Virginia Department of Health Professions
Board of Social Work

Agenda
Full Board Meeting
February 19, 2025
9960 Mayland Dr.
2nd Floor, Board Room 3
4:00 p.m.

If you cannot attend in person, please contact Jaime Hoyle at jaime.hoyle@dhp.virginia.gov

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

- Welcome/Introductions

Approval of Minutes

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Presentation from and dialogue with the Association of Social Work Boards

Stacey Hardy-Chandler, LCSW, JD, PhD, CEO

2025 Virginia General Assembly Update

Follow-up from November Stakeholder Discussion

- Documents provided by Joseph Lynch, LCSW
  - Board of Health Professions Report on the Policies and Procedures for the Evaluation of the Need to Regulate Professions and Occupations----------Page 6
  - Guidance Document 75-2----------Page 22
  - Summary----------Page 39
  - 2000-2016 Virginia Pass/Fail Rates----------Page 40
- Virginia and Virginia Schools 2023 Pass/Fail Rates----------Page 45
- Report to Senator Favola Regarding Efforts to Diversify and Strengthen the Clinical Social Work Workforce----------Page 53
- Statements from stakeholders
- Potential Survey of Licensees
  - Examples:
    - Kansas Survey----------Page 75
    - ASWB Survey----------Page 77

Public Comment/Discussion with Stakeholders

- Potential interest and options for alternative pathways to licensure (limited to 20 minutes)

Next Meeting

Adjournment

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

Virginia Department of Health Professions
Board of Social Work

DRAFT

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

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

BOARD MEMBERS ABSENT: Martha Meadows, MA, LCSW

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

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

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

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

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

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

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

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

DISCUSSION WITH STAKEHOLDERS:

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

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

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

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

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

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

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

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

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

NEXT STEPS:

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

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

those pathways.

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

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

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

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Sherwood Randolph Jr., MSW, LCSW

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Jaime Hoyle, JD, Executive Director

Virginia Department of Health Professions
Board of Social Work

Agenda

Full Board Meeting
January 8, 2025
9960 Mayland Dr.
2nd Floor, Board Room 4
4:00 p.m.

WebEX Access
https://covaconf.webex.com/covaconf/j.php?MTID=maa0434faac45e6bbe7b518906380d27e

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

- Welcome/Introductions

Approval of Minutes

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Follow-up from November Stakeholder Discussion

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

Discussion with Stakeholders

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

2025 Virginia General Assembly

Next Meeting

Adjournment

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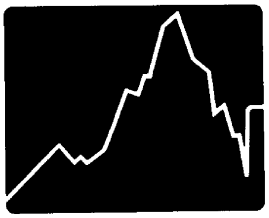

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

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

VIRGINIA BOARD OF HEALTH PROFESSIONS

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

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Introduction

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

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§54.1-2409.2. Board to set criteria for determining need for professional regulation.
The Board of Health Professions shall study and prepare a report for submission to the Governor and the General Assembly by October 1, 1997, containing its findings and recommendations on the appropriate criteria to be applied in determining the need for regulation of any health care occupation or profession. Such criteria shall address at a minimum the following principles:

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

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

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

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

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

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

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

Authority

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

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

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

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

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

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

Policies

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

Statute

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

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

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

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

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

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

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

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

The Criteria and Their Application

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

VIRGINIA BOARD OF HEALTH PROFESSIONS
CRITERIA FOR EVALUATING THE NEED FOR REGULATION
Initially Adopted October, 1991
Readopted February, 1998

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

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

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

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

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

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

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

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

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

RISK: High potential, attributable to the nature of the practice.
SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.
SCOPE OF PRACTICE: Definable in enforceable legal terms.
COST: High
APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

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

RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
SCOPE OF PRACTICE: Definable, but not stipulated in law.
COST: Variable, depending upon level of restriction of supply of practitioners.
APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

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

RISK: Low potential, but consumers need to know that redress is possible.
SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.
AUTONOMY: Variable.
APPLICATION OF CRITERIA: When applying for registration, Criteria 1, 4, 5, and 6 must be met.

