the allegations are found to be true, the social worker may face disciplinary action by the Board, including a reprimand or sanction, assessment of a monetary fine, or temporary or permanent loss of licensure, certification, or registration.

GUIDING PRINCIPLES

Social networks and the Internet provide unparalleled opportunities for rapid knowledge exchange and dissemination among many people, but this exchange does not come without risk. Social workers and students have an obligation to understand the nature, benefits, and consequences of participating in social networking or providing technology-assisted therapy of all types. Online content and behavior has the potential to enhance or undermine not only the individual practitioner's career, but also the profession.

HOW TO AVOID PROBLEMS USING SOCIAL MEDIA

It is important to recognize that instances of inappropriate use of social media can and do occur, but with awareness and caution, social workers can avoid inadvertently disclosing confidential or private information about clients.

The following guidelines are intended to minimize the risks of using social media:

- Recognize the ethical and legal obligations to maintain client privacy and confidentiality at all times.
- Client-identifying information transmitted electronically should be done in accordance with established policies and state and federal law.
- Do not share, post, or otherwise disseminate any information, including images, about a client or information gained in the practitioner-client relationship with anyone unless permitted or required by applicable law.
- Do not identify clients by name or post or publish information that may lead to the identification of a client. Limiting access to postings through privacy settings is not sufficient to ensure privacy.
- Do not refer to clients in a disparaging manner, or otherwise degrade or embarrass the client, even if the client is not identified.

- Do not take photos or videos of clients on personal devices, including cell phones. Follow employer policies for taking photographs or video of clients for treatment or other legitimate purposes using employer-provided devices.
- Maintain professional boundaries in the use of electronic media. Like in-person relationships, the practitioner has the obligation to establish, communicate and enforce professional boundaries with clients in the online environment. Use caution when having online social contact with clients or former clients. Online contact with clients or former clients blurs the distinction between a professional and personal relationship. The fact that a client may initiate contact with the practitioner does not permit the practitioner to engage in a personal relationship with the client.
- Consult employer policies or an appropriate leader within the organization for guidance regarding work related postings.
- Promptly report any identified breach of confidentiality or privacy in accordance with state and federal laws.

CONCLUSION

Social/ electronic media and technology-assisted therapy possess tremendous potential for strengthening professional relationships and providing valuable information to health care consumers. Social workers need to be aware of the potential ramifications of disclosing client-related information via social media or through technology-assisted therapy. Social workers should be mindful of relevant state and federal laws, professional standards regarding confidentiality, and the application of those standards. Social workers should also ensure the standards of practice set forth in 18 VAC 140-20-150 are met when performing technology-assisted therapy.

Virginia Board of Social Work

Possible Disciplinary or Alternative Actions

For

Non-compliance with Continuing Education

The Board has adopted the following guidelines for resolution of cases of noncompliance with continuing education requirements:

CAUSE	POSSIBLE ACTION
Short due to unacceptable hours	Confidential Consent Agreement: 30 day make up
Short 1–9 hours.	Confidential Consent Agreement: 30 day make up.
Short 10-14 hours	Consent Order: $500, 30 day make up.
Short 15-20 hours	Consent Order: $600, 30 day make up.
Short 21-30 hours	Consent Order: $1,000, 30 day make up
Did not respond to audit request	Informal Conference

The Board will review the implementation of these actions annually at its Fall or Winter meeting.

Virginia Board of Counseling

Possible Disciplinary or Alternative Actions For Non-Compliance with Continuing Education Requirements

Revised: May 1, 2015

The Board has adopted the following guidelines for resolution of cases of non-compliance with continuing education requirements:

CAUSE	POSSIBLE ACTION
Short due to unacceptable hours	Confidential Consent Agreement; 30 day make up
Short 1 - 10 hours	Confidential Consent Agreement; 30 day make up
Short 11 - 15 hours	Consent Order; Monetary penalty of $300; 30 day make up
Short 16 - 20 hours	Consent Order; Monetary penalty of $500; 30 day make up
Did not respond to audit request	Informal Fact-Finding Conference

NOTE: In all cases the licensee will be audited the following renewal cycle.

Virginia Board of Psychology

Possible Disciplinary or Alternative Actions For Non-Compliance with Continuing Education Requirements

The Board has adopted the following guidelines for resolution of cases of non-compliance with continuing education requirements. In all cases of non-compliance, the licensee will also be audited for the next renewal cycle.

CAUSE	POSSIBLE ACTION
Short due to unacceptable hours	Confidential Consent Agreement; 30 day make up
Short 1 - 14 hours	Confidential Consent Agreement; 30 day make up
Did not respond to audit request	Informal Fact-Finding Conference
False attestation of continuing education completion	Informal Fact-Finding Conference
Repeat offense in subsequent year	Informal Fact-Finding Conference

If requested prior to the renewal date, the board may grant an extension for good cause of up to one year for the completion of continuing education requirements. Such extension does not relieve the licensee of the continuing education requirement.

Virginia Department of
Health Professions
Board of Social Work

Resource

provided by

The American Telemedicine Association

Practice Guidelines for Videoconferencing-Based Telemental Health

AMERICAN TELEMEDICINE ASSOCIATION

PRACTICE GUIDELINES FOR VIDEOCONFERENCING-BASED TELEMENTAL HEALTH

Telemental Health Standards and Guidelines Working Group

Co-Chairs:

Brian Grady, MD
Kathleen Myers, MD, MPH
Eve-Lynn Nelson, PhD

Writing Committees:

Evidence-Based Practice for Telemental Health
Norbert Belz, MHSA RHIA, Leslie Bennett, LCSW, Lisa Carnahan, PhD, Veronica Decker, APRN, BC, MBA, Brian Grady, MD, Dwight Holden, MD, Kathleen Myers, MD, MPH, Eve-Lynn Nelson, PhD, Gregg Perry, MD, Lynne S. Rosenthal, PhD, Nancy Rowe, Ryan Spaulding, PhD, Carolyn Turvey, PhD, Debbie Voyles, Robert White, MA, LCPC

Practice Guidelines for Videoconferencing-Based Telemental Health
Peter Yellowlees, MD, Jay Shore, MD, Lisa Roberts, PhD

Contributors:

Working Group Members [WG], Consultants [C], Reviewers [R], Telemental Health Special Interest Group Chairs [MH], ATA Standards and Guidelines Committee Member [SG], ATA Staff [S]

Nina Antoniotti, RN, MBA, PhD [Chair, SG]
Ron Mazik [R]
Richard S. Bakalar, MD [SG]
Dennis Mohatt [R]
Norbert Belz, MHSA RHIA [WG]
Kathleen Myers, MD, MPH [Co-Chair, WG]
Leslie Bennett, LCSW [WG]
Eve-Lynn Nelson, PhD [Co-Chair, WG]
Jordana Bernard, MBA [S]
Hon S. Pak, LTC MC USA [SG]
Anne Burdick, MD, MPH [Vice Chair, SG]
Gregg Perry, MD [WG]
David Brennan, MSBE [SG]
Antonio Pignatiello, MD [R]
Sharon Cain, MD [R]
Terry Rabinowitz, MD [C]
Lisa Carnahan, PhD [SG, WG]
Lisa Roberts, PhD [Chair, MH, C]
Jerry Cavallerano, PhD, OD [SG]
Lynne S. Rosenthal, PhD [SG, WG]
Robert Cuyler, PhD [R]
Nancy Rowe [WG]
Veronica Decker, APRN, BC, MBA [WG]
Jay H. Shore, MD, MPH [Vice Chair, MH, C]
Kenneth Drude, PhD [R]
Ryan Spaulding, PhD [WG]
Sara Gibson, MD [R] Lou Theurer [SG]
Brian Grady, MD [Co-Chair, WG
Christopher Thomas, MD [R]
Tom Hirota, DO [SG] Carolyn Turvey, PhD [WG]
Dwight Holden, MD [WG] Doug Urness, MD [R]
Barbara Johnston, MSN [C]
Debbie Voyles, MBA [WG]
Thomas J. Kim, MD, MPH [C]
Tannis Walc [R]
Mark Koltek, MD [R]
Robert K. White, MA, LCPC [WG]
Elizabeth Krupinski, PhD [SG, C
Jill Winters, PhD, RN [SG]
Jonathan Linkous, MPA [S]
Peter Yellowlees, MD [C]
Liz Loewen, RN, BFA, MN [R]

Practice Guidelines for Videoconferencing-Based Telemental Health

Table of Contents

Preamble

The American Telemedicine Association (ATA), with members from throughout the United States and throughout the world, is the principal organization bringing together telemedicine practitioners, healthcare institutions, vendors and others involved in providing remote healthcare using telecommunications. ATA is a nonprofit organization that seeks to bring together diverse groups from traditional medicine, academia, technology and telecommunications companies, e-health, allied professional and nursing associations, medical societies, government and others to overcome barriers to the advancement of telemedicine through the professional, ethical and equitable improvement in health care delivery.

ATA has embarked on an effort to establish practice guidelines and technical standards for telemedicine to help advance the science and to assure the uniform quality of service to patients. They are developed by panels that include experts from the field and other strategic stakeholders and designed to serve as both an operational reference and an educational tool to aid in providing appropriate care for patients. The guidelines and standards generated by ATA will undergo a thorough consensus and rigorous review, with final approval by the ATA Board of Directors. Existing products will be reviewed and updated periodically.

