Virginia Department of Health Professions
Board of Counseling

Agenda

Full Board Meeting
February 18, 2022
10:00 a.m.
9960 Mayland Dr
2nd Floor
Richmond, VA 23233

10:00 a.m. Call to Order– Johnston Brendel, Ed.D., LPC, LMFT, Board Chair

- Welcome and Introductions
- Establishment of Quorum
- Mission of the Board Page 3

10:05 a.m. Public Hearing

The purpose of the public hearing is to discuss the proposed regulations resulting from the periodic review of the Regulations Governing the Practice of Professional Counseling, the Regulations Governing the Practice of Marriage and Family Therapy, and the Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners.

Adoption 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.

Consideration of Summary Suspension*

Approval of Minutes

- Board Meeting – November 5, 2021* Page 4

Agency Director's Report - David E. Brown, DC, Director, Department of Health Professions (DHP)

Presentations

"Virginia Association of Community Services Boards, Mental Health Council Presents on QMHPs"- Lisa Snider, Loudoun County Departmnet of Mental Health, Substance Abuse, and Developmental Services Page 7

Chair Report – Dr. Brendel

Legislation and Regulatory Actions – Elaine Yeatts, DHP, Senior Policy Analyst

- Chart of Regulatory Actions Page 26
- General Assembly Update Page 27

Unfinished Business

- Telehealth Guidance Document Page 34
  - Standards of Practice Page 34
  - Current Telehealth Guidance Document Page 38
  - State of Teleheath in the US Report Page 40
  - Board of Medicine Telemedicine Guidance Document Page 77
  - Sample Board of Medicine Email Page 85

Staff Reports

- Executive Director's Report – Jaime Hoyle
- Discipline Report – Jennifer Lang, Deputy Executive Director, Boards of Counseling, Psychology, and Social Work Page 86
- Licensing Report – Charlotte Lenart, Deputy Executive Director of Licensing, Boards of Counseling, Psychology, and Social Work Page 88

Consideration of Recommended Decisions*

Next Meeting – May 13, 2022

Meeting Adjournment

*Indicates a Board Vote is required.
**Indicates these items will be discussed within closed session.
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 Counseling

MISSION STATEMENT

Our mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.

Virginia Department of Health Professions
Board of Counseling

DRAFT

Board of Counseling

Board Meeting Minutes

Friday, November 5, 2021 at 10:00am

9960 Mayland Drive, Henrico, VA 23233

Board Room 2

PRESIDING: Johnston Brendel, Ed.D., LPC, LMFT, Chairperson

BOARD MEMBERS PRESENT:
Angela Charlton, Ph.D., LPC
Barry Alvarez, LMFT
Bev-Freda L. Jackson, Ph.D., MA, Citizen Member
Danielle Hunt, LPC, Vice-Chairperson
Gerard Lawson, Ph.D., LPC, LSATP
Holly Tracy, LPC, LMFT
Maria Stransky, LPC, CSAC, CSOTP
Terry R. Tinsley, Ph.D., LPC, LMFT, CSOTP
Tiffinee Yancey, Ph.D., LPC
Vivian Sanchez-Jones, Citizen Member

BOARD MEMBERS ABSENT: Natalie Harris, LPC, LMFT

BOARD STAFF PRESENT:
Charlotte Lenart, Deputy Executive Director- Licensing
Jaime Hoyle, J.D., Executive Director
Jennifer Lang, Deputy Executive Director- Discipline
Jordan Mudd, Executive Assistant

DHP STAFF PRESENT:
David E. Brown, D.C., DHP Director
Barbara Allison-Bryant, M.D., DHP Chief Deputy Director
Elaine Yeatts, DHP Senior Policy Analyst

PUBLIC ATTENDEES:
Debbie Oswalt
Denise Dalykonrad VHCF
Lauren Turnman

CALL TO ORDER: Dr. Brendel called the Board of Counseling Quarterly meeting to order at 10:02 am.

ESTABLISHMENT OF A QUORUM/ROLL CALL: Dr. Brendel requested board members and staff introduce themselves. Ms. Hoyle announced that with eleven members present at roll call with one member absent, a quorum was established.

MISSION STATEMENT: Dr. Brendel read the mission statement of the Department of Health Professions, which was also the mission statement of the Board of Counseling. Dr. Brendel read the emergency egress for Board Room 2.

ADOPTIONS OF AGENDA: The agenda was adopted as presented.

PUBLIC COMMENT: No public comment was provided.

APPROVAL OF MINUTES: With no amendments to the August 20, 2021 meeting minutes, the minutes were approved as presented.

AGENCY REPORT: Dr. Brown went over our trials and tribulations with holding meetings virtually. He explained that he is unsure if virtual meetings will continue in the future. Dr. Brown

addressed the sound issues we have had in the conference center and how some of our equipment could use a refresh. He explained he is working with a contractor to get us updated and modern equipment. Dr. Brown explained how the pandemic brought work force issues to light. Dr. Allison-Bryan gave an update on Covid cases in Virginia and explained that cases are falling. She stated that Virginia ranks 10th in the nation as far as our proportion for citizens that are vaccinated. She stated the Pfizer vaccine has been approved for 5-11 year olds in Virginia. She announced that she thinks we will be back in office by the beginning of next year with a "new normal". Dr. Brown explained the definition "new normal" which will consist of teleworking from home three days a week. He says the combination of teleworking and some focus on in person work will be the new normal. Dr. Brendel asked about the changes in DHP with the recent state election. Dr. Brown stated that the issues at hand in the agency will not change and that a lot of what happens in the agency will be unaffected by the election.

PRESENTATIONS:

Virginia's Licensed Professional Counselor Workforce: 2021 - Yetty Shobo, Ph.D., Deputy Director, DHP Healthcare Workforce Data Center
Assessment of Virginia's Licensed Behavioral Health Workforce – Debbie Oswalt, Virginia Health Care Foundation
(Attached)

UNFINISHED BUSINESS:

Ms. Hoyle addressed the counseling compact as unfinished business. She updated the board that Georgia and Maryland have passed the counseling compact. She stated Virginia may be moving forward with the counseling association carrying legislation for the compact. The board discussed what they believed to be the concerning and the favorable traits of the compact. Danielle proposed a motion in support of the compact. Barry Alvarez seconded the motion. The motion passed unanimously with no one abstaining.

CHAIR REPORT:

Dr. Brendel reported that we continue to be a productive board.

LEGISLATIONAN AND REGULATORY ACTIONS:

A policy for electronic participation in meetings was presented for consideration by Ms. Elaine Yeatts.
She read the conditions that must be met should a member request to participate virtually. A motion was made by Barry Alvarez to adopt the policy as written and was seconded by Vivian Sanchez- Jones. The motion passed unanimously with none opposed.

NEW BUSINESS:

Adoption of Proposed Regulations for the Licensure of Art Therapists:
Elaine noted the support of the licensure of art therapists shown in the comments section of the Town Hall website. She reviewed the regulations as recommended to the board by the Advisory Board of Art Therapy and discussed the role of an advisory board.

Motion: Dr. Brendel made a motion to adopt proposed regulations for the licensure of art therapists with the condition of changing the word "counseling" to "art therapy" throughout the document. The motion passed unanimously with none abstaining.

STAFF REPORTS:

Ms. Jaime Hoyle stated we have a new budget director so there is not a financial report in this quarter's report as he is still settling in. Jaime introduced Ms. Mudd as her new executive assistant.
Ms. Lenart gave her licensing report stating that we are seeing a lot of applications and staff is working very hard to approve applications within the 30 day timeline. She says overall everything is okay and we are continuing to move forward.

Ms. Lang gave her disciplinary report. She stated that we are having a lot of cancellations of IFC and FH dates due to positive Covid-19 cases and exposures.

NEXT MEETING DATES: February 18, 2022

ADJOURNMENT: Dr. Brendel adjourned the board of counseling quarterly meeting at 12:21p.m.

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Johnston Brendel. Ed.D., LPC, LMFT, Board Chair

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Jaime Hoyle, J.D., Executive Director

Virginia Association Of Community Services Boards, Inc.

Making a Difference Together

VACSB's Mental Health Council Presentation to the Virginia Board of Counseling

February 18, 2022

VACSB—Who are We?

- Represents the 40 Community Service Boards (CSBs) that provide services across Virginia
- Services provided for individuals with serious mental illness, substance use disorders and/or developmental disabilities

CSBs Serve Virginia's Most Vulnerable Populations as public safety net providers.

Virginia Association Of
Community Services Boards, Inc.

Making a Difference Together

Workforce Crisis

Workforce Crisis

- 18% vacancy rate at CSBs in FY 21
- 21% Average turnover rate in CSBs during FY21

Services have been reduced and suspended based on the workforce crisis

Workforce Crisis

- 3-6 months to fill QMHP level positions at CSBs
- Less than 50% of applicants meet requirements for QMHP/QMHP-E Positions

"It is worrisome that the requirements for qualifications are so burdensome when it is already difficult to recruit and retrain staff to work with individuals with severe and persistent mental illness."