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

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

Alternatives to Occupational and Professional Regulation

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

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

Procedures

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

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

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

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

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

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

How is a study conducted?

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

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

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

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

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

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

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

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

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

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

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

Sample Criticality Scales for Rating Risk of Harm

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

TASK 1: Scaling teeth above the gum line.

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

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

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

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

1. Can sometimes omit – This activity could sometimes be omitted for some clients without a substantial risk of unnecessary complications, impairment of function or serious distress.

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

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

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

What happens to the results?

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

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

Appendix

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

A. GENERAL INFORMATION

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

B. QUESTIONS WHICH ADDRESS THE CRITERIA

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

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

5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent practitioner?
6. Does a potential for fraud exist because of the inability for third party payors to determine competency?

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

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

1. What are the educational or training requirements for entry into this occupation? Are these programs accredited? By whom?
    - Are sample curricula available?
    - Are there training programs in Virginia?
2. If no programs exist in Virginia, what information is available on programs elsewhere which prepare practitioners for practice in the Commonwealth? What are the minimum competencies (knowledge, skills, and abilities) required for entry into the profession? How were they derived?
3. Are there national, regional, and/or state examinations available to assess entry-level competency?
    - Who develops and administers the examination?
    - What content domains are tested?
    - Are the examinations psychometrically sound -- in keeping with *The Standards for Educational and Psychological Testing*?

4 Are there requirements and mechanisms for ensuring continuing competence? For example, are there mandatory education requirements, re-examination, peer review, practice audits, institutional review, practice simulations, or self-assessment models?

5. Why does the public require state assurance of initial and continuing competence? What assurances do the public have already through private credentialing or certification or institutional standards, etc.?

6. Are there currently recognized or emerging specialties (or levels or classifications) within the occupational grouping? If so,
    - What are these specialties? How are they recognized? (by whom and through what mechanisms – e.g., specialty certification by a national academy, society or other organization)?
    - What are the various levels of specialties in terms of the functions or services performed by each?
    - How can the public differentiate among these levels or specialties for classification of practitioners?
    - Is a "generic" regulatory program appropriate, or should classifications (specialties/levels) be regulated separately (e.g., basic licensure with specialty certification)?

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

1. What is the nature of the judgments and decisions which the practitioner must make in practice?
    - Is the practitioner responsible for making diagnoses?
    - Does the practitioner design or approve treatment plans?
    - Does the practitioner direct or supervise patient care?
    - Does the practitioner use dangerous equipment or substance in performing his functions?

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

- What is contained in a typical supervisory or collaborative arrangement protocol?

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

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

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

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

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

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

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

2. Does the institution or organization where the practitioners practice set and enforce standards of care? How?
3. Does the occupational group participate in a nongovernmental credentialing program, either thorough a national certifying agency or professional association (e.g., National Organization for Competency Assurance)?
    - How are the standards set and enforced in the program?
    - What is the extent of participation of practitioners in the program?
4. Does a Code of Ethics exist for this profession?
    - What is it?
    - Who established the Code?
    - How is it enforced?
    - Is adherence mandatory?

5. Does any peer group evaluation mechanism exist in Virginia or elsewhere? Elaborate.
6. How is a practitioner disciplined and for what causes? Violation of standards of care? Unprofessional conduct? Other causes?
7. Are there specific legal offenses which, upon conviction, preclude a practitioner from practice?
8. Does any other means exist within the occupational group to protect the consumer from negligence or incompetence (e.g., malpractice insurance, review boards that handle complaints)? How are challenges to a practitioner's competency handled?
9. What is the most appropriate level of regulation?

Virginia Department of
Health Professions
Board of Health Professions

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

2019

Table of Contents

Introduction

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

In 1998, the Board updated the 1992 version in response to an independent analysis of its approach pursuant to *Code of Virginia* §54.1-2409.2.[1] The study reaffirmed the Board's policies and procedures but offered that additional sources of objective data could strengthen the approach. Hence, the Board added malpractice insurance information and job analysis data to the methodology.