The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. Accordingly, it should be recognized that compliance with these guidelines will not guarantee accurate diagnoses or successful outcomes. The purpose of these standards is to assist practitioners in pursuing a sound course of action to provide effective and safe medical care that is founded on current information, available resources, and patient needs. The practice guidelines and technical standards recognize that safe and effective practices require specific training, skills, and techniques, as described in each document. The resulting products are properties of ATA and any reproduction or modification of the published practice guideline and technical standards must receive prior approval by ATA.

If circumstances warrant, a practitioner may responsibly pursue a course of action different from the guidelines when, in the reasonable judgment of the practitioner, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from these guidelines is strongly advised to provide documentation, in the patient record, that is adequate to explain the approach pursued.

This guidelines document focuses on interactive video-conferencing based mental health services and telemental health/telehealth. The document is a companion document to ATA's Evidence-Based Practice for Telemental Health, an educational tool to aid practitioners in meeting these practice guidelines.

Scope

These guidelines are designed to serve as both a consensus operational best practice reference based on clinical empirical experience and an educational tool to aid practitioners in providing appropriate telehealth care for patients. The term telehealth indicates an inclusion of all health professionals, ranging from medicine to mental health, to educators, and to nurses. The use of telehealth also refers to the broader scope of e-health and distance education. Telemental health therefore, is the practice of mental health specialties at a distance. The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. It should be recognized that adherence to these guidelines will not guarantee accurate diagnoses or successful outcomes. The purpose of these guidelines is to assist practitioners in pursuing a sound course of action to provide effective and safe medical care that is founded on current information, available resources, and patient needs. The guidelines are not meant to be unbending requirements of practice and they are not designed to, nor should they be used, to establish a legal standard of care. The American Telemedicine Association advises against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.

The primary care or managing practitioner is responsible for the decision about the appropriateness of a specific procedure or course of action, considering all presenting circumstances. An approach that differs from the ATA guidelines does not necessarily imply that the approach varied from the standard of care. If circumstances warrant, a practitioner may responsibly pursue a course of action different from these guidelines when, in the reasonable judgment of the practitioner, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from these guidelines is advised to document in the patient record information to explain the approach pursued.

Introduction

Telemental health is one of the most active applications of telehealth rendered in the United States. Mental health is particularly suited to the use of advanced communication technologies and the internet for delivery of care. By using advanced communication technologies, mental health professionals are able to widen their reach to patients in a cost-effective manner, ameliorating the maldistribution of specialty care. The following Guidelines are designed to aid

in the development and practice of coherent, effective, safe and sustainable telemental health practices. Establishing guidelines for telemental health improves clinical outcomes and promotes informed and reasonable patient expectations. When guidelines, position statements, or standards from a professional organization or society such as (but not limited to) the American Psychiatric Association[i], American Psychological Association[ii] or National Association of Social Workers[iii] exist, it is advised that mental health professionals review these documents and incorporate them into practice.

Telemental health, like telemedicine, is an intentionally broad term referring to the provision of mental health and substance abuse services from a distance. This guideline focuses on two-way, interactive videoconferencing as the modality by which telemental health services are provided. In the future, additional sections will be added to address the use of the internet and other asynchronous or social relationship environments for interactions between mental health professionals and their patients and families. The use of other modern technologies such as virtual reality, electronic mail, remote monitoring devices (home telehealth store and forward technology), chat rooms, and web-based clients are not included in this version of the telemental health guidelines.

The ATA provides the core standards for telemedicine operations and provides overarching guidance for administrative, clinical, and technical standards (http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3311). The Practice Guidelines for Videoconferencing-Based Telemental Health covers all areas, reflecting the basic component processes associated with most telemental health consultations. The telemental health guidelines give further detail to these core standards in relation to the specialty area. This section of the guideline contains requirements, recommendations, or actions that are identified by text containing the keywords “shall,” “should,” or “may.” “Shall” indicates that it is required whenever feasible and practical under local conditions. “Should” indicates an optimal recommended action that is particularly suitable, without mentioning or excluding others. “May” indicates additional points that may be considered to further optimize the telemental health care process.

A glossary of terms, references to literature, and informative web sites are included at the end of the document.

Application for the Practice of Telemedicine

a. Clinical Applications

Currently, the point of delivery for telemental health services is as varied as the type of services that are being provided. Sites include hospitals, emergency rooms, community mental health centers, clinics, physician offices, nursing homes, assisted living facilities, prisons, schools, and patient homes. With careful planning, telemental health services can significantly impact the quality, timeliness, and availability of services in almost any mental health care delivery system.[iv, v, vi, vii, viii, ix, x, xi, xii, xiii, xiv, xv, xvi, xvii, xviii]

Scope of Services

Clinical applications of telemedicine encompass diagnostic, therapeutic, and forensic modalities across the lifespan. Common applications include pre-hospitalization assessment and post-hospital follow-up care, scheduled and urgent outpatient visits, medication management, psychotherapy and consultation.

Clinical Interviews

Telemental health interviews may be conducted between physicians in consultation, between a physician and another health care provider (e.g., a case manager, clinical nurse practitioner or physician assistant), or between mental health professionals and a patient. Other persons, such as another health care provider or family member, may also be present in a patient interview. The Telemental health interview may be an adjunct to periodic face-to-face contact or may be the only contact; and is typically supported by additional communications technologies such as faxed or emailed consultation information or transmission of an electronic medical record.

Emergency Evaluations

Many programs across the United States provide emergency evaluations by telemedicine successfully with minimal support staff and standards in place at the patient site. Emergency evaluations for psychiatric hospitalization can be conducted via telemedicine, and usually will require additional personnel to provide physical control of the environment and possibly the patient, for patient safety. Situations such as a patient who is suicidal, homicidal, or suffering from dementia or acute psychosis may require additional personnel in the room in addition to family members. In general, adequate support staff or responsible family members shall be present at the remote site in order to safely care for the patient. If other alternatives are immediately available to meet the patient's needs without transfer, services are preferred to be provided on-site and in-person. In the event that support staff and family members are not present, the telemental health provider **must** make a determination whether immediate

intervention is deemed necessary for patient safety. [xix, xx, xxi, xxii] Special attention shall be paid to the enhanced need for privacy and confidentiality and every attempt to preserve the patient's right to privacy shall be employed.

Case Management

In large distributed systems where multi-provider case management is needed, videoconferencing allows collaboration between all the involved clinical participants regardless of distance. Clinical treatment plans can be developed with input from experts who would not otherwise be available.[xxiii, xxiv, xxv, xxvi]

Clinical Supervision

Supervision of trainees (residents or interns) at a distant site can facilitate both training and patient care. Supervision may be done either in real-time with the supervisor present via videoconferencing, or, when appropriate, by the use of store and forward technology.[xxvii] Supervising practitioners shall comply with state and federal requirements for in-person supervision for residents and other practitioners whose positions are federally or state funded.

b. Non-Clinical Applications of Videoconferencing

Distance Learning

Videoconferencing technologies for education encompass a broad range of applications. These include, but are not limited to, point-to-point applications, such as physician-to-physician, physician-to-patient, or multipoint sessions such as a classroom setting where a teacher is at one site and the "pupils" are at other multiple remote sites. Distance learning modalities can be used for off-site mentoring to teach new techniques, or multi-site transmission of "grand rounds" conferences and continuing medical education (CME) events. These can be streamed via the internet or transmitted a number of ways including point-to-point circuits and the public Internet (if transmitting protected health information or other sensitive information via the public internet, AES encryption or a virtual private network (VPN) ***shall*** be used to secure the transmission).[xxviii, xxix] Distance education modalities can also be used for clinical care of patients, e.g. patient teaching regarding medications, therapies, or compliance with treatment plans.

Research

Telemedicine has been applied as an effective and reliable means of gathering research data from clinical populations. Telemental health enables multi-site and remote acquisition of information via in-person interviews or direct observation, as well as providing a simple means of archiving patient-provider interactions in video format for later scoring and evaluation. All

requirements for human subjects research ***shall*** be applied to the use of telemental health for research purposes, especially when research involves the use of video or audio taping of the telemedicine conversations. Attention ***shall*** be paid to issues of confidentiality and informed consent, ensuring that patients who are involved in research trials via telemedicine understand consent is for the purposes of research and not for receiving care via telemental health. Efforts ***shall*** be made to ensure that patients receiving telemental health services are aware that telemedicine conversations will be recorded only with their consent.[xxx]

Administration

Interactive two-way audio-visual communication between distant hospitals, clinics, schools, and justice centers is an effective means of providing administrative services and support and helps organizations to achieve cost savings in large or geographically dispersed systems. Any discussion of protected health information ***shall*** be secured through use of a private, point-to-point circuit, an ISDN connection, or AES encryption or a virtual private network (VPN) ***shall*** be used for transmissions via the public internet.

Guidelines for the Practice of Telemental Health

Any organization or provider considering the use of telecommunications equipment for the purpose of providing mental health or substance abuse care to a remote site ***shall*** have in place prior to initiating such a service a set of Standard Operating Procedures or Protocols that ***shall*** include (but are not limited to) the following administrative, clinical and technical specifications.