-VACSB MH Council Member

Virginia Association Of
Community Services Boards, Inc.
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Current Requirements

Current Requirements

- QMHPs recognized for work in programs licensed by DBHDS
- Requires specific human service degree; Human service credits-QMHP-A
- QMHP-E must:
  - Be supervised by Licensed Mental Health Professional (or LMHP-E)
- QMHP-E Supervisor *NOT Required to:*
  - Be a QMHP
  - Have supervisory experience
  - Complete and training

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Proposed Changes

Proposed Changes

- **Revise Supervision Requirements for QMHP-Trainees**
  - QMHP with years of experience to supervise QMHP-Es
  - QMHP who completes a Supervisory Training
- **Expand List of Accepted Human Service Degrees for QMHPs**
  - Revision of Board of Counseling Guidance document

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Why These Changes?

Why These Changes?

Reason 1. - Not Enough LMHPs

LMHPs are needed to:

- Provide diagnosis, direct therapy, assessment and evaluation
- Oversee the individual's treatment plan

Lack of LMHPs

- Rural areas only have 1-2 LMHPs on staff
- CSBs having to suspend or reduce services
- Waitlists for Services

Virginia Association Of Community Services Boards, Inc.

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"We had to decide whether to reduce a LMHP's workload to supervise QMHP-Es or reduce service capacity as we could not fill the QMHP position."

-VACSB MH Council Member

Why These Changes?

Reason 2. – LMHPs trained to be LMHPs; not QMHPs

Supervision by LMHP could inadvertently be off or misguided from what the QMHP needs for the day-to-day QMHP role

- **LMHPs often do not have QMHP experience or training**
- **LMHPs may not even be trained supervisors**
- **LMHPs serve a different role than QMHPs**

Why These Changes?

Reason 3. - Seasoned and specially trained QMHPs can provide supervision

- QMHPs have hands-on invaluable experience to share with QMHP-Es
- Seasoned QMHPs are in a better position share the practicalities of the QMHP role
  - real on-the-job training
  - understand the day-to-day work and nuances of role
  - teach role boundaries

Why These Changes?

Reason 4. - A Precedent Set with Peer Recovery Specialists

- Peer Recovery Specialist Supervisor Qualifications-
  - 2 consecutive years of experience
  - be a certified peer specialist
  - complete DBHDS supervisor training

- Used for Developing recommendations for regulation revision

Why These Changes?

Reason 5. – Provides Opportunity to Keep Experienced QMHPs

Leverage the Current Workforce

- QMHPs with experience in direct work and can help provide supervision
- Encourages staff with experience to stay in role
- Assists with recruitment

"The last thing we want is to lose QMHPs who have vast knowledge and experience who want to grow in their career but not become licensed."
- VACSB MH Council Member

Why These Changes?

Reason 6. – Increase Workforce Pool

50% of the applicants for QMHP/QMHP-E positions meet the QMHP requirements

- QMHPs are invaluable for providing Community Based Service
- Small list of approved degrees to be a QMHP
- Many applicants have qualifying experience, but degrees in other human service areas

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Community Services Boards, Inc.

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Next Steps

Next Steps

- **Revise Supervision Requirements for QMHP-Es**
  - VACSB files a petition with Board of Counseling to Revise Regulations to allow QMHP with the following to supervise QMHP-Es
    - 2 years experience
    - No founded Board of Counseling complaints
    - Completed a Supervisory Training: VACSB and DBHDS can develop training
- **Expand List of Accepted Human Service Fields for QMHPs**
  - VACSB can provide recommendations of degrees to add

Report of Regulatory Actions - Board of Counseling

Chapter		Action / Stage Information
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Periodic review [Action 5230] Proposed - *Register Date: 1/31/22* *Comment period: 1/31/22 to 4/1/22*
[18 VAC 115 - 30]	Regulations Governing the Certification of Substance Abuse Counselors	Clarification on independent practice [Action 5692] Fast-Track - *Register Date: 1/3/22* *Effective: 2/17/22*
[18 VAC 115 - 90]	Regulations Governing the Practice of Art Therapy (under development)	New chapter for licensure [Action 5656] Proposed - *AT Attorney General's Office* [Stage 9495]

Legislation in the 2022 General Assembly

Board of Counseling

*** Updates and status of bills will be given at the meeting

HB 80 Healthcare Regulatory Sandbox Program; established, report, sunset date.

Chief patron: Davis

Summary as introduced:
Healthcare Regulatory Sandbox Program; established. Requires the Department of Health to establish the Healthcare Regulatory Sandbox Program to enable a person to obtain limited access to the market in the Commonwealth to temporarily test an innovative healthcare product or service on a limited basis without otherwise being licensed or authorized to act under the laws of the Commonwealth. Under the Program, an applicant requests the waiver of certain laws, regulations, or other requirements for a 24-month testing period, with an option to request an additional six-month testing period. The bill provides application requirements, consumer protections, procedures for exiting the Program or requesting an extension, and recordkeeping and reporting requirements. The bill requires the Department to provide an annual report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health that provides information regarding each Program participant and that provides recommendations regarding the effectiveness of the Program. The bill has an expiration date of July 1, 2027.

HB 242 Professional counselors, licensed; added to list of providers who can disclose or recommend records.

Chief patron: Adams, D.M.

Summary as introduced:
Practice of licensed professional counselors. Adds licensed professional counselors to the list of eligible providers who can disclose or recommend the withholding of patient records, face a malpractice review panel, and provide recommendations on involuntary temporary detention orders.

HB 244 Regulatory Budget Program; DPB to establish a continuous Program, report.

Chief patron: Webert

Summary as introduced:
Department of Planning and Budget; Regulatory Budget Program; report. Directs the Department of Planning and Budget, under the direction of the Secretary of Finance, to establish a continuous Regulatory Budget Program with the goal of setting a target for each executive

branch agency subject to the Administrative Process Act to (i) reduce regulations and regulatory requirements, (ii) maintain the current number of regulations and regulatory requirements, or (iii) allow regulations and regulatory requirements to increase by a specific amount over a two-year period. The bill requires the Secretary of Finance to report to the Speaker of the House of Delegates and the Chairman of the Senate Committee on Rules on the status of the Program no later than October 1 of each odd-numbered year. Finally, the bill provides that the Department, in consultation with the Office of the Attorney General, shall, by October 1, 2024, issue guidance for agencies regarding the Program and how an agency can comply with the requirements of the Program.

HB 264 Public health emergency; out-of-state licenses, deemed licensure.

Chief patron: Head

Summary as introduced:
Public health emergency; out-of-state licensees; deemed licensure. Provides that when the Board of Health has entered an emergency order for the purpose of suppressing nuisances dangerous to the public health or communicable, contagious or infectious diseases or other dangers to the public life and health, a practitioner of a profession regulated by the Board of Medicine who is licensed in another state, the District of Columbia, or a United States territory or possession and who is in good standing with the applicable regulatory agency in that state, the District of Columbia, or that United States territory or possession shall not be prevented or prohibited from engaging in the practice of that profession in the Commonwealth with a patient located in the Commonwealth when (i) such practice is for the purpose of providing continuity of care through the use of telemedicine services and (ii) the patient is a current patient of the practitioner with whom the practitioner has previously established a practitioner-patient relationship.

The bill also provides that when the Board of Health has entered an emergency order for the purpose of suppressing nuisances dangerous to the public health or communicable, contagious or infectious diseases or other dangers to the public life and health, individuals licensed or certified to practice medicine, osteopathic medicine, or podiatry or as a physician assistant, respiratory therapist, advanced practice registered nurse, registered nurse, licensed practical nurse, or nurse aide by another state, the District of Columbia, or a United States territory or possession shall be deemed to be licensed or certified to practice in the Commonwealth for a period of 30 days when certain criteria are met.

HB 444 Virginia Freedom of Information Act; meetings conducted through electronic meetings.

Chief patron: Bennett-Parker

Summary as introduced:
Virginia Freedom of Information Act; meetings conducted through electronic meetings. Amends existing provisions concerning electronic meetings by keeping the provisions for electronic meetings held in response to declared states of emergency, repealing the provisions

that are specific to regional and state public bodies, and allowing public bodies to conduct all-virtual public meetings where all of the members who participate do so remotely and that the public may access through electronic communications means. Definitions, procedural requirements, and limitations for all-virtual public meetings are set forth in the bill, along with technical amendments.

HB 527 Interstate Medical Licensure Compact and Commission; created.

Chief patron: Helmer

Summary as introduced:
Interstate Medical Licensure Compact. Creates the Interstate Medical Licensure Compact to create a process for expedited issuance of a license to practice medicine in the Commonwealth for qualifying physicians to enhance the portability of medical licenses while protecting patient safety. The bill establishes requirements for coordination of information systems among member states and procedures for investigation and discipline of physicians alleged to have engaged in unprofessional conduct. The bill creates the Interstate Medical Licensure Compact Commission to administer the compact.