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

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

Authority

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

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

Code of Virginia § 54.1-2510 provides that

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

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

[2] See the Appendix for References

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

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

Policies

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

Statute

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

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

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

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

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

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

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

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

In addition to amending §54.1-100, Chapter 467 also created a new section, §54.1-310.1[4] which governs the petitioning of state regulation for an unregulated commercial profession or occupation and details the Board of Professional and Occupational Regulation's sunrise review responsibilities. Subsection (A) mandates that evaluation requests be submitted no later than December 1 of any year for analysis and evaluation during the following year. Although the Board of Health Professions is not bound by this section, in order to allow sufficient time and resources for each study, preference for proposals submitted before December 1 will be considered.

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

The Criteria and Their Application

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

VIRGINIA BOARD OF HEALTH PROFESSIONS
CRITERIA FOR EVALUATING THE NEED FOR REGULATION
Initially Adopted 1991
Readopted 1998 and 2019

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

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

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

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

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

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

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

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

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

RISK: High potential, attributable to the nature of the practice.
SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.
SCOPE OF PRACTICE: Definable in enforceable legal terms.
COST: High
APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

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

RISK: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
SKILL & TRAINING: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
AUTONOMY: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
SCOPE OF PRACTICE: Definable, but not stipulated in law.
COST: Variable, depending upon level of restriction of supply of practitioners.
APPLICATION OF CRITERIA: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, and 6.

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

RISK: Low potential, but consumers need to know that redress is possible.
SKILL & TRAINING: Variable, but can be differentiated for ordinary work and labor.
AUTONOMY: Variable.
APPLICATION OF CRITERIA: When applying for registration, Criteria 1, 4, 5, and 6 must be met.

Alternatives to Occupational and Professional Regulation

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

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

Procedures

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

Who may request a study and how?

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

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

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

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

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

How is a study conducted?

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

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

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

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

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

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

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

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

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

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

Sample Criticality Scales for Rating Risk of Harm

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

TASK 1: Scaling teeth above the gum line.

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

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

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

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

1. Can sometimes omit – This activity could sometimes be omitted for some clients without a substantial risk of unnecessary complications, impairment of function or serious distress.

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

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

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

What happens to the results?

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

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

Appendix

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

A. GENERAL INFORMATION

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

B. QUESTIONS WHICH ADDRESS THE CRITERIA

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

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

- lack of supervision
- practices inherent in the occupation
- characteristics of the client/patients being served
- characteristics of the practice setting
- other (specify)

5. Does a potential for fraud exist because of the inability of the public to make an informed choice in selecting a competent practitioner?
6. Does a potential for fraud exist because of the inability for third party payors to determine Competency?
7. Is the public seeking regulation or greater accountability of this group?

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

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

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

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

- Does the practitioner direct or supervise patient care?
- Does the practitioner use dangerous equipment or substance in performing his functions?

If the practitioner is not responsible for diagnosis, treatment design or approval, or directing patient care, who is responsible for these functions?

2. Which functions typically performed by this practitioner group are **unsupervised**, i.e., neither directly monitored or routinely checked?
    - What proportion of the practitioner's time is spent in unsupervised activity?
    - Who is legally accountable/liable for acts performed with no supervision?
    3. Which functions are performed **only under supervision**?
        - Is the supervision *direct* (i.e., the supervisor is on the premises and responsible) or *general* (i.e., supervisor is responsible but not necessarily on the premises)?
        - Who provides the supervision? How frequently? Where? For what purpose?
        - Who is legally accountable/liable for acts performed under supervision?

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

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

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

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

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

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

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

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

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****SUMMARY****

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

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

RISK: High potential, attributable to the nature of the practice.
SKILL & TRAINING: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
AUTONOMY: Practices independently with a high degree of autonomy; little or no direct supervision.
SCOPE OF PRACTICE: Definable in enforceable legal terms.
COST: High
APPLICATION OF THE CRITERIA: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

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

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

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

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

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

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

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

Association of Social Work Boards
School Pass/Fail Summary

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

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

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

Association of Social Work Boards

School Pass/Fail Summary

School: George Mason University **Examination: CLINICAL**

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

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

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

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

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Association of Social Work Boards