The guidelines ***shall*** specifically describe roles, responsibilities (i.e., daytime and after-hours coverage), communication, and procedures around emergency issues. The degree of involvement of the telemental health provider will vary greatly between remote sites and be determined by legal issues, local resources, and staffing available to the clinic.[xxxi]

a. Standard Operating Procedures/Protocols

Telemental health organizations and providers ***shall*** ensure that appropriate staff is available to meet patient and provider needs before, during, and after telemental health encounters of all types. Organizations and practitioners ***shall*** have agreements in place to assure licensing, credentialing, training, and authentication of patients and practitioners as appropriate and according to local, state, and national requirements.

Telemental health organizations and practitioners ***shall b***e aware of the enhanced requirements for privacy and confidentiality that is afforded to patients receiving mental health

care. In the United States, additional state regulations for privacy, confidentiality and patient rights apply above and beyond requirements in place for general health care interactions.

Telemental health organizations and practitioners ***shall*** have billing and coding processes in place that share information across systems for the purposes of payment that do not risk exposure of mental health patients' personal health information.

Telemental health organizations and practitioners ***shall*** determine processes for documentation, storage, and retrieval of telemental health records. Specific descriptions ***shall*** be in place that address who can have access to the records. Most organizations institute a higher level of security on mental health patients' records than on other patients' records.

Patients receiving mental health and substance abuse services are afforded a higher degree of patients' rights as well as organizational responsibilities. Telemental health organizations ***shall*** be aware of these additional responsibilities and ensure that they are achieved.
Telemental health organizations and practitioners ***shall*** have in place policies and procedures that address all aspects of administrative, clinical, and technical components regarding the provision of telemental health and ***shall*** keep the policies and procedures updated on an annual basis or more often as needed.

Telemental health organizations and practitioners ***shall*** have in place a systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management. The quality improvement indicators ***shall*** address the critical components of providing telemental health services and ***shall*** be used to make programmatic and clinical changes.

Telemental health organizations and practitioners ***shall*** comply with the specific consents to treat and for medication administration that apply to the area of mental health. Although no special consents are needed to use telemental health to serve patients, additional layers of consent are required during the course of treatment of persons with mental health conditions. Procedures ***shall*** be in place between organizations and telemental health practitioners for the purposes of obtaining and sharing consents for mental health treatment and services.

Telemental health professionals ***shall*** be aware of who has regulatory authority and any and all requirements (including those for liability insurance) that apply when practicing telehealth in another jurisdiction (eg. Across state lines), with particular attention to the additional responsibility that might apply in mental health encounters.

b. Clinical Specifications

- The telemedicine operation and its health professionals ***shall*** ensure that the standard of care delivered via telemedicine is equivalent to any other type of care that can be

delivered to the patient/client, considering the specific context, location and timing, and relative availability of in-person care.

- Health professionals ***shall*** be responsible for maintaining professional discipline and clinical practice guidelines in the delivery of care in the telemedicine setting, recognizing that certain modifications may need to be made to accommodate specific circumstances.

- Any modifications to specialty specific clinical practice standards for the telemedicine setting ***shall*** ensure that clinical requirements specific to the discipline are maintained.

- Health professionals providing telemedicine services ***shall*** have the necessary education, training/orientation, and continuing education/professional development to insure they possess the necessary competencies for the provision of quality health services.

1. General Telemental Health Practice Issues

- ***Exam Inclusion Criteria/Scope*****:** The inclusion of cases for a telemental health consult is at the discretion of the referring and consulting clinicians. There are no absolute contraindications to patients being assessed using telemental health.[xxxii]

- ***Consult Request Data:*** Information ***shall*** be available to the consulting practitioner that meets legal and regulatory requirements for referral and that provides supportive and data to the practitioner in preparation for evaluating the Telemental health patient, and for on-going patient management. Procedures ***shall*** be in place between organizations and practitioners for sharing patient mental health information.

- ***Cultural Competency:*** The clinician practicing telemental health ***should*** have cultural competency in the population he or she is serving at a distance.[xxxiii, xxxiv] Cultural influences may be different between the patient and the practitioner sites and means of assessing the difference and notifying the practitioner shall be in place.

- ***Cognitive Testing:*** Cognitive testing may be provided via telemedicine but ***may*** need to be modified for use via video. Organizations administrating cognitive testing via videoconferencing ***shall*** be aware of the properties of the individual test instrument, how it may be impacted by videoconferencing, and potential needed modifications. Computer-based testing ***may*** be provided at the patient location and results securely transmitted to the telemental health practitioner for scoring and interpretation. On-site testers are appropriate to be used for cognitive testing and telemental health organizations ***shall*** have in place arrangements for the use of

ancillary staff to administer cognitive testing and the sharing of results with the telemental health provider.[24,xxxv,xxxvi,xxxvii,xxxviii,xxxix,40]

- ***Videoteleconferencing (VTC):*** The following guidelines are recommended to ensure the safety of patients and also accurate diagnosis, appropriate intervention, and supportive ongoing care.

  All persons in the exam room at both sites ***shall*** be identified to all participants prior to the consultation room. Disclosing persons who are attending the consultation ***shall*** be done by panning each end of the consultation with the video camera or at a minimum, announcing the presence of individuals present and asking the patient's permission for additional persons to be in the room. Permission from the patient is not required if safety concerns mandate the presence of another individual or if the patient is being legally detained, but should be encouraged by the practitioner.

  Clinical History/Results**:** The sharing of clinical history and results ***shall*** comply with established legal and regulatory requirements. Telemental health organizations and practitioners shall have agreements in place that outline the procedure for securely sharing such clinical history and results. Laboratory or procedure results ***should*** be reviewed by the telemental health consultant via remote health record access or facsimile. Telemental health consultants need to have access to relevant clinical data as if the patient were being seen in person. Electronic prescribing ***should*** be used where available.[xl, xli, xlii, xliii]

  Reports**:** As with any consultation, there ***shall*** be a traceable record of the teleconsultation at both the referring and consulting sites. The practitioner at a minimum shall have documentation including pertinent and required aspects of the clinical encounter, and the patient site shall have documentation that a telemental health visit occurred with the patient. The consultant's opinion and any services that were ordered or performed ***shall*** also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source (e.g., physician assistant, nurse practitioner, doctor of chiropractics, physical therapist, occupational therapist, speech-language therapist, psychologist, social worker, lawyer, insurance company) as required by professional conduct, legal, or regulatory requirements. Recommended language for the consultant includes "Based on the video images and history provided, my impression is as follows." Verbal communication with referring practitioners, or other pertinent entities may be given and written records of the interaction ***shall*** be kept according to legal and regulatory requirements at least at one site (referring and/or consulting). Reports may be faxed, mailed or electronically sent after the interaction has ended and ***should*** be done using secure methods. A consultant report ***shall*** include at a minimum the diagnosis and/or differential diagnoses, a summary of the findings, and recommended management.

Psychotherapy: Standard practice guidelines for therapy ***shall*** direct psychotherapy services within the telemedicine setting. Evidence-based practice and empirically supported treatments ***shall*** be followed and adapted by the telemental health practitioner as appropriate for videoconferencing. Persons engaged in providing psychotherapy services ***shall*** be aware of their professional organizations positions on telemental health and incorporate the professional association standards whenever possible.

Medication Management: Expert pharmacotherapy is the most frequently requested telemental health service[xliv, xlv] and various methods have been employed, including: a) the telepsychiatrist consults to the referring primary care or managing physician (PCP) who prescribes the medications; b) the telepsychiatrist works with a mid-level professional at the patient site who writes the prescriptions; and c) the telepsychiatrist directly prescribes. In this last scenario, clear procedures ***shall*** be established and communicated to all parties regarding the method for obtaining initial prescriptions and refills and reporting adverse effects. Pharmacotherapy ***shall*** comply with the APA and AACAP[xlvi] practice parameters.

2. Psychiatric Emergencies

Psychiatric emergencies can be experienced in a telehealth visit similar to an in-person visit. Provisions for routine or emergent local medical management ***shall*** be included in any local operating procedure or protocol. The following specific recommendations were adapted from a previous set of published clinical guidelines on emergency telepsychiatry.[xlvii]

a. ***Administrative Issues:*** A patient site assessment ***shall*** be undertaken that includes obtaining information on local regulations and emergency resources, identification of potential local collaborators to help with emergency management. Emergency protocols ***shall*** be created for all telepsychiatry clinics with clear explanation of roles and responsibilities in emergency situations, determination of outside clinic hours emergency coverage, and guidelines for determining at what point other staff and resources should be brought in to help manage emergency situations.

b. ***Legal Issues:*** Clinicians ***shall*** be familiar with local civil commitment regulations and have arrangements where possible to work with local staff to initiate/assist with civil commitments.

c. ***General Clinical Issues:*** Clinicians ***shall*** *b*e aware of the impact of telepsychiatry on provider's perception of control over the clinical interaction, and how this might impact provider's management. Clinicians ***shall*** *b*e aware of safety issues with patients displaying strong affective or behavioral states upon conclusion of a session, and how patients may then interact with remote site staff.