HB 555 Health care providers; transfer of patient records in conjunction with closure, etc.

Chief patron: Hayes

Summary as introduced:
Health care providers; transfer of patient records in conjunction with closure, sale, or relocation of practice; electronic notice permitted. Allows health care providers to notify patients either electronically or by mail prior to the transfer of patient records in conjunction with the closure, sale, or relocation of the health care provider's practice. Current law requires health care providers to provide such notice by mail.

HB 580 Covenants not to compete; health care professionals, civil penalty.

Chief patron: VanValkenburg

Summary as introduced:
Covenants not to compete; health care professionals; civil penalty. Adds health care professionals as a category of employee with whom no employer shall enter into, enforce, or threaten to enforce a covenant not to compete. The bill defines health care professional as any physician, nurse, nurse practitioner, physician's assistant, pharmacist, social worker, dietitian, physical and occupational therapist, and medical technologist authorized to provide health care services in the Commonwealth. The bill provides that any employer that violates the prohibition against covenants not to complete with an employee health care professional is subject to a civil penalty of $10,000 for each violation.

HB 864 Professions and occupations; proof of identity to obtain a license, etc.

Chief patron: Lopez

Summary as introduced:
Professions and occupations; proof of identity. Replaces the requirement for proof of citizenship to obtain a license, certificate, registration, or other authorization issued by the Commonwealth to engage in a business, trade, profession, or occupation with a requirement to provide proof of identity. The bill contains technical amendments.

HB 916 Health care providers; health records of minors, available via secure website.

Chief patron: Robinson

Summary as introduced:
Health care providers; health records of minors; available via secure website. Provides that every hospital and health care provider that makes patients' health records available to such patients through a secure website shall make all health records of a patient who is a minor available to such patient's parent through such secure website.

HB 981 Health professions, certain; licensure by endorsement.

Chief patron: Scott, P.A.

Summary as introduced:
Certain health professions; licensure by endorsement. Requires the Boards of Dentistry, Medicine, and Nursing to grant an application by endorsement to any applicant who is licensed, certified, or registered in another state, the District of Columbia, or a United States territory or possession upon submission of evidence satisfactory to such board. Currently, the Boards of Dentistry, Medicine, and Nursing are authorized but not required to grant a license, certification, or registration by endorsement for applicants wishing to practice regulated professions.

HB 1240 Counseling, Board of; licensure of professional counselors without examination.

Chief patron: Scott, P.A.

Summary as introduced:
Board of Counseling; licensure of professional counselors without examination.

HB 1359 Health care; consent to services and disclosure of records.

Chief patron: Byron

Summary as introduced:

Health care; consent to services and disclosure of records. Eliminates authority of a minor to consent to medical or health services needed in the case of outpatient care, treatment, or rehabilitation for medical illness or emotional disturbance and the disclosure of medical records

related thereto. The bill also provides that an authorization for the disclosure of health records shall remain in effect until such time as it is revoked in writing to the person in possession of the health record subject to the authorization; shall include authorization for the release of all health records of the person created by the health care entity to whom permission to release health records was granted from the date on which the authorization was executed; and shall include authorization for the person named in the authorization to assist the person who is the subject of the health record in accessing health care services, including scheduling appointments for the person who is the subject of the health record and attending appointments together with the person who is the subject of the health record. The bill also provides that every health care provider shall make health records of a patient available to any person designated by a patient in an authorization to release medical records and that a health care provider shall allow a person to make an appointment for medical services on behalf of another person, regardless of whether the other person has executed an authorization to release medical records, provided that such health care provider shall not release protected health information to the person making the appointment for medical services on behalf of another person unless such person has executed an authorization to release medical records to the person making the appointment.

SB 257 Counseling Compact; Dept. of Health Professions shall review merits entering into Compact.

Chief patron: Hashmi

Summary as introduced:
Licensure of professional counselors; Counseling Compact. Authorizes Virginia to become a signatory to the Counseling Compact. The Compact permits eligible licensed professional counselors to practice in Compact member states, provided that they are licensed in at least one member state. The bill has a delayed effective date of January 1, 2023, and directs the Board of Counseling to adopt emergency regulations to implement the provisions of the bill. The Compact takes effect when it is enacted by a tenth member state.

SB 317 Out-of-state health care practitioners; temporary authorization to practice.

Chief patron: Favola

Summary as introduced:
Out-of-state health care practitioners; temporary authorization to practice; licensure by reciprocity for physicians; emergency. Allows a health care practitioner licensed in another state or the District of Columbia who has submitted an application for licensure to the appropriate health regulatory board to temporarily practice for a period of 90 days pending licensure, provided that certain conditions are met. The bill directs the Department of Health Professions to pursue reciprocity agreements with jurisdictions that surround the Commonwealth to streamline the application process in order to facilitate the practice of medicine. The bill requires the Department of Health Professions to annually report to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions the number of out-of-state health care practitioners who have utilized the temporary

authorization to practice pending licensure and have not subsequently been issued full licensure. The bill contains an emergency clause.

EMERGENCY

SB 668 Death with Dignity Act; penalties.

Chief patron: Hashmi

Summary as introduced:

Death with Dignity Act; penalties. Allows an adult who has been determined by an attending physician and consulting physician to be suffering from a terminal condition to request medication for the purpose of ending his life in a humane and dignified manner. The bill requires that a patient's request for medication to end his life be given orally on two occasions, that such request be in writing, signed by the patient and two witnesses, and that the patient be given an express opportunity to rescind his request. The bill requires that before a patient is prescribed medication to end his life, the attending physician must (i) confirm that the patient is making an informed decision; (ii) refer the patient to a capacity reviewer if the physician is uncertain as to whether the patient is making an informed decision; (iii) refer the patient to a consulting physician for confirmation or rejection of the attending physician's diagnosis; and (iv) inform the patient that he may rescind the request at any time. The bill provides that neither a patient's request for medication to end his life in a humane and dignified manner nor his act of ingesting such medication shall have any effect upon a life, health, or accident insurance policy or an annuity contract. The bill makes it a Class 2 felony (a) to willfully and deliberately alter, forge, conceal, or destroy a patient's request, or rescission of request, for medication to end his life with the intent and effect of causing the patient's death or (b) to coerce, intimidate, or exert undue influence on a patient to request medication for the purpose of ending his life or to destroy the patient's rescission of such request with the intent and effect of causing the patient's death. Finally, the bill grants immunity from civil or criminal liability and professional disciplinary action to any person who complies with the provisions of the bill and allows health care providers to refuse to participate in the provision of medication to a patient for the purpose of ending the patient's life.

SB 676 Associate physicians; licensure and practice.

Chief patron: DeSteph

Summary as introduced:
Licensure and practice of associate physicians. Authorizes the Board of Medicine to issue a two-year license to practice as an associate physician to an applicant who is 18 years of age or older, is of good moral character, has graduated from an accredited medical school, has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination, and has not completed a medical internship or residency program. The bill requires all associate physicians to practice in accordance with a practice agreement entered into between the associate

physician and a physician licensed by the Board and provides for prescriptive authority of associate physicians in accordance with regulations of the Board.

Part V
Standards of Practice; Unprofessional Conduct; Disciplinary Actions; Reinstatement

18VAC115-20-130. Standards of practice.

A. 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. Regardless of the delivery method, whether in person, by phone, or electronically, these standards shall apply to the practice of counseling.

B. Persons licensed or registered by the board shall:

1. Practice in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare;

2. Practice only within the boundaries of their competence, based on their education, training, supervised experience, and appropriate professional experience and represent their education, training, and experience accurately to clients;

3. Stay abreast of new counseling information, concepts, applications, and practices that are necessary to providing appropriate, effective professional services;

4. Be able to justify all services rendered to clients as necessary and appropriate for diagnostic or therapeutic purposes;

5. Document the need for and steps taken to terminate a counseling relationship when it becomes clear that the client is not benefiting from the relationship. Document the assistance provided in making appropriate arrangements for the continuation of treatment for clients, when necessary, following termination of a counseling relationship;

6. Make appropriate arrangements for continuation of services, when necessary, during interruptions such as vacations, unavailability, relocation, illness, and disability;

7. Disclose to clients all experimental methods of treatment and inform clients of the risks and benefits of any such treatment. Ensure that the welfare of the clients is in no way compromised in any experimentation or research involving those clients;

8. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services;

9. Inform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed; the limitations of confidentiality; and other pertinent information when counseling is initiated and throughout the counseling process as necessary. Provide clients with accurate information regarding the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements;

10. Select tests for use with clients that are valid, reliable, and appropriate and carefully interpret the performance of individuals not represented in standardized norms;

11. Determine whether a client is receiving services from another mental health service provider, and if so, refrain from providing services to the client without having an informed consent discussion with the client and having been granted communication privileges with the other professional;

12. Use only in connection with one's practice as a mental health professional those educational and professional degrees or titles that have been earned at a college or university accredited by an accrediting agency recognized by the U.S. Department of Education, or credentials granted by a national certifying agency, and that are counseling in nature;