3. Special Groups

a. Children: Children generally respond very positively to videoconferencing consultations.[xlviii] VTC procedures for the evaluation and treatment of youth ***shall*** follow the same guidelines presented for adult with modifications to consider the developmental status of youth, such as motor functioning, speech and language capabilities, and relatedness. When legally required, families ***shall*** be informed when a telehealth appointment is scheduled for their child, in order to prepare their child for a VTC appointment.

a. The room at the originating site (patient site) ***should*** be large enough to include the youth and a parent, and one to two other individuals and to allow the camera to scan an area large enough to adequately observe children's motor skills as they move about the room, play, and separate from their parents.[xlix, l]

b. A table ***should*** be available to provide a surface for the child to draw or play while the parent relates the history, but the table ***should*** not interfere with communication or viewing the youth's motor skills. Some simple toys ***should*** be provided both to occupy the child and to allow assessment of skills and ***should*** be selected based on age-appropriateness and child safety standards.

c. The care and the clinical procedures used with children ***should*** follow the practice parameters developed by the American Academy of Child and Adolescent Psychiatry.

b. Elderly Populations*:* Sensory deficits, especially visual and auditory, can impair the ability to interact over a videoconference connection.[li] Clinics ***shall*** consider the use of technologies that can help with visual or auditory impairment. The geriatric patient often has multiple medical problems, many of which affect cognitive/behavioral state, require appropriate laboratory, radiologic, and other diagnostic procedures. The inclusion of family members ***should*** be undertaken as clinically appropriate and with the permission of the patient. Interviewing techniques shall be appropriate for a patient who may be cognitively impaired, or find it difficult to adapt to the technology.

c. Rural Populations: Clinicians working with patients from rural or frontier issues ***shall*** be aware of issues unique to working with rural populations via telehealth.

a. Clinicians ***shall*** discuss firearm ownership, safety, sanctioned use of firearms and meaning of firearms to patients in rural areas. Clinicians ***shall*** be prepared to negotiate with patients over firearm disposition, and consider involvement of patients' families as appropriate.

b. Clinicians ***shall*** be sensitive of impact of disclosures made during emergency management on patient confidentiality and relationships in small communities.

c. Clinicians ***shall*** consider including families in emergency treatment situations where possible and clinically appropriate, while also assessing and be attentive to exacerbation of family tensions in small communities.

d. Clinicians ***shall*** assess substance issues, be familiar with local resources for substance use assessment and treatment, and be prepared to play a more active role in substance use treatment.[lii, liii]

4. Ethical Consideration

Although telemedicine is not a practice in and of itself, practicing at a distance creates a unique relationship with the patient that requires attention to and adherence to professional ethical principles. An organization or health professional that adheres to ethical telemedicine principles ***shall:***

a. Incorporate organizational values and ethics statements into the administrative policies and procedures for telemedicine

b. Be aware of medical and other professional discipline codes of ethics when using telemedicine

c. Inform the patient of their rights and responsibilities when receiving care at a distance (through telemedicine) including the right to refuse to use telemedicine

d. Provide patients and providers with a formal process for resolving ethical questions and issues that might arise as a result of a telemedicine encounter

e. Eliminate any conflict of interest to influence decisions made about, for, or with patients who receive care via telemedicine.

c. Technical Specifications

Videoconferencing is a communications tool that has made possible the recreation of clinical, consultative, and educational settings regardless of the geographic location of participants. A wide array of equipment and standards-based software is available that can greatly enhance the capabilities and usefulness of the videoconferencing system.

Telemental health users where available, practical and affordable ***should*** be able to, when cost-effective:

- Display static pictures, diagrams, or objects.
- View and share a computer desktop or applications.
- Play videos or CDs so people at other locations can see and hear them.
- Record meetings when clinically appropriate and with patient permission.
- Share information on a common white board or via computer files.

Other desirable features of a videoconferencing system include:

- Ease of use with minimum operator training.
- Have remote camera control so that a clinician can pan, tilt, and zoom (PTZ) the camera on the patient end for close-ups.
- Easy-to-understand visual cues to give user feedback on features selected.
- On screen messages to notify the user of such conditions as loss of far end video, incomplete or dropped connections, mute/unmute etc.
- Option to view the picture sent as well as the picture received simultaneously (known as 'picture-in-picture' or PIP).
- Audio at 7 kHz full duplex with echo cancellation (capable of eliminating room return audio echo), with easy-to-use mute function and volume adjustment.
- Standard computer and peripheral ports for transmission of data.
- Ability to operate at a bandwidth of 384 Kbps or higher.
- Capacity for software upgrades as improvements become available.

Currently, most videoconferencing takes place via digital telephone lines (ISDN) or over TCP/IP (utilizing a local area network (LAN), wide area network (WAN), or broadband Internet connection). Low bandwidth videophones are often found in home care programs, or in situations or areas where higher bandwidth connections are either unavailable or cost prohibitive. Satellite communications are increasingly being used in remote areas, whether for Internet connectivity, or direct satellite telephony. Conferencing can be established between just two locations (called point-to-point) or among a number of sites simultaneously (called multi-point).

High quality microphones and speakers ensure effective aural communication and ***should*** be used in telemental health consultations to ensure accurate interpretation of the patient's and provider's spoken communication. High-quality audio is essential to the success of telemental health services, capturing the nuances of conversation that are often vital in making appropriate diagnoses. Microphone type and placement are extremely important, as are the acoustical properties of the room used. Most flat "conference-style" microphones are adequate to pick up sounds around a table or in a room, as long as the microphones are placed on a hard, flat surface at desk or table-top level. Many will also work well if placed on a flat wall at about head level for a seated person. If no flat surface is

available, or if patients may be active or agitated, an omni-directional microphone can be hung from the center of the ceiling. “Quiet” rooms (those with carpeting, soft furniture, acoustical treatments, or other sound absorbing characteristics) allow for better intelligibility of transmitted speech.[liv, lv , lvi, lvii, lviii, lix, lx, lxi, lxii, lxiii, lxiv, lxv, lxvi]

1. Transmission Speed and Bandwidth

Most telemental health programs use systems that transmit data at a minimum of 384 Kbps. Transmission speed ***shall*** be the minimum necessary to allow the smooth and natural communication pace necessary for clinical encounters. Research into the quality of data transmission has shown that viewers perceive a marked difference in quality between 128 and 384 Kbps, but report less noticeable difference between 384 and 768 Kbps, although the proportionate cost increase is often much larger at the higher transmission speed. The use of lower bandwidths is necessary in some locations due to lack of or expense of broadband access and the need to provide services to disparate and/or remote populations. The use of the Internet has gained popularity in recent years as a medium by which providers and patients can bridge the digital gap and remain connected.[lxvii]

2. Image Storage, Retrieval and Transmission

a. ***Security****:* For telemental services provided within the United States, the United States Health Insurance Portability & Accountability Act (HIPAA)[lxviii] and state privacy requirements ***shall*** be followed at all times to protect patient privacy. Privacy requirements in other countries ***shall*** be followed for telemental services provided in those countries. Telemental health services being provided across political boundaries ***shall*** be in conformance with privacy requirements in both locations. Network and software security protocols to protect privacy and confidentiality ***shall*** be provided as well as appropriate user accessibility and authentication protocols. Measures to safeguard data against intentional and unintentional corruption ***shall*** be in place during both storage and transmission.

b. ***Encryption*****:** Within the United States, HIPAA requires that encryption (128 bit) of Electronic Protected Health Information ***shall*** be addressed.[lxix] Consistent with HIPAA and good practice, video sessions ***shall*** be secured to the greatest practical extent.

c. ***Resolution:*** The resolution of the display monitor ***should*** match as closely as possible the resolution of the acquired image being displayed, or the originally acquired image resolution should be accessible using zoom and pan functions.

d. ***Interoperability:*** Interoperability of videoconferencing equipment has improved significantly in the past few years through a number of standards that have

arisen in the industry. Most telecommunications standards are established by the International Telecommunications Union (ITU), an agency of the United Nations. Equipment ***shall*** be based on these standards which allow successful conferencing regardless of platform or manufacturer. The ITU standards that ***shall*** be used comprise the H (video), G (audio) and T (data) series.

e. ***Videoconferencing with Personal Computers:*** Computers utilized for VTC ***shall*** comply with all facility, state, and federal regulations.

f. ***TCP/IP:*** There are continuing innovations in software protocols designed to assure consistently high quality signals (called "quality of service" or QOS) for videoconferencing systems using IP networks. The use of these protocols (which are usually implemented in the videoconferencing system itself) can significantly improve the quality of transmission over an IP network.

g. ***Integrated Services Digital Network (ISDN):*** Videoconferencing over ISDN is governed by the H.320 ITU standard, which includes a number of associated standards to control video, audio, and data flow. ISDN connections usually use a multiplexer (MUX) to aggregate 2-6 individual phone lines into a single high-bandwidth connection. As each line transmits at 64 kbps, a minimum of 6 lines ***should*** be used to ensure transmission at least at 384 kbps.

3. Physical Location/Room Requirements

a. ***Room Set-up:*** During a telemental health session, both locations ***shall*** be considered a patient examination room regardless of a room's intended use. Both sites ***shall*** be appropriately designed with audio and visual privacy and additionally the originating site ***shall*** have the ability to accommodate posture and movement visualization by the provider.[lxx] The ability to view written or drawn material ***should*** also be available. Rooms ***shall*** be designated private for the duration of the VTC and no unauthorized access shall be permitted. The organization ***shall*** take every precaution to ensure the privacy of the consult and the confidentiality of the patient. All persons in the exam room at both sites ***shall*** be identified to all participants prior to the consultation and the patient's permission ***shall*** be obtained for any visitors or clinicians to be present during the session.

b. ***Room Lighting:*** The room in which videoconferencing is used ***shall*** be well lit (150 ft candles at the patient is recommended), preferably using light sources as close to day light as possible (i.e., fluorescent day-light or full spectrum bulbs rather than incandescent). The room ***shall*** be comfortably lit for the patient and lit well enough for the provider to see the patient without shadows falling on the patient's face or other areas where clinical data is being displayed (such as lower extremities, hands, etc.). The lighting of the provider's space ***shall*** meet the

same requirements in that the patient must be able to see the face of the provider with no shadowing. Daylight is often the softest and more comfortable light for the patient to view the clinician.

c. ***Backdrop:*** Backdrops behind the patient and provider ***should*** be clean and plain in color and not full of distractions such as office papers, book shelves, etc. Blue is an optimum color for backdrops as blue neither reflects or absorbs light, is a calming color, and helps to accentuate the area of interest.

d. ***Ergonomic Considerations*****:** The comfort of the mental health professional undertaking the consultations ***should*** be considered to prevent fatigue and computer vision syndrome problems common with increased computer interactions.[lxxi] *Gaze Angle:* Gaze angle is the angle between the near participant's camera and where the near participant looks at the onscreen far participant (eye contact). The vertical location of the far participant on the screen will affect gaze angle. Gaze angles of approximately 5 to 7 degrees are imperceptible to most persons[1,1]. Gaze angle ***should*** be as small as practical.

d. Administrative Issues

1. Organizations ***shall*** ensure the technical readiness of the telehealth equipment and the clinical environment.[lxxii] Organizations providing telehealth services ***shall*** have processes in place to ensure the safety and effectiveness of equipment through on-going support and maintenance.[lxxiii, lxxiv] Organizations providing telehealth services ***shall*** have policies and procedures in place to ensure the physical security of telehealth equipment and the electronic security of data.[lxxv] Organizations ***shal*****l** have appropriate redundant systems and appropriate recovery procedures in place that ensure availability of the network for critical connectivity. Organizations ***shall*** ensure compliance with all relevant safety laws, regulations, and codes for technology and technical safety.[xiv, xv] Organizations ***shall*** have infection control policies and procedures in place for the use of telehealth equipment and patient peripherals.

2. Policy Related Steps to Optimize Telemental Health Practices

   It is critical to develop policies and procedures to ensure consistent implementation of telemental health program functions. Key policies that ***shall*** be addressed include:

   - Release of information and informed consent
   - Identifying all required patient information for a referral/consultation
   - A reliable process for communicating findings after consults
   - Ensuring privacy and confidentiality
   - Intake procedures and screening
   - Staff roles and responsibilities

- Transmission of patient data
- Use of electronic medical records
- Appointment scheduling; synchronizing schedules at all sites
- Transmission of prescriptions, lab orders and progress notes
- Evaluation and measurement of patient outcomes
- Quality improvement
- Safety
- Licensing, liability and malpractice insurance
- Continuous training

Appendix

A: Existing Digital Imaging Standards

This is not meant to be a comprehensive list of all existing standards, but rather provides a description of the standards most relevant to the practice of telemental health.

ITU-T: The International Telecommunications Union has established a series of standards (H.300) for VTC. It includes such sections as the H.320 series for circuit-switched, n x 64 (i.e., ITU-T); the H.323series: packet-switched/network, Internet Protocol; and the H.324: Plain Old Telephone Service (POTS).

Session Initiation Protocol (SIP): The Internet Engineering Task Force RFC 3261 also applies to VTC. SIP is a text-based protocol for initiating interactive communication sessions between users, including voice, video, chat, and virtual reality.

JPEG/TIF/WAV: Some of the most common compression methods used for still images include the following. The method used depends on the achievable compression ratio and the number and types of artifacts created during compression. *Lossless compression* allows for the reconstruction of the exact original data prior to compression without any loss of information. *Lossy compression* refers to methods that lose data once the image has been compressed and uncompressed. The level of compression and method used affect the amount of data loss and whether or not it is visually perceptible. The type and level of compression may vary depending on the type of exam. Different compression algorithms will achieve different compression ratios with varying degrees of artifacts. The choice of compression method and level should be reviewed periodically for each image and exam type, to insure that artifacts are not perceptible. It should be noted that lossy compression can affect the colors in an image.

- **JPEG (2000):** JPEG 2000 uses wavelet technology that allows an image to be retained without any distortion or loss. [71] File extensions for JPEG 2000 are either .jp2 or .j2c (traditional JPEG is either .jpg or .jpeg).

- **TIF:** Tagged Image File Format used for formatting and compressing images. It can be lossy or lossless. The file extension TIF is .tiff or .tif.

- **WAV:** A method of compression using wavelets transforms (mathematical functions that divide data based on frequency components). There are a variety of file extensions depending on the wavelet method used. It can be lossy or lossless.

HL7: Health Level Seven is one of several American National Standards Institute (ANSI) Standards Developing Organizations (SDOs) operating in the healthcare arena. Health Level Seven's domain is clinical and administrative data.[lxxvi]

US HIPAA: The United Sates Health Insurance Portability & Accountability Act of 1996 (Public Law 104-191)calls for improved efficiency in healthcare delivery by standardizing electronic data interchange, and the protection of confidentiality and security of health data through setting and enforcing standards.[lxxvii,lxxviii] It has rules for:

- Standardization of electronic patient health, administrative and financial data
- Unique health identifiers for individuals, employers, health plans and health care providers

- Security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

JCAHO: The Joint Commission evaluates and accredits nearly 15,000 health care organizations and programs in the United States. An independent, not-for-profit organization, The Joint Commission is a standards-setting and accrediting body in health care. Since 1951, The Joint Commission has maintained state-of-the-art standards that focus on improving the quality and safety of care provided by health care organizations. The Joint Commission's comprehensive accreditation process evaluates an organization's compliance with these standards and other accreditation requirements. Joint Commission accreditation is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain The Joint Commission's Gold Seal of Approval™, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years. (Laboratories must be surveyed every two years.)

B: Telemedicine/Telehealth Glossary

The following is a list of terms and definitions that are commonly used in telemedicine and telehealth. The list was assembled for the purpose of encouraging consistency in employing these terms in ATA related documents and resource materials. The list is not all-inclusive and may be augmented by specialty areas as deemed appropriate.

Application Service Provider (ASP): An ASP hosts a variety of applications on a central server. For a fee, customers can access the applications that interest them over secure Internet connections or a private network. This means that they do not need to purchase, install and maintain the software themselves; instead they rent the applications they need from their ASP. Even new releases, such as software upgrades, are generally included in the price.

Asynchronous: This term is sometimes used to describe store and forward transmission of medical images or information because the transmission typically occurs in one direction in time. This is the opposite of synchronous (see below).

Authentication: A method of verifying the identity of a person sending or receiving information using passwords, keys and other automated identifiers.

Bandwidth: A measure of the information carrying capacity of a communications channel; a practical limit to the size, cost, and capability of a telemedicine service.

Bluetooth Wireless: Bluetooth is an industrial specification for wireless personal area networks (PANs). Bluetooth provides a way to connect and exchange information between devices such as mobile phones, laptops, PCs, printers, digital cameras and video game consoles over a secure, globally unlicensed short-range radio frequency. The Bluetooth specifications are developed and licensed by the Bluetooth Special Interest Group.

Broadband: Communications (e.g., broadcast television, microwave, and satellite) capable of carrying a wide range of frequencies; refers to transmission of signals in a frequency-modulated fashion, over a segment of the total bandwidth available, thereby permitting simultaneous transmission of several messages.

Clinical Information System: Relating exclusively to the information regarding the care of a patient, rather than administrative data, this hospital-based information system is designed to collect and organize data.

CODEC: Acronym for coder-decoder. This is the videoconferencing device (e.g., Polycom, Tandberg, Sony, Panasonic, etc) that converts analog video and audio signals to digital video and audio code and vice versa. CODECs typically compress the digital code to conserve bandwidth on a telecommunications path.

Compressed video: Video images that have been processed to reduce the amount of bandwidth needed to capture the necessary information so that the information can be sent over a telephone network.

Computer-based Patient Record (CPR): An electronic form of individual patient information that is designed to provide access to complete and accurate patient data.

Data Compression: A method to reduce the volume of data using encoding to reduce image processing, transmission times, bandwidth requirements, and storage space requirements. Some compression techniques result in the loss of some information, which may or may not be clinically important.

Diagnostic Equipment (Scopes, Cameras & Other Peripheral Devices): A hardware device not part of the central computer (e.g. digitizers, stethoscope, or camera) that can provide medical data input to or accept output from the computer.

Digital Camera (still images): A digital camera is typically used to take still images of a patient. General uses for this type of camera include dermatology and wound care. This camera

produces images that can be downloaded to a PC and sent to a provider/consultant over a network.

Digital Imaging and Communication in Medicine (DICOM): A standard for communications among medical imaging devices; a set of protocols describing how images are identified and formatted that is vendor-independent and developed by the American College of Radiology and the National Electronic Manufacturers Association.

Disease Management: A continuous coordinated health care process that seeks to manage and improve the health status of a carefully defined patient population over the entire course of a disease (e.g., CHF, DM) The patient populations targeted are high-risk, high-cost patients with chronic conditions that depend on appropriate care for proper maintenance.