13. Advertise professional services fairly and accurately in a manner that is not false, misleading, or deceptive; and

14. Not engage in conversion therapy with any person younger than 18 years of age.

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C. In regard to patient records, persons licensed by the board shall:

1. Maintain written or electronic clinical records for each client to include treatment dates and identifying information to substantiate diagnosis and treatment plan, client progress, and termination;

2. Maintain client records securely, inform all employees of the requirements of confidentiality, and provide for the destruction of records that are no longer useful in a manner that ensures client confidentiality;

3. Disclose or release records to others only with the client's expressed written consent or that of the client's legally authorized representative in accordance with § 32.1-127.1:03 of the Code of Virginia;

4. Ensure confidentiality in the usage of client records and clinical materials by obtaining informed consent from the client or the client's legally authorized representative before (i) videotaping, (ii) audio recording, (iii) permitting third party observation, or (iv) using identifiable client records and clinical materials in teaching, writing, or public presentations; and

5. Maintain client records for a minimum of five years or as otherwise required by law from the date of termination of the counseling relationship with the following exceptions:

a. At minimum, records of a minor child shall be maintained for five years after attaining the age of majority (18 years) or 10 years following termination, whichever comes later;

b. Records that are required by contractual obligation or federal law to be maintained for a longer period of time; or

c. Records that have been transferred to another mental health service provider or given to the client or his legally authorized representative.

D. In regard to dual relationships, persons licensed by the board shall:

1. Avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients. Examples of such relationships include, but are not limited to, familial, social, financial, business, bartering, or close personal relationships with clients. Counselors shall take appropriate professional precautions when a dual relationship cannot be avoided, such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs;

2. Not engage in any type of romantic relationships or sexual intimacies with clients or those included in a collateral relationship with the client and not counsel persons with whom they have had a romantic relationship or sexual intimacy. Counselors shall not engage in romantic relationships or sexual intimacies with former clients within a minimum of five years after terminating the counseling relationship. Counselors who engage in such relationship or intimacy after five years following termination shall have the responsibility to examine and document thoroughly that such relations do not have an exploitive nature, based on factors such as duration of counseling, amount of time since counseling, termination circumstances, client's personal history and mental status, or adverse impact on the client. A client's consent to, initiation of, or participation in sexual behavior or involvement with a counselor does not change the nature of the conduct nor lift the regulatory prohibition;

3. Not engage in any romantic relationship or sexual intimacy or establish a counseling or psychotherapeutic relationship with a supervisee or student. Counselors shall avoid any nonsexual dual relationship with a supervisee or student in which there is a risk of exploitation or potential harm to the supervisee or student or the potential for interference with the supervisor's professional judgment; and

4. Recognize conflicts of interest and inform all parties of the nature and directions of loyalties and responsibilities involved.

E. Persons licensed by this board shall report to the board known or suspected violations of the laws and regulations governing the practice of professional counseling.

F. Persons licensed by the board shall advise their clients of their right to report to the Department of Health Professions any information of which the licensee may become aware in his professional capacity indicating that there is a reasonable probability that a person licensed or

certified as a mental health service provider, as defined in § 54.1-2400.1 of the Code of Virginia, may have engaged in unethical, fraudulent, or unprofessional conduct as defined by the pertinent licensing statutes and regulations.

Virginia Board of Counseling

Guidance on Technology-Assisted Counseling and Technology-Assisted Supervision

The Board's regulations for Standards of Practice (18VAC115-20-130) are prefaced by the following:

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. Regardless of the delivery method, whether in person, by phone or electronically, these standards shall apply to the practice of counseling.

Therefore, the standards of practice set forth in section 130 of the regulations and in the Code of Virginia apply regardless of the method of delivery. The Board of Counseling recommends the following when a licensee uses technology-assisted counseling as the delivery method:

1. Counseling is most commonly offered in a face-to-face relationship. Counseling that from the outset is delivered in a technology-assisted manner may be problematic in that the counseling relationship, client identity and other issues may be compromised.

2. The counselor must take steps to protect client confidentiality and security.

3. The counselor should seek training or otherwise demonstrate expertise in the use of technology-assisted devices, especially in the matter of protecting confidentiality and security.

4. When working with a client who is not in Virginia, counselors 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 counseling by an individual who is unlicensed by that state.

5. Counselors must follow the same code of ethics for technology-assisted counseling as they do in a traditional counseling setting.

Guidance for Technology-assisted Supervision

The Board of Counseling recommends the following in the use of technology-assisted supervision:

1. Supervision is most commonly offered in a face-to-face relationship. Supervision that from the outset is delivered in a technology-assisted manner may be problematic in that the supervisory relationship, client identity and other issues may be compromised. Face-to-face means the in-person delivery of clinical services. For the purposes of meeting the 2,000 hours of face-to-face client contact, in-person may include the use of secured technology that maintains client

confidentiality and provides real-time, visual contact between the resident and the client. Telephonic services may be used toward ancillary counseling service hours.

2. The supervisor must take steps to protect resident confidentiality and security.

3. The supervisor should seek training or otherwise demonstrate expertise in the use of technology-assisted devices, especially in the matter of protecting resident confidentiality and security.

4. Supervisors must follow the same code of ethics for technology assisted supervision as they do in a traditional counseling/supervision setting. Licensed residents in counseling, marriage and family therapy and substance abuse treatment are allowed to provide tele-assisted counseling to clients in Virginia. The resident must adhere to standards of practice, ensure confidentiality, and seek training as needed to be competent in the services they provide.

5. The Board of Counseling governs the practice of counseling in Virginia. Counselors who are working with a client who is not in Virginia are advised to check the regulations of the state board in which a supervisee/resident is located. It is important to be mindful that certain states may regulate or prohibit supervision by an individual who is unlicensed by that state.

State of Telehealth in the U.S.

Presented by

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to the

Virginia Board of Counseling

Regulatory Committee – May 14, 2021

Full Board – May 21, 2021

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Executive Summary

At the request of the Virginia Board of Counseling, a review of national telemental health guidelines, ethical standards, legal regulations, and best practices for the purpose of developing recommendations for a revised practice guidance document for licensees under the Board of Counseling was conducted. A brief history of telehealth, definitions, the methods of review, a summary of the findings, and recommendations to the Board of Counseling have been provided in this report. Fourteen key standards of telehealth were identified through this comprehensive review and recommendations for each are provided. The key standards are

1. Appropriate Intake and Screening
2. Informed consent
3. Disclosures
4. Counseling Relationship/Boundaries
5. Client Verification
6. Confidentiality
7. Standards of Care
8. Scope of Practice
9. Documentation
10. Virtual Presence
11. Training and Competence
12. Current Technology
13. Professionalism
14. Multiculturalism

State of Telehealth in the U.S.

History

While an emerging modality in mental health, technology has been used for medical services for at least a couple of centuries. In 1879, the *Lancet* published an article about the impact telephones could have on improving medical access (Aronson, 1977). During the mid-1950s, Drs. Cecil Wittson and Reba Benschoter at the University of Nebraska pioneered several telemedicine innovations, including two-way closed-circuit television systems (Schleicher, 2015). In the 1950s, Dr. Carl Rogers began his pioneering work with using telephone and television technologies to counsel clients and train and supervise counselors-in-training. In fact, he has been referred to as the Father of Telebehavioral Health or Telepsychiatry (Stretch, 2020). The American Telemedicine Association formed in 1993, and California had the first telemedicine law in 1996 (Stretch, 2021). Two federal agencies are leaders in the utilization of telehealth. The National Aeronautics and Space Administration (NASA, 2020) began using telehealth in the 1950s and a project with Russia resulted in the first recorded medical use of the Internet. The Veterans Administration (2020) implemented telehealth in the 1960s and has consistently been on the forefront of telehealth development.

With the development of the Internet in the 1990s, telehealth exploded, and regulatory boards began to realize the need for regulations to protect the public. However, progress was slow to keep up with the demand for telehealth and the changes in technology. Everything changed with the onset of the COVID-19 public health emergency in March 2020. In July 2020, Health and Human Services noted that less than one percent (0.1%) of primary care visits in February 2020 were via telehealth as compared to over forty percent (43.5%) in April 2020. The

COVID-19 public health emergency has expedited the acceptance and utilization of telehealth by lawmakers, health professionals, and clients (HHS, 2020), as well as the need for clear and consistent regulations to protect the public.

Resource: https://www.genpsych.com/post/an-illustrated-history-of-telemedicine-from-1879-to-the-future

Definitions

In an initial review of current telehealth and telemedicine laws and regulations in the U.S., thirty-eight different definitions of telehealth emerged. In addition, the jurisdictions utilized eight different terms, including telehealth services, telehealth, teletherapy, technology-assisted counseling, telemedicine, distance counseling, distance professional services, and telepractice. The most common terms were "telehealth" and "telemedicine," with telehealth referring to behavioral or non-medical services and telemedicine referring to medical services. For the purpose of this review, telehealth services "means the use of telecommunications and information technology to provide access to health assessments, diagnosis, intervention, consultation, supervision, and information across distance. 'Telehealth services' includes the use of such technologies as telephones, facsimile machines, electronic mail systems, store-and-forward technologies, and remote patient monitoring devices that are used to collect and transmit patient data for monitoring and interpretation" (Virginia's Legislative Information System, 2020).