Distance Learning: The incorporation of video and audio technologies, allowing students to "attend" classes and training sessions that are being presented at a remote location. Distance learning systems are usually interactive and are a tool in the delivery of training and education to widely dispersed students, or in instances in which the instructor cannot travel to the student's site.

Distant Site: The distant site is defined as the telehealth site where the provider/specialist is seeing the patient at a distance or consulting with a patient's provider. (CMS) Others common names for this term include – hub site, specialty site, provider/physician site and referral site. The site may also be referred to as the consulting site.

Document Camera: A camera that can display written or typed information (e.g., lab results), photographs, graphics (e.g., ECG strips) and in some cases x-rays.

Electronic Data Interchange (EDI): The sending and receiving of data directly between trading partners without paper or human intervention.

Electronic Patient Record: An electronic form of individual patient information that is designed to provide access to complete and accurate patient data, alerts, reminders, clinical decision support systems, links to medical knowledge, and other aids.

Encryption: A system of encoding data on a Web page or e-mail where the information can only be retrieved and decoded by the person or computer system authorized to access it.

Firewall: Computer hardware and software that block unauthorized communications between an institution's computer network and external networks.

Full-motion Video: This describes a standard video signal that allows video to be shown at the distant end in smooth, uninterrupted images.

Guideline: A statement of policy or procedures by which to determine a course of action, or give guidance for setting standards (Loane & Wootton, 2002).

H.320: This is the technical standard for videoconferencing compression standards that allow different equipment to interoperate via T1 or ISDN connections.

H.323: This is the technical standard for videoconferencing compression standards that allow different equipment to interoperate via the Internet Protocol (see below).

H.324: This is the technical standard for videoconferencing compression standards that allow different equipment to interoperate via Plain Old Telephone Service (POTS).

Health Level-7 Data Communications Protocol (HL-7): This communication standard guides the transmission of health-related information. *HL7* allows the integration of various applications, such as bedside terminals, radiological imaging stations, hospital census, order entries, and patient accounting, into one system.

HIPAA: Acronym for Health Information Portability Act.

Home Health Care & Remote Monitoring Systems: Home health care is care provided to individuals and families in their place of residence for promoting, maintaining, or restoring health; or for minimizing the effects of disability and illness, including terminal illness. In the Medicare Current Beneficiary Survey and Medicare claims and enrollment data, home health care refers to home visits by professionals including nurses, physicians, social workers, therapists, and home health aides. Using remote monitoring and interactive devices allows the patient to send in vital signs on a regular basis to a provider without the need for travel.

Informatics: The use of computer science and information technologies to the management and processing of data, information and knowledge.

Integrated Services Digital Network (ISDN): This is a common dial-up transmission path for videoconferencing. Since ISDN services are used on demand by dialing another ISDN based device, per minute charges accumulate at some contracted rate and then are billed to the site placing the call. This service is analogous to using the dialing features associated with a long distance telephone call. The initiator of the call will pay the bill. ISDN permits connections up to 128Kbps.

Interactive Video/Television: This is analogous with video conferencing technologies that allow for two-way, synchronous, interactive video and audio signals for the purpose of delivering telehealth, telemedicine or distant education services. It is often referred to by the acronyms – ITV, IATV or VTC (video teleconference).

Internet Protocol: The Internet Protocol (IP) is the protocol by which data is sent from one computer to another on the Internet. Each computer on the Internet has at least one address

that uniquely identifies it from all other computers on the Internet. IP is a connectionless protocol, which means that there is no established connection between the end points that are communicating. The IP address of a videoconferencing system is its phone number.

Interoperability: Interoperability refers to the ability of two of more systems* to interact with one another and exchange information in order to achieve predictable results (*refers to more than technical systems) (Bergman, Ulmer and Sargious, 2001). There are three types of interoperability: human/operational; clinical; and technical (Canadian Society for Telehealth, 2001). Interoperability refers to the ability of two or more systems (computers, communication devices, networks, software, and other information technology components) to interact with one another and exchange data according to a prescribed method in order to achieve predictable results (ISO ITC-215).

ISDN Basic Rate Interface (BRI): This is an ISDN interface that provides 128k of bandwidth for videoconferencing or simultaneous voice and data services. Multiple BRI lines can be linked together using a multiplexer (see below) to achieve higher bandwidth levels. For instance, a popular choice among telehealth networks is to combine 3 BRI lines to provide 384k of bandwidth for video-conferencing. It should be noted that BRI services are not available in some rural locations. One should check with their telecommunications providers on the availability of BRI service before ordering videoconferencing equipment that uses this type of service.

ISDN Primary Rate Interface (PRI): This is an ISDN interface standard that operates using 23, 64k channels and one 64k data channel. With the proper multiplexing equipment the ISDN PRI channels can be selected by the user for a video call. For instance if the user wants to have a videoconference at 384k of bandwidth then they can instruct the multiplexer to use channels 1 through 6 (6 x 64k = 384k). This is important because the user typically pays charges based on the number of 64k channels used during a videoconference. The fewer channels used to obtain a quality video signal the less expensive the call.

JCAHO: Acronym for Joint Commission on Accreditation of Healthcare Organizations.

Lossless: A format of data compression, typically of an order of less than 2:1, in which none of the original data information is lost when the image is reproduced.

Lossy: A process of data compression at a relatively high ratio, which leads to some permanent loss of information upon reconstruction.

Medical/ Nursing Call Center: A call center is a centralized office that answers incoming telephone calls from patients. Such an office may also respond to letters, faxes, e-mails and similar written correspondence. Usually staffed by nurses, call centers provide basic health information and instructions to callers but do not provide an official diagnosis of conditions or prescribe medicine. Call centers act as an initial triage point for patients.

Mobile Telehealth: The provision of health care services with the assistance of a van, trailer, or other mobile unit in which the health care provider might provide patient services at a distance from a normal medical facility. Services may also be provided through mobile technologies that allow a mobile vehicle equipped with medical technologies to attach to an existing health care facility, such as mobile CT, MRI, or teledentistry.

Multiplexer (MUX): A device that combines multiple inputs (ISDN PRI channels or ISDN BRI lines) into an aggregate signal to be transported via a single transmission path.

Multi-point Control Unit (MCU): A device that can link multiple videoconferencing sites into a single videoconference. An MCU is also often referred to as a "bridge".

Multi-point Teleconferencing: Interactive electronic communication between multiple users at two or more sites which facilitates voice, video, and/or data transmission systems: audio, graphics, computer and video systems. Multi-point teleconferencing requires a MCU or bridging device to link multiple sites into a single videoconference.

Network Integrators: Organizations specializing in the development of software and related services that allows devices and systems to share data and communicate to one another.

Originating Site: The originating site is where the patient and/or the patient's physician is located during the telehealth encounter or consult (CMS). Other common names for this term include – spoke site, patient site, remote site, and rural site.

Patient Exam Camera (video): This is the camera typically used to examine the general condition of the patient. Types of cameras include those that may be embedded with set-top videoconferencing units, handheld video cameras, gooseneck cameras, camcorders, etc. The camera may be analog or digital depending upon the connection to the videoconferencing unit.

Peripheral Devices: Any device that is attached to a computer externally, i.e. Scanners, mouse pointers, printers, keyboards; and clinical monitors such as pulse oximeters, weight scales, are all examples of this.

Pharmacy Solutions: The use of electronic information and communication technology to provide and support comprehensive pharmacy services when distance separates the participants.

POTS: Acronym for Plain Old Telephone Service.

Presenter (Patient Presenter): Telehealth encounters require the distant provider to perform an exam of a patient from many miles away. In order to accomplish that task an individual with a clinical background (e.g., LPN, RN, etc) trained in the use of the equipment must be available at the originating site to "present" the patient, manage the cameras and perform any "hands-on" activities to successfully complete the exam. For example, a neurological diagnostic exam

usually requires a nurse capable of testing a patient's reflexes and other manipulative activities. It should be noted that in certain cases, such as interview based clinical consultations such as Telemental Health or Nutrition Services, that a licensed practitioner such as an RN or LPN, might not be necessary, and a non-licensed provider such as support staff, could provide telepresenting functions.

RHIO: Regional Health Information Organization (RHIO) and Health Information Exchange (HIE) are often used interchangeably. RHIO is a group of organizations with a business stake in improving the quality, safety, and efficiency of healthcare delivery. RHIOs are the building blocks of the proposed National Health Information Network (NHIN) initiative at the Office of the National Coordinator for Health Information Technology (ONCHIT).

Router: This device provides an interface between two networks or connects sub-networks within a single organization. It routes network traffic between multiple locations and it can find the best route between any two sites. For example, PCs or H.323 videoconferencing devices tell the routers where the destination device is located and the routers find the best way to get the information to that distant point.

Standard: A statement established by consensus or authority, that provides a benchmark for measuring quality, that is aimed at achieving optimal results (NIFTE Research Consortium, 2003).

Store and Forward (S&F): S&F is a type of telehealth encounter or consult that uses still digital images of a patient for the purpose of rendering a medical opinion or diagnosis. Common types of S&F services include radiology, pathology, dermatology and wound care. Store and forward also includes the asynchronous transmission of clinical data, such as blood glucose levels and electrocardiogram (ECG) measurements, from one site (e.g., patient's home) to another site (e.g., home health agency, hospital, clinic).