Method

This review focused on four primary sources of telehealth policy: codes of ethics, regulatory board guidance documents, regulations, and laws. The review had five phases. The first phase consisted of a comprehensive review of seven behavioral health codes of ethics and two sets of telehealth guidelines from professional associations, including the following:

- American Association for Marriage and Family Therapy (AAMFT, 2015)
- American Counseling Association (2014)
- American Mental Health Counselors Association (AMHCA, 2020)
- American Psychological Association (2013, 2017)
- Association of Social Work Boards (2014)
- NAADAC and NCC AP (2016)
- National Association of Social Workers (2017)
- National Board for Certified Counselors (2012)

Fourteen course standards (see Table 1) emerged from the ethical review and will be the core areas addressed in the results. Appendix A - Key Standards by Ethical Code/Professional Telehealth Guidelines cross references the ethical codes and professional telehealth guidelines with the key standards listed in Table 1.

Table 1 – Key Practice Standards of Telehealth

1. Appropriate Intake and Screening	2. Scope of Practice
3. Informed Consent	4. Documentation
5. Disclosures	6. Virtual Presence
7. Counseling Relationship/Boundaries	8. Training and Competence
9. Client Verification	10. Current Technology
11. Confidentiality	12. Professionalism
13. Standards of Care	14. Multiculturalism

The second phase assessed fifteen (15) regulatory board guidelines, thirty-four (36) administrative codes, thirty-three (35) legal statutes, and two (2) executive orders from all fifty states and the District of Columbia. Appendix B – Key Standards by State provides a snapshot of the state of telemental health law across the U.S. The third phase reviewed the websites of the regulatory boards with responsibility for oversight of professional counseling for any information related to telehealth. The fourth phase examined four telehealth related databases: Aleldade (2020), the Center for Connected Health Policy (2021), Telehealth Certification Institute (2021), and Epstein Becker Green (2020). The final step of the review was a search of Google Scholar, ERIC, and PubMed for telehealth articles from 2017 to current day utilizing the following keywords: telehealth, history of telehealth, telehealth + law, telehealth + legal, and technolog* + counsel*. The goal of the article search was to identify any additional regulatory guidance or mention of other professional standards related to telehealth. Since

federal laws are already applicable to providers licensed in the Commonwealth, these were excluded from this review.

Results

Appropriate Intake and Screening

The ethical codes and professional standards, as well as legal content from sixteen states, highlighted the importance of appropriate intake and screening. Most notably, all professional associations noted the importance of service providers assessing the appropriateness of telehealth for the client based on the client's intellectual, emotional, physical, and linguistic ability to fully utilize the technologies. AMHCA (2020), APA (2013), and ASWB (2015) also required or encouraged an in-person meeting for the initial assessment of fit.

Informed Consent

Thirty-five states require informed consent at the commencement of therapy and/or for the disclosure of client identifying information. Informed consent is the client's acknowledgement of disclosures shared by the counselor and their agreement to engage in a therapeutic relationship via telehealth. Informed consent should be obtained upon the initial contact with the client once the provider has ascertained that the client can provide consent. Each of the ethical codes and professional standards agree that informed consent should be obtained from the client after the client has received the required disclosures regarding telehealth, which will be covered in the next section, and that informed consent is an ongoing process throughout the therapeutic relationship.

Disclosures

Twenty-eight states require disclosures specific to telehealth. Similarly, the ethical codes and professional standards identify specific information that providers should disclose so that clients can provide informed consent. These disclosures are specific to telehealth considerations and are in addition to the general disclosures expected in an in-person therapeutic relationship.

- Provider's credentials for both counseling and telehealth, location, and contact information;
- Types of services available;
- Risks, limitations, and benefits of telehealth modality;
- Technology requirements and recommendations (equipment, network, security, etc.);
- Alternate means of communication should technology fail;
- Who else may have access to communications and session content;
- Anticipated response time and preferred mode of communication;
- Limits of and threats to confidentiality;
- Documentation requirements, including retention and destruction;
- Emergency resources local to client and emergency protocol;
- Social media and relationship policy;
- Potential insurance coverage of telehealth sessions (as applicable);
- Time zone differences;
- Verification process for provider and client;
- Prohibition of recording and distributing session content without mutual consent;

- Cultural and linguistic considerations; and
- Licensure portability across state lines and scope of practice requirements.

Counseling Relationship/Boundaries

Several aspects of the counseling relationship are unique to telehealth. The client and the provider may have greater access to each other's personal worlds while engaging in telehealth and the boundaries between personal and professional can become blurred in the virtual world. Seven states provide guidance on counseling relationship specific to telehealth. As such, providers should establish clear boundaries in relation to availability, response time, and the nature of the counseling relationship (ACA, 2014; NAADAC, 2016). Providers should address communication challenges in telehealth to reduce the opportunities for misunderstanding (ACA, 2014; ASWB, 2015). Providers should not seek testimonial endorsements from current or past clients (APA, 2017; NASW, 2017).

Client Verification

Six of the ethical codes (ACA, 2014; APA, 2013; ASWB, 2015; NASW, 2017; NBCC, 2012; NAADAC, 2016) stressed the importance of verifying a client's identity while engaging in telehealth. Likewise, nineteen states now have requirements related to client verification. Providers should have a written verification policy and procedure in place to ensure all communications are with the client. In addition, the ASWB (2015) noted the importance of verifying the location of the client when engaging in telehealth to verify jurisdiction and in case emergency services are necessary.

Confidentiality

All the ethical codes and professional standards address confidentiality of communication and documentation. About half the states (n=25) have requirements specific to the confidentiality in telehealth. The professional associations note the importance of utilizing technology that adhere to the best practices of security particularly in relation to encryption. In general, providers should take reasonable efforts to protect client information. When a breach occurs, the provider should disclose the nature of the breach and be responsive to rectifying the security issues that resulted in the breach (AMHCA, 2020; ASWB, 2015; NASW, 2017; NAADAC, 2016).

Standards of Care

Twenty-three states require providers utilize current standards of care that are appropriate for the client's treatment while using telehealth. Three professional associations address standards of care for telehealth in their ethical codes (AAMFT, 2015; AMCHA, 2020; APA, 2013). Providers should utilize an evidence-informed approach to telehealth and stay current with best practices for providing mental health services via telehealth. Standards of care also include providing referral for follow-up care and knowing the local crisis/emergency resources local to each client (AMHCA, 2020; APA, 2013).

Scope of Practice

Scope of practice is an area with significant variety across the country. Forty-seven states and the District of Columbia specify licensing requirements for proving telehealth within the boundaries of each state. While some ethical codes, such as AAMFT (2015), simply direct the provider to follow applicable laws, other ethical codes provide more specific guidance.

There are currently four possible ways for determining if a counselor is eligible from a jurisdictional perspective to provide services to a client:

1. Is the counselor licensed where the client is located (AMHCA, 2020; ASWB, 2015)?
2. Is the counselor licensed in both the counselor's location and the client's place of residence (ACA, 2014)?
3. Is the counselor licensed where the client resides (APA, 2013)?
4. Is the counselor licensed in both the counselor's location and where the client is located (NASW, 2017; NBCC, 2012; NAADAC, 2016)?

Documentation

Thirty states require some form of documentation related to telehealth. The professional associations agree that the provider should document informed consent in response to the required disclosures. Several ethical codes indicate any communication with a client should be maintained within the client's electronic record. APA (2013) also indicates that the technology used with the client should be documented, and ASWB (2015) requires providers inform clients of their right to examine their records.

Virtual Presence

Most ethical codes indicate that providers need to develop and disclose a social media policy, in relation to online reviews, friend or linking requests, communicating with clients, etc. Providers who have a virtual presence on social media or who maintain a website should provide links to certification and licensure boards to assist clients in verifying credentials and filing complaints (ACA, 2014; NAADAC, 2016). In addition, providers should clearly distinguish between personal and professional virtual presence (ACA, 2014; AMHCA, 2020; APA, 2013;

ASWB, 2015; NASW, 2017). Providers should also avoid searching client's virtual presence unless given consent by the client or in the case of an emergency (ACA, 2014; AMHCA, 2020; ASWB, 2015; NASW, 2017). Surprisingly, only four states currently have specific guidance for virtual presence, but most states use either the ACA (2014) or NBCC (2012) codes, both of which have guidance related to virtual presence.

Training and Competence

Telehealth is a constantly emerging modality for mental health services. As such, providers of telehealth must actively engage in ongoing training to achieve and maintain competence. Each of the ethical codes and professional standards stress the importance of specialized competence for engaging in telehealth. Several of the ethical codes note providers should acquire enough training prior to engaging in telehealth (AAMFT, 2015; AMHCA, 2020; APA, 2017; NASW, 2017; NBCC, 2012). There is no specific ethical guidance on what constitutes sufficient training. Currently, only a few states have specific training requirements, and only five states specify the amount of training: Louisiana (3 hours), Alaska (4 hours), Georgia (6 hours), Alabama (15 hours), and Kentucky (15 hours).

Current Technology

As rapidly as telehealth technologies change, it is not surprising that thirty-three states require providers utilize current technology capable of meeting privacy law standards. Four of the ethical codes noted that providers should stay current with technology and ensure that the technologies utilized comply with applicable privacy laws (AAMFT, 2015; AMHCA, 2020; NBCC, 2012; NAADAC, 2016). Providers need to utilize consistent, reliable, and secure technologies to provide quality care to clients (AAMFT, 2015; AMHCA, 2020; NAADAC, 2016).

Professionalism

Only five states provide specific guidance regarding professionalism; however, many of the other states have codified the ACA (2014) Code of Ethics, which includes clear expectations of professional behavior. AMHCA (2020) notes that providers should utilize an ethical decision-making model to ensure continuity of care. APA (2017) and ASWB (2015) caution providers to be intentional and accurate in public communications in any form. ASWB (2015) and NASW (2017) stress the importance of professional communication with clients and peers as well as efforts to correct or stop inaccurate information or unethical behavior via technology.

Multiculturalism

Five states include multicultural considerations, including disability, that providers should consider while engaging in telehealth. ACA (2014), AMHCA (2020), ASWB (2015), and NASW (2107) address the importance of providing culturally appropriate services when engaging in telehealth. Ultimately, providers need to assess the implications of disability, language, emotional well-being, cultural, environmental, and age when proving mental health services via telehealth.

Recommendations

The Virginia Board of Counseling, to be referred to as the "Board," regulates "the practice of counseling, substance abuse treatment, and marriage and family therapy" (Virginia Legislature, 2010, § 54.1-3503). The 2010 Code of Virginia establishes the Board and the scope of the Board's work. In the statute, the Board should "stay abreast of community and professional needs" and "ensure that licensees conduct their practices in a competent manner and in conformance with the relevant regulations" (Virginia Legislature, 2010, § 54.1-3503).

This review of telehealth service law, regulation, and guidance demonstrates that specialized training and standards of practice need to be in place for the Board to fulfill its regulatory duty to protect the "best interest of the public" (Virginia Board of Counseling, 2019, 18VAC115-20-130).

The Board has established regulations, which "regardless of the delivery method, whether in person, by phone or electronically…apply to the practice of counseling" (Virginia Board of Counseling, 2019, 18VAC115-20-130). Currently, the Standards of Practice (Virginia Board of Counseling, 2019, 18VAC115-20-130) regulate seven of the fourteen key standards of telehealth at least in part. The regulations are enforceable and there are consequences for failing to uphold the Standards of Practice. The current *Guidance on Technology-Assisted Counseling and Technology-Assisted Supervision* (Virginia Board of Counseling, 2020), however, is simply guidance and does not have the force and effect of law as regulations do. The Board's guidance document, while helpful to counselors and supervisors, only provides insight into the Board's policy and approach regarding four key standards of telehealth addressed in the guidance document. Therefore, additional regulations would strengthen the Board's ability to regulate counseling and protect the public. The proposed additional regulations are

1. Intake and Appropriate Assessment. Persons licensed by this board will assess clients to determine the client's readiness to engage intellectually, emotionally, physically, linguistically, and functionally with technology for the purpose of telehealth services and will verify that each client understands the purpose, risks, and operation of any technology to be used in the delivery of telehealth services.

2. Disclosures. Persons licensed by this board will inform the clients about the use of telehealth, verbally and in writing, to include
    a. Provider's credentials, location, and contact information;
    b. Types of services available;
    c. Risks, limitations, and benefits of telehealth modality;
    d. Technology requirements and recommendations (equipment, network, security, etc.);
    e. Alternate means of communication should technology fail;
    f. Who else may have access to communications and session content;
    g. Anticipated response time and preferred mode of communication;
    h. Limits of and threats to confidentiality;
    i. Documentation requirements, including retention and destruction;
    j. Emergency resources local to client and emergency protocol;
    k. Social media and relationship policy;
    l. Potential insurance coverage of telehealth sessions (as applicable);
    m. Time zone differences;
    n. Verification process for provider and client;
    o. Prohibition of recording and distributing session content without mutual consent;
    p. Cultural and linguistic considerations; and
    q. Licensure portability across state lines and scope of practice requirements.

3. Informed consent. Persons licensed by this board will obtain oral or written informed consent from clients in a language understandable to the client at the onset of telehealth services and will explain that the client may end telehealth services at any time and request in-person counseling services or a referral for in-person counseling services. Informed consent is understood to be an ongoing process. Informed consent will be documented in the client's record. If the client is a minor, consent will be obtained from the minor's legal guardian, and where appropriate, assent will be obtained from the minor.
4. Counseling Relationship and Boundaries. Persons licensed by this board will explain and establish professional boundaries with each client regarding the appropriate use and limitations of technology within the counseling relationship.
5. Client Verification: Persons licensed by this board will verify the client's identity through a government issued identification and will have verification procedures through passwords or identification throughout the delivery of telehealth services. Persons licensed by this board will verify the client's location each time telehealth services are provided and will seek and disclose an alternate means of communication with the client in case of technical failure or emergency.
6. Standards of Care. Persons licensed by this board will maintain an emergency plan with the client to include contact information of emergency services local to the client's location.
7. Confidentiality. Persons licensed by this board will abide by current privacy laws and regulations related to health care information and the client's right to access their

records. Persons licensed by this board will utilize best practices of telehealth services to ensure client confidentiality and the security of all transmissions of protected health information.

8. Standards of Care. Persons licensed by this board will use standards of care specific to telehealth services that are appropriate to a client's developmental level, intellectual and linguistic abilities, mental and physical needs, and treatment goals. The standards of care must at a minimum be consistent with the standards of care for in-person counseling services.
9. Scope of Practice. Persons providing telehealth services to clients located in the Virginia must be licensed in the Commonwealth of Virginia. Persons licensed by this board serving clients outside Virginia should verify the regulations of the state board who has jurisdiction where the client is located.
10. Documentation. Persons licensed by this board will create and maintain a record for each client that documents informed consent, disclosures provided, an emergency plan with contacts local to the client, client verification, session notes, treatment plan, assessment results, communications with the client, and termination. Records will be stored in accordance with state and federal retention regulations and best practices. Clients must know how to access their clinical records.
11. Virtual Presence. Persons licensed by this board who maintain a virtual presence will clearly distinguish between personal and professional presence and maintain a social media policy. Persons licensed by this board who maintain a website will provide working electronic links to relevant certification and licensure boards to ensure clients

can verify credentials and protect their rights. Persons licensed by this board will not use electronic search engines or social media to gather information about clients without the client's signed, written consent. Clients must have full disclosure of how the information gathered will be used before giving consent.

12. Current Technology. When providing telehealth services, persons licensed by this board may use two-way interactive audio, visual, or audio-visual technologies that utilize current encryption standards. Persons licensed by this board should provide consistent, secure access to technologies to provide continuity of care.
13. Training and Competence: Persons licensed by this board will limit their telehealth services to their areas of competence achieved through education, training, and supervision. At a minimum, persons licensed by this board will document six (6) hours of training specific to telehealth services before commencing telehealth services and two (2) hours minimum of continuing education with each licensure renewal to maintain current competency.
14. Multiculturalism. Persons licensed by this board will account for cultural, linguistic, and accessibility considerations that may impact the effectiveness and quality of telehealth services.