Switch: A switch in the videoconferencing world is an electrical device that selects the path of the video transmission. It may be thought of as an intelligent hub (see hub above) because it can be programmed to direct traffic on specific ports to specific destinations. Hub ports feed the same information to each device.

Synchronous: This term is sometimes used to describe interactive video connections because the transmission of information in both directions is occurring at exactly the same period.

System/Network Integration: The use of software that allows devices and systems to share data and communicate to one another.

T1/DS1: A digital carrier or type of telephone line service offering high-speed data, voice, or compressed video access in two directions, with a transmission rate of 1.544 Mbps.

T3/DS3: A carrier of *45* Mbps.

TCP/IP (Transmission Control Protocol/Internet Protocol): The underlying communications rules and protocols that allow computers to interact with each other and exchange data on the Internet.

Telecommunications Providers: An entity licensed by the government (the Federal Communications Commission in the U.S.) to provide telecommunications services to individuals or institutions.

Teleconferencing: Interactive electronic communication between multiple users at two or more sites which facilitates voice, video, and/or data transmission systems: audio, graphics, computer and video systems.

Telehealth and Telemedicine: Telemedicine and telehealth both describe the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Although evolving, telemedicine is sometimes associated with direct patient clinical services and telehealth is sometimes associated with a broader definition of remote healthcare services.

Telematics: The use of information processing based on a computer in telecommunications, and the use of telecommunications to permit computers to transfer programs and data to one another.

Telementoring: The use of audio, video, and other telecommunications and electronic information processing technologies to provide individual guidance or direction. An example of this help may involve a consultant aiding a distant clinician in a new medical procedure.

Telemonitoring: The process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patience from a distance.

Telepresence: The method of using robotic and other instruments that permit a clinician to perform a procedure at a remote location by manipulating devices and receiving feedback or sensory information that contributes to a sense of being present at the remote site and allows a satisfactory degree of technical achievement. For example, this term could be applied to a surgeon using lasers or dental hand pieces and receiving pressure similar to that created by touching a patient so that it seems as though s/he is actually present, permitting a satisfactory degree of dexterity.

Teleradiology and Picture Archiving and Communications Systems (PACs): The electronic transmission of radiological images, such as x-rays, CTs, and MRIs, for the purposes of interpretation and/or consultation. Digital images are transmitted over a distance using standard telephone lines, satellite connections, or local area networks (LANs). Teleradiology also is beginning to include the process of interfacing with the hospital information

systems/radiology information systems (HIS/RIS) in the transport of digital images. PACs provide centralized storage and access to medical images over information systems.

Ultrasound: A device that uses high-frequency sound waves to examine structures inside the body. It can rapidly detect tumors and other abnormalities, often right in the physician's office.

Universal Service Administrative Company (USAC): The Universal Service Administrative Company administers the Universal Service Fund (USF), which provides communities across the country with affordable telecommunication services. The Rural Health Care Division (RHCD) of USAC manages the telecommunications discount program for health care.

Videoconferencing Systems: Equipment and software that provide real-time, generally two way transmission of digitized video images between multiple locations; uses telecommunications to bring people at physically remote locations together for meetings. Each individual location in a *videoconferencing* system requires a room equipped to send and receive video.

Videoconferencing: Real-time, generally two way transmission of digitized video images between multiple locations; uses telecommunications to bring people at physically remote locations together for meetings. Each individual location in a *videoconferencing* system requires a room equipped to send and receive video.

WiFi: Originally licensed by the Wi-Fi Alliance to describe the underlying technology of wireless local area networks (WLAN) based on the IEEE 802.11 specifications. It was developed to be used for mobile computing devices, such as laptops, in LANs, but is now increasingly used for more services, including Internet and VoIP phone access, gaming, and basic connectivity of consumer electronics such as televisions and DVD players, or digital cameras. (Wikipedia)

C: References

[i] APA Resource Document On Telepsychiatry Via Videoconferencing, accessed December 15, 2007, http://www.psych.org/psych_pract/tp_paper.cfm.

[ii] APA Statement on Services by Telephone, Teleconferencing, and Internet. Accessed December 15, 2007, http://www.apa.org/ethics/stmnt01.html.

[iii] National Association of Social Workers and Association of Social Work Boards, Standards for Technology and Social Work Practice. Accessed December 15, 2007. http://www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf.

[iv] Broder E, Manson E, Boydell K, Teshima J. Use of Telepsychiatry for Child Psychiatric Issues: First 500 Cases. CPA Bulletin De l'APC June 2004 11-15.

[v] Kennedy C, Yellowlees P. The effectiveness of telepsychiatry measured using the Health of the Nation Outcome Scale and the Mental Health Inventory. J Telemed Telecare. 2003;9(1):12-6.

[vi] Zaylor C. Clinical Outcomes in Telepsychiatry. J Telemed Telecare. 1999;5 Suppl 1:S59-60.
[vii] O'Reilly R, Bishop J, Maddox K, Hutchinson L, Fisman M, Takhar J. Is telepsychiatry equivalent to face-to-face psychiatry? Results from a randomized controlled equivalence trial. Psychiatr Serv. 2007 Jun;58(6):836-43.

[viii] Nelson EL, Barnard M, Cain S. Treating childhood depression over videoconferencing Telemed J E Health. 2003 Spring;9(1):49-55.
[ix] Miller TW, Kraus RF, Kaak O, Sprang R, Burton D. Telemedicine: a child psychiatry case report. Telemed J E Health. 2002 Spring;8(1):139-41.
[x] Gallagher TE. Augmentation of special-needs services and information to students and teachers "ASSIST"--a telehealth innovation providing school-based medical interventions. Hawaii Med J. 2004 Oct;63(10):300-9.
[xi] Young TL, Ireson C. Effectiveness of school-based telehealth care in urban and rural elementary schools. Pediatrics. 2003 Nov;112(5):1088-94.
[xii] Sorvaniemi M, Santamaki O: Telepsychiatry in emergency consultation. Journal of Telemedicine and Telecare 8: 183-184, 2002.

[xiii] Mielonen ML, Ohinmaa A, Moring J, Isohanni M. Psychiatric inpatient care planning via telemedicine. J Telemed Telecare. 2000;6(3):152-7.

[xiv] Pollard SE, LePage JP. Telepsychiatry in a rural inpatient setting. Psychiatr Serv. 2001 Dec;52(12):1659.

[xv] Montani C, Billaud N, Tyrrell J, Fluchaire I, Malterre C, Lauvernay N, Couturier P, Franco A Psychological impact of a remote psychometric consultation with hospitalized elderly people. J Telemed Telecare. 1997;3(3):140-5.
[xvi] Pollard SE, LePage JP. Telepsychiatry in a rural inpatient setting. Psychiatr Serv. 2001 Dec;52(12):1659.
[xvii] Major J. Telemedicine room design. J Telemed Telecare. 2005;11(1):10-4.
[xviii] Pineau G, Moqadem K, St-Hilaire C, Perreault R, Levac E, Hamel B, et al. Telehealth: Clinical Guidelines and Technical Standards for Telepsychiatry.
http://www.bibliotheque.assnat.qc.ca/01/mono/2006/09/912275.pdf accessed 17 July 2007.
[xix] Brennan JA, Kealy JA, Gerardi LH, Shih R, Allegra J, Sannipoli L, Lutz D. Telemedicine in the emergency department: a randomized controlled trial. J Telemed Telecare. 1999;5(1):18-22
[xx] Shore JH, Hilty DM, Yellowlees P. Emergency management guidelines for telepsychiatry. Gen Hosp Psychiatry. 2007 May-Jun;29(3):199-206.

[xxi] Yellowlees P The use of telemedicine to perform psychiatric assessments under the Mental Health Act. J Telemed Telecare. 1997;3(4):224-6.
[xxii] Yellowlees P, Burke MM, Marks SL, Hilty DM, Shore JH. Emergency telepsychiatry.J Telemed Telecare. 2008;14(6):277-81.
[xxiii] Sorvaniemi M, Santamaki O: Telepsychiatry in emergency consultation. Journal of Telemedicine and Telecare 8: 183-184, 2002.

[xxiv] Montani C, Billaud N, Tyrrell J, Fluchaire I, Malterre C, Lauvernay N, Couturier P, Franco A Psychological impact of a remote psychometric consultation with hospitalized elderly people. J Telemed Telecare. 1997;3(3):140-5.

[xxv] McLaren P, Jegan S, Ahlbom J, Gallo F, Gaughran F, Forni C. Controlled trial of discharge planning by video-link in a UK urban mental health service: responses of staff and service users. J Telemed Telecare. 2002 Dec;8 Suppl 3(6):44-46.

[xxvi] Rosina R, Starling J, Nunn K, Dossetor D, Bridgland K. Telenursing: clinical nurse consultancy for rural paediatric nurses. J Telemed Telecare. 2002;8 Suppl 3:S3:48-9.

[xxvii] Simpson S, Knox J, Mitchell D, Ferguson J, Brebner J, Brebner E. A multidisciplinary approach to the treatment of eating disorders via videoconferencing in north-east Scotland. J Telemed Telecare. 2003;9 Suppl 1:S37-8.

[xxviii] Gallagher TE. Augmentation of special-needs services and information to students and teachers "ASSIST"--a telehealth innovation providing school-based medical interventions. Hawaii Med J. 2004 Oct;63(10):300-9.