Table 2 – Key Standards Currently Addressed

State	Appropriate Intake and Screen	Informed Consent	Disclosures	Counseling Relationship/ Boundaries	Client Verification	Confidentiality	Standards of Care	Scope of Practice	Documentation	Virtual Presence	Training and Competence	Current Technology	Professionalism	Multiculturalism
Virginia		X	X		X	X	X	X	X		X	X	X	X
18VAC115-20-130. Standards of practice.		C.4.	B.7., B.9			C.4.	B.3., B.4., B.6., B.10.		B.5., C.1., C.2., C.5.a.-c.		B.2., B.12		B.8., B.11., B.13., D.1. – 4., F.	
Guidelines on Technology-Assisted Counseling (C) and Technology-Assisted Supervision (S)						C-2, 3		C-4			C-3		C-5	

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Appendix A

Key Standards by Ethical Code/Professional Telehealth Guidelines

	Appropriate Intake and Screen	Informed Consent	Disclosures	Counseling Relationship/ Boundaries	Client Verification	Confidentiality	Standards of Care	Scope of Practice	Documentation	Virtual Presence	Training and Competence	Current Technology	Professionalism	Multiculturalism
American Association for Marriage and Family Therapy (AAMFT, 2015)	X	X	X	X		X	X	X	X		X	X		X
American Counseling Association (ACA, 2014)	X	X	X	X	X	X	X	X	X	X	X			X
American Mental Health Counselors Association (AMHCA, 2015)	X	X	X			X	X	X	X	X	X	X	X	X
American Psychological Association (APA, 2013)	X	X	X	X		X	X	X	X	X	X			
American Psychological Association (APA, 2017)	X	X	X	X		X	X	X	X	X	X		X	X
Association of Social Work Boards (ASWB, 2014)	X	X	X	X	X	X		X	X	X	X		X	X
NAADAC and NCC AP (NAADAC, 2016)	X	X	X	X	X	X		X	X	X	X	X		
National Association of Social Workers (NASW, 2017)	X	X	X	X	X	X		X	X	X	X	X	X	X
National Board for Certified Counselors (NBCC, 2012)	X	X	X	X	X	X		X	X	X	X	X		

Appendix B

Key Standards by State

State	Appropriate Intake and Screen	Informed Consent	Disclosures	Counseling Relationship/ Boundaries	Client Verification	Confidentiality	Standards of Care	Scope of Practice	Documentation	Virtual Presence	Training and Competence	Current Technology	Professionalism	Multiculturalism
Alabama		X	X	X				X				X		
Alaska						X		X						
Arizona		X	X		X	X		X	X			X		
Arkansas	X	X	X	X		X	X	x	X			X		
California	X	X	X		X	X		X	X			X		
Colorado	X	X	X		X			X				X		
Connecticut		X	X				X	X	X			X		
Delaware		X	X		X	X	X	X	X	X	X	X		
DC								X						
Florida	X	X				X	X	X	X			X		
Georgia		X	X					X			X	X		
Hawaii						X		X	X					
Idaho	X	X	X		X	X	X	X	X		X	X		
Illinois							X	X				X		
Indiana		X	X	X	X		X	X	X					
Iowa		X	X			X		X				X		
Kansas		X		X			X	X	X			X		
Kentucky	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Louisiana	X	X	X	X	X	X	X	X	X	X	X	X		X
Maine			X			X		X	X					
Maryland	X	X	X		X	X	X	X	X			X		
Massachusetts		X	X		X	X	X	X	X		X		X	

State	Appropriate Intake and Screen	Informed Consent	Disclosures	Counseling Relationship/ Boundaries	Client Verification	Confidentiality	Standards of Care	Scope of Practice	Documentation	Virtual Presence	Training and Competence	Current Technology	Professionalism	Multiculturalism
Michigan		X						X				X		
Minnesota														
Mississippi								X			X	X		
Missouri		X		X		X		X	X			X		
Montana	X						X							
Nebraska		X	X					X	X					
Nevada								X				X		
New Jersey		X	X		X		X	X	X			X		
New Mexico								X	X					
New York		X						X				X		
North Carolina	X	X	X		X	X	X	X	X		X	X	X	
North Dakota								X						
Ohio	X	X	X		X	X	X	X	X	X	X	X		X
Oklahoma						X		X				X		
Oregon	X	X	X					X	X					X
Pennsylvania		X	X		X		X	X	X			X		
Rhode Island		X	X			X			X					
South Carolina		X			X		X	X	X			X		
South Dakota		X	X		X		X	X	X		X			
Tennessee	X		X		X	X		X	X			X		
Texas	X	X						X	X					
Utah	X	X					X	X				X		
Vermont		X					X	X	X			X		
Virginia		X	X		X	X	X	X	X		X	X	X	X
Washington						X		X						

State	Appropriate Intake and Screen	Informed Consent	Disclosures	Counseling Relationship/ Boundaries	Client Verification	Confidentiality	Standards of Care	Scope of Practice	Documentation	Virtual Presence	Training and Competence	Current Technology	Professionalism	Multiculturalism
West Virginia	X	X	X		X	X	X	X			X	X		
Wisconsin		X				X		X						
Wyoming						X		X					X	

Virginia Board of Medicine

Telemedicine
NOTE: DOES NOT REFLECT RECENT FEDERAL GUIDANCE ON HIPAA COMPLIANCE
(*See link on BOM website for current federal guidance*)

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For the purpose of prescribing controlled substances, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303. A practitioner should conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;

- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;
- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present,[1] a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.[2] While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

Section Three: Guidelines for the Appropriate Use of Telemedicine Services.
The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

[1] This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.
[2] The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

Evaluation and Treatment of the Patient:

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and

procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Section Four: Prescribing.

Prescribing controlled substances requires the establishment of a bona fide practitioner-patient relationship in accordance with § 54.1-3303 (A) of the Code of Virginia. Prescribing controlled substances, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe controlled substances as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A). Prescribing controlled substances in Schedule II through V via telemedicine also requires compliance with federal rules for the practice of telemedicine. Practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

For the purpose of prescribing Schedule VI controlled substances, "telemedicine services" is defined as it is in § 38.2-3418.16 of the Code of Virginia. Under that definition, *"telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire*.

Section Five: Electronic Medical Services That Do Not Require Licensure.

The Code of Virginia has two sections of law that are pertinent to telemedicine and the requirement of a Virginia license to provide services to a patient residing in the Commonwealth.

The first is the "consultant exemption" found in § 54.1-2901 which lists Exceptions and Exemptions Generally to licensure. Subsection (A)(15) reads as follows: "*Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed practitioners in this Commonwealth*." This statute is intended to have a Virginia practitioner involved in the care of the patient when a practitioner in another state/country consults with the

Virginia practitioner or the patient. It provides an opportunity for Virginia residents to benefit from the expertise of practitioners known for specializing in certain conditions. There must be regular communication between the consultant and the Virginia practitioner while the consultation/care is being provided.

The second section of the Code of Virginia pertinent to telemedicine is § 38.2-3418.16 of the Code of Virginia, which provides the definition of telemedicine in the Insurance Title. The section enumerates what does and what does not constitute telemedicine. Section 38.2-3418.16 defines telemedicine as "*the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided*." To practice telemedicine into Virginia requires a license from the Board of Medicine. The Board notes that § 38.2-3418.16 states "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. The Board believes that these communications do not constitute telemedicine, and therefore do not require licensure, when used in the follow-up care of a Virginia resident with whom a bona fide practitioner-patient relationship has been previously established. The establishment of a new practitioner-patient relationship requires a Virginia license and must comport with the requirements for telemedicine found in § 54.1-3303 of the Code of Virginia.

Section six: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Statutory references:

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed certified midwife pursuant to § 54.1-2957.04, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32.

B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship or veterinarian-client-patient relationship. If a practitioner is providing expedited partner therapy consistent with the recommendations of the Centers for Disease Control and Prevention, then a bona fide practitioner-patient relationship shall not be required.

A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; and (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient via telemedicine if such prescribing is in compliance with federal requirements for the practice of telemedicine and, in the case of the prescribing of a Schedule II through V controlled substance, the prescriber maintains a practice at a physical location in the Commonwealth or is able to make appropriate referral of patients to a licensed practitioner located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care.

A prescriber may establish a bona fide practitioner-patient relationship for the purpose of prescribing Schedule II through VI controlled substances by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and federal laws and regulations; (h) the establishment of a bona fide practitioner-patient relationship via telemedicine is consistent with the standard of care, and the standard of care does not require an in-person examination for the purpose of diagnosis; and (i) the establishment of a bona fide practitioner patient relationship via telemedicine is consistent with federal law and regulations and any waiver thereof. Nothing in this paragraph shall apply to (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients….

C. A prescription shall only be issued for a medicinal or therapeutic purpose in the usual course of treatment or for authorized research. A prescription not issued in the usual course of treatment or for authorized research is not a valid prescription. A practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than for medicinal or therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

§ 54.1-3408.01. Requirements for prescriptions.

A. The written prescription referred to in § 54.1-3408 shall be written with ink or individually typed or printed. The prescription shall contain the name, address, and telephone number of the prescriber. A prescription for a controlled substance other than one controlled in Schedule VI shall also contain the federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, electronically printed, typewritten, rubber stamped, or printed by hand.

The written prescription shall contain the first and last name of the patient for whom the drug is prescribed. The address of the patient shall either be placed upon the written prescription by the prescriber or his agent, or by the dispenser of the prescription. If not otherwise prohibited by law, the dispenser may record the address of the patient in an electronic prescription dispensing record for that patient in lieu of recording it on the prescription. Each written prescription shall be dated as of, and signed by the prescriber on, the day when issued. The prescription may be prepared by an agent for the prescriber's signature.

This section shall not prohibit a prescriber from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

No written prescription order form shall include more than one prescription. However, this provision shall not apply (i) to prescriptions written as chart orders for patients in hospitals and long-term-care facilities, patients receiving home infusion services or hospice patients, or (ii) to a prescription ordered through a pharmacy operated by or for the Department of Corrections or the Department of Juvenile Justice, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Behavioral Health and Developmental Services; or (iii) to prescriptions written for patients residing in adult and juvenile detention centers, local or regional jails, or work release centers operated by the Department of Corrections.

B. Prescribers' orders, whether written as chart orders or prescriptions, for Schedules II, III, IV, and V controlled drugs to be administered to (i) patients or residents of long-term care facilities served by a Virginia pharmacy from a remote location or (ii) patients receiving parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion therapy and served by a home infusion pharmacy from a remote location, may be transmitted to that remote pharmacy by an electronic communications device over telephone lines which send the exact image to the receiver in hard copy form, and such facsimile copy shall be treated as a valid original prescription order. If the order is for a radiopharmaceutical, a physician authorized by state or federal law to possess and administer medical radioactive materials may authorize a nuclear medicine technologist to transmit a prescriber's verbal or written orders for radiopharmaceuticals.

C. The oral prescription referred to in § 54.1-3408 shall be transmitted to the pharmacy of the patient's choice by the prescriber or his authorized agent. For the purposes of this section, an authorized agent of

the prescriber shall be an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber.

Virginia Department of Health Professions

Virginia Board of Medicine

Dear Colleague:

You should have recently received edition #93 of the Board Briefs. I hope you took a look at it, particularly the first item on mental health treatment. This item was prompted by a fellow physician who was concerned that healthcare professionals, and not just physicians, were reluctant to seek mental health treatment for a variety of reasons. One of those reasons is concern about how the Board of Medicine views mental health treatment. At its October 14th meeting, the Board thought the attached one-pager should be sent as a stand-alone in hopes of allaying concerns about seeking mental health treatment.

The Board would like to have this information spread as far and wide as possible. If you are the Dean of a medical or nursing school, please make it available to your students. If you are a residency program director, please make it available to your residents. If you are the director of a training program, be it respiratory therapy, occupational therapy, athletic training or one of the other many professions the Board licenses, please make it available to your students. If you are an officer in your local or state professional society, please see that your membership gets it. And if you have colleagues that may not have read it, please mention "The Board's Perspective on Mental Health Treatment," so we can all be on the same page.

Thanks and kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine

Virginia Department of
Health Professions
Board of Counseling

Discipline Reports

10/21/2021 - 02/02/2022

NEW CASES RECEIVED IN BOARD 10/21/2021 - 02/02/2022				
	Counseling	**Psychology**	**Social Work**	**BSU Total**
Cases **Received** for Board review	99	27	24	***150***

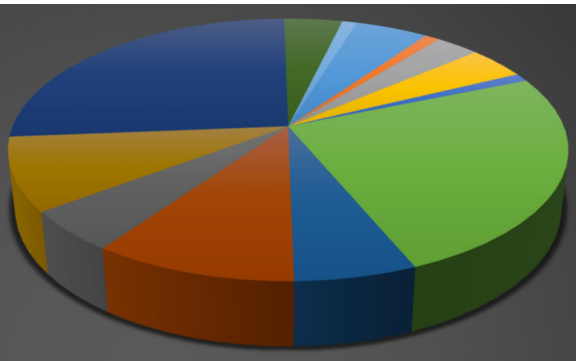
OPEN CASES (as of 02/02/2022)				
Open Case Stage	**Counseling**	**Psychology**	**Social Work**	**BSU Total**
Probable Cause Review	45	108	20	
Scheduled for Informal Conferences	27	0	17	
Scheduled for Formal Hearings	4	1	0	
Other (pending CCA, PHCO, hold, etc.)	23	11	10	
Cases with APD for processing (IFC, FH, Consent Order)	9	5	0	
TOTAL CASES AT BOARD LEVEL	**108**	**125**	**47**	***280***
OPEN INVESTIGATIONS	**101**	**34**	**21**	***156***
TOTAL OPEN CASES	**209**	**159**	**68**	***436***

UPCOMING CONFERENCES AND HEARINGS		
Informal Conferences	Conferences Held:	December 10, 2021 (Special Conference Committee) January 24, 2022 (Agency Subordinate)
	Scheduled Conferences:	February 25, 2022 (Special Conference Committee) March 7, 2022 (Agency Subordinate) April 11, 2022 (Agency Subordinate) April 29, 2022 (Special Conference Committee) June 24, 2022 (Special Conference Committee)
Formal Hearings	Hearings Held:	November 5, 2021
	Scheduled Hearings:	TBD

Virginia Department of
Health Professions
Board of Counseling

CASES CLOSED (10/21/2021 - 02/02/2022)	
Closed – **no violation**	81
Closed – **undetermined**	7
Closed – **violation**	6
Credentials/Reinstatement – **Denied**	4
Credentials/Reinstatement – **Approved**	2
TOTAL CASES CLOSED	**100**

Closed Case Categories



- Abuse/Abandonment/Neglect (5)
- Business Practice Issues (1)
- CE Noncompliance (3) 2 violations
- Confidentiality (4)
- Criminal Activity (1)
- Diagnosis/Treatment (25) 1 violation
- Eligibility (6) 1 violation
- Fraud, patient care (10) 1 violation
- Inability to Safely Practice (5)
- Inappropriate Relationship (9) 2 violations
- No jurisdiction (26)
- Records Release (4)
- Unlicensed Activity (1)

AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	**186**
Avg. time in Enforcement (investigations)	101
Avg. time in APD (IFC/FH preparation)	71
Avg. time in Board (includes hearings, reviews, etc).	87
Avg. time with board member (probable cause review)	41

Virginia Department of
Health Professions
Board of Counseling

LICENSING REPORT

Satisfaction Survey Results
2022 1st Quarter (July 1, 2021 to September 30, 2021)
91.3%

Totals as of February 7, 2022*

Current Licenses	
Certified Substance Abuse Counselor	1,817
Substance Abuse Trainee	2,122
Substance Abuse Counseling Assistant	250
Licensed Marriage and Family Therapist	995
Marriage & Family Therapist Resident	140
Licensed Professional Counselor	7,738
Resident in Counseling	2,504
Substance Abuse Treatment Practitioner	367
Substance Abuse Treatment Residents	13
Rehabilitation Provider	143
Qualified Mental Health Prof-Adult	6,998
Qualified Mental Health Prof-Child	5,141
Trainee for Qualified Mental Health Prof	6,583
Registered Peer Recovery Specialist	375
Total	**35,186***

*Unofficial numbers (for informational purposes only)

Virginia Department of
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Board of Counseling

Licenses, Certifications and Registrations Issued

License Type	September 2021	October 2021	November 2021	December 2021*	January 2022*
Certified Substance Abuse Counselor	3	6	6	9	6
Substance Abuse Trainee	40	19	26	37	14
Certified Substance Abuse Counseling Assistant	3	3	2	1	0
Licensed Marriage and Family Therapist	7	6	8	7	13
Marriage & Family Therapist Resident	1	6	4	3	4
Pre-Education Review for LMFT	0	1	1	0	0
Licensed Professional Counselor	112	74	77	76	90
Resident in Counseling	87	87	60	53	82
Pre-Education Review for LPC	2	3	8	4	2
Substance Abuse Treatment Practitioner	4	6	8	2	4
Substance Abuse Treatment Residents	1	0	2	0	0
Pre-Education Review for LSATP	0	0	0	0	0
Rehabilitation Provider	0	1	0	0	0
Qualified Mental Health Prof-Adult	59	39	37	47	37
Qualified Mental Health Prof-Child	49	37	35	33	29
Trainee for Qualified Mental Health Prof	213	153	122	152	153
Registered Peer Recovery Specialist	16	6	12	6	9
Total	**597**	**447**	**408**	**430**	**443**

*Unofficial numbers (for informational purposes only)

Virginia Department of
Health Professions
Board of Counseling

Licenses, Certifications and Registration Applications Received

Applications Received	September 2021*	October 2021*	November 2021*	December 2021*	January 2022*
Certified Substance Abuse Counselor	11	8	11	10	13
Substance Abuse Trainee	28	16	38	21	12
Certified Substance Abuse Counseling Assistant	7	0	0	8	4
Licensed Marriage and Family Therapist	15	6	10	14	17
Marriage & Family Therapist Resident	6	7	4	3	4
Pre-Education Review for LMFT	0	0	0	0	0
Licensed Professional Counselor	68	93	98	115	111
Resident in Counseling	98	80	50	84	117
Pre-Education Review for LPC	2	10	6	2	7
Substance Abuse Treatment Practitioner	7	12	3	3	6
Substance Abuse Treatment Residents	0	0	1	0	1
Pre-Education Review for LSATP	0	0	0	0	0
Rehabilitation Provider	1	1	0	0	0
Qualified Mental Health Prof-Adult	89	74	70	83	93
Qualified Mental Health Prof-Child	81	60	55	47	57
Trainee for Qualified Mental Health Prof	220	196	154	162	226
Registered Peer Recovery Specialist	13	8	15	12	17
Total	**646**	**571**	**515**	**564**	**685**

*Unofficial numbers (for informational purposes only)