[xxix] Fahey A, Day NA, Gelber H. Tele-education in child mental health for rural allied health workers. J Telemed Telecare. 2003;9(2):84-8.

[xxx] Yellowlees P, Marks S, Hilty D, Shore JH.Using e-health to enable culturally appropriate mental healthcare in rural areas.Telemed J E Health. 2008 Jun;14(5):486-92.

[xxxi] Shore JH, Hilty DM, Yellowlees P. Emergency management guidelines for telepsychiatry. Gen Hosp Psychiatry. 2007 May-Jun;29(3):199-206.

[xxxii] Yellowlees P, "Your Health in the Information Age" (2008) Pub iUniverse

[xxxiii] Shore JH, Savin DM, Novins D, Manson SM. Cultural aspects of telepsychiatry. J Telemed Telecare. 2006;12(3):116-21.

[xxxiv] Nieves Nieves JE, Stack KM. Hispanics and telepsychiatry. Psychiatr Serv. 2007 Jun;58(6):877-8.

[xxxv] Cullum, C.M., Weiner, M.F., Gehrmann, H.R., & Hynan, L.S. (2006). Feasibility of telecognitive assessment in dementia. *Assessment*, *13*(4), 385-390.

[xxxvi] Hildebrand, R., Chow, H., Williams, C., Nelson, M., & Wass, P. (2004). Feasibility of neuropsychological testing of older adults via videoconference: Implications for assessing the capacity for independent living. *Journal of Telemedicine and Telecare*, *10,* 130-134.

[xxxvii] Jacobsen, S.E., Sprenger, T., Andersson, S., & Krogstad, J. (2003). Neuropsychological assessment: A preliminary study examining the reliability of neuropsychology services performed via telecommunication. *Journal of the International Neuropsychological Society, 9*(3), 472-478.

[xxxviii] Lee, J.H., Kim, J.H., Jhoo, J.H., Lee, K.U., Kim, K.W., Lee D.Y., et al. (2000). A telemedicine system as a care modality for dementia patients in Korea. *Alzheimer Disease and Related Disorders, 14*, 94-101.

[xxxix] Loh, P.K., Donaldson, M., Flicker, L., Maher, S., Goldswain, P. (2007). Developoment of a telemedicine protocol for the diagnosis of Alzheimer's disease. Journal of Telemedicine and Telecare. 13(2):90-4.

[xl] Ball C, Puffett A. The assessment of cognitive function in the elderly using videoconferencing. J Telemed Telecare. 1998;4 Suppl 1:36-8.

[xli] Montani C, Billaud N, Couturier P, Fluchaire I, Lemaire R, Malterre C, Lauvernay N, Piquard JF, Frossard M, Franco A. Telepsychometry: a remote psychometry consultation in clinical gerontology: preliminary study. Telemed J. 1996 Summer;2(2):145-50.

[xlii] Ball C, Tyrrel J, Long C Scoring written material from the Mini-Mental State Examination: a comparison of face-to-face, fax and video-linked scoring. J Telemed Telecare. 1999;5(4):253-6

[xliii] Jacobsen SE, Sprenger T, Andersson S, Krogstad JM. Neuropsychological assessment and telemedicine: a preliminary study examining the reliability of neuropsychology services performed via telecommunication. J Int Neuropsychol Soc. 2003 Mar;9(3):472-8.

[xliv] Cain S, Spaulding R Telepsychiatry: lessons from two models of care, Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006.

[xlv] Myers K, Valentine J, Melzer SM, Morganthaler R. Telepsychiatry with incarcerated youth. J Adolesc Health 2006 38:643-648.

[xlvi] American Academy of Child and Adolescent Psychiatry. Practice parameter on the use of psychotropic medications in children and adolescents. J Am Acad Child Adolesc Psychiatry in press.

[xlvii] Shore J, Yellowlees P, Hilty DM et al 2007. Shore JH, Hilty DM, Yellowlees P. Emergency management guidelines for telepsychiatry. Gen Hosp Psychiatry. 2007 May-Jun;29(3):199-206.

[xlviii] American Academy of Child and Adolescent Psychiatry. Practice parameters for Telepsychiatry with Children and Adolescents. J Am Acad of Child Adolesc Psychology, 47:12, Dec 2008: 1468-1483.

[xlix] American Academy of Child and Adolescent Psychiatry. Practice parameters for the psychiatric assessment of children and adolescents. J Am Acad Child Adolesc Psychiatry 1997 36(10Suppl):4S-20S.

[l] American Academy of Child and Adolescent Psychiatry. Practice parameters for the psychiatric assessment of infants and toddlers (0-36 months). J Am Acad Child Adolesc Psychiatry 1997 36(10Suppl):21S-36S.

[li] Montani C, Billaud N, Couturier P, Fluchaire I, Lemaire R, Malterre C, Lauvernay N, Piquard JF, Frossard M, Franco A. Telepsychometry: a remote psychometry consultation in clinical gerontology: preliminary study. Telemed J. 1996 Summer;2(2):145-50.

[lii] Shore JH, Savin DM, Novins D, Manson SM. Cultural aspects of telepsychiatry. J Telemed Telecare. 2006;12(3):116-21.

[liii] Brennan JA, Kealy JA, Gerardi LH, Shih R, Allegra J, Sannipoli L, Lutz D. Telemedicine in the emergency department: a randomized controlled trial. J Telemed Telecare. 1999;5(1):18-22.

[liv] Tandberg White Papers. http://www.tandberg.com/vcb/white_papers.jsp Accessed 24 March 2008.

[lv] Polycom Video White Papers. http://www.polycom.com/usa/en/support/documentation/whitepapers.html Accessed 24 March 2008.

[lvi] 21st Century Video Limited. www.c21video.com/standards.html Accessed 24 March 2008.

[lvii] Harte L. Introduction to IP Video: Digitization, Compression and Transmission. USA Althos Publishing 2007.

[lviii] Wootton R, Yellowlees P, McLaren P. Telepsychiatry and e-Mental Health. Glasgow: Bell and Bain. 2003.

[lix] The Computer Technology Documentation Project. www.comptechdoc.org Accessed 24 March 2008.

[lx] Video Communications: Building Blocks for a Simpler Deployment www.polycom.com/common/documents/whitepapers/video_communication_building_blocks_for_simpler_deployment.pdf Accessed 24 March 2008.

[lxi] Verizon New Jersey. Network Considerations and Fundamentals for the Videoconferencing. www.accessnewjersey.net/anj/videoportal/vptech_faq3.asp Accessed 24 March 2008.

[lxii]

www.polycom.com/common/documents/whitepapers/video_communication_building_blocks_for_simpler_deployment.pdf Accessed 24 March 2008.

[lxiii] Video Conferencing Standards. www.tandberg.com/collateral/white_papers/whitepaper_Videoconferencing_standards.pdf Accessed 24 March 2008.

[lxiv] H.264 Videoconferencing. www.tandberg.com/collateral/white_papers/whitepaper_h264.pdf Accessed 24 March 2008.

[lxv] Tam T, Cafazzo JA, Seto E, Salenieks ME, Rossos PG. Perception of eye contact in video teleconsultation. J Telemed Telecare. 2007;13(1):35-9.

[lxvi] Milton Chen. Leveraging the asymmetric sensitivity of eye contact for videoconferencing. In: Proceedings of the SIGCHI conference on Human factors in computing systems 2002. Minneapolis, Minnesota: ACM Press: 49–56.

[lxvii] Yellowlees PM, "Your Health in the Information Age" 2008 Pub iUniverse.

[lxviii] Health Insurance Portability and Accountability Act (HIPAA). Last accessed February 26, 2007.

http://www.cms.hhs.gov/HIPAAGenInfo/.

[lxix] Health Insurance Portability and Accountability Act (HIPPA) Security Standard. Last accessed February 28, 2007. http://www.cms.hhs.gov/SecurityStandard/.

[lxx] Telemental Health in Canada: A Status Report, October 2004. accessed December 15, 2007 http://www.hc-sc.gc.ca/hcs-sss/alt_formats/iacb-dgiac/pdf/pubs/2004-tele-mental/2004-tele-mentale.pdf/.

[lxxi] Occupational Safety & Health Administration (OSHA) workstation solutions. http://www.osha.gov/SLTC/etools/computerworkstations/index.html.

[lxxii] Joint Commission and Joint Commission International. Last accessed May 7, 2007 http://www.jcrinc.com/.

[lxxiii] Joint Commission and Joint Commission International. Last accessed May 7, 2007 http://www.jcrinc.com/.

[lxxiv] Occupational Safety & Health Administration (OSHA). Last accessed May 7, 2007.) http://www.osha.gov/.

[lxxv] Health Insurance Portability and Accountability Act (HIPAA). Last accessed February 26, 2007 http://www.cms.hhs.gov/HIPAAGenInfo/.

[lxxvi] Health Insurance Portability and Accountability Act (HIPPA) Security Standard. Last accessed February 28, 2007. http://www.cms.hhs.gov/SecurityStandard/.

[lxxvii] Health Insurance Portability and Accountability Act (HIPAA). Last accessed February 26, 2007. http://www.cms.hhs.gov/HIPAAGenInfo/.

[lxxviii] Health Insurance Portability and Accountability Act (HIPPA) Security Standard. Last accessed February 28, 2007.http://www.cms.hhs.gov/SecurityStandard/.