School Pass/Fail Summary

School: Norfolk State University

Examination: CLINICAL

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

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

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

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

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Association of Social Work Boards

School Pass/Fail Summary

School: Radford University

Examination: CLINICAL

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

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

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

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

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Association of Social Work Boards

School Pass/Fail Summary

School: Virginia Commonwealth University **Examination: CLINICAL**

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

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

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

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

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

2023 pass rate summary report

Jurisdiction: Virginia
Date: June 2024

The table presents the numbers of examinations administered to candidates who were authorized by the state or jurisdiction listed above. Figures indicate the percentage of first-time, repeat, and total test-takers who passed the indicated exam categories during the year 2023. Note that test-takers who are unsuccessful may repeat the examination more than once.

Exam category and group type	Total number of examinations	Pass rate	
		Number	Percent
Bachelors			
First-time	12	6	50
Repeat	0	0	-
Total	12	6	50
Masters			
First-time	158	123	77.8
Repeat	55	18	32.7
Total	213	141	66.2
Clinical			
First-time	518	369	71.2
Repeat	397	97	24.4
Total	915	466	50.9
Advanced Generalist			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-
Associate			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-

2023 school pass rate summary report

School: George Mason University
Date: June 2024

The table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total test-takers who passed the indicated exam categories during the year 2023. Note that test-takers who are unsuccessful may repeat the examination more than once.

Exam category and group type	Total number of examinations	Pass rate	
		Number	Percent
Bachelors			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-
Masters			
First-time	43	37	86
Repeat	6	3	50
Total	49	40	81.6
Clinical			
First-time	66	51	77.3
Repeat	20	7	35
Total	86	58	67.4
Advanced Generalist			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-

2023 school pass rate summary report

School: James Madison University
Date: June 2024

The table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total test-takers who passed the indicated exam categories during the year 2023. Note that test-takers who are unsuccessful may repeat the examination more than once.

Exam category and group type	Total number of examinations	Pass rate	
		Number	Percent
Bachelors			
First-time	2	2	100
Repeat	0	0	-
Total	2	2	100
Masters			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-
Clinical			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-
Advanced Generalist			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-

2023 school pass rate summary report

School: Liberty University
Date: June 2024

The table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total test-takers who passed the indicated exam categories during the year 2023. Note that test-takers who are unsuccessful may repeat the examination more than once.

Exam category and group type	Total number of examinations	Pass rate	
		Number	Percent
Bachelors			
First-time	25	23	92
Repeat	8	3	37.5
Total	33	26	78.8
Masters			
First-time	8	6	75
Repeat	0	0	-
Total	8	6	75
Clinical			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-
Advanced Generalist			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-

2023 school pass rate summary report

School: Longwood University
Date: June 2024

The table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total test-takers who passed the indicated exam categories during the year 2023. Note that test-takers who are unsuccessful may repeat the examination more than once.

Exam category and group type	Total number of examinations	Pass rate	
		Number	Percent
Bachelors			
First-time	1	1	100
Repeat	0	0	-
Total	1	1	100
Masters			
First-time	1	1	100
Repeat	0	0	-
Total	1	1	100
Clinical			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-
Advanced Generalist			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-

2023 school pass rate summary report

School: Norfolk State University
Date: June 2024

The table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total test-takers who passed the indicated exam categories during the year 2023. Note that test-takers who are unsuccessful may repeat the examination more than once.

Exam category and group type	Total number of examinations	Pass rate	
		Number	Percent
Bachelors			
First-time	1	0	0
Repeat	0	0	-
Total	1	0	0
Masters			
First-time	11	6	54.5
Repeat	11	5	45.5
Total	22	11	50
Clinical			
First-time	54	19	35.2
Repeat	113	22	19.5
Total	167	41	24.6
Advanced Generalist			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-

2023 school pass rate summary report

School: Radford University
Date: June 2024

The table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total test-takers who passed the indicated exam categories during the year 2023. Note that test-takers who are unsuccessful may repeat the examination more than once.

Exam category and group type	Total number of examinations	Pass rate	
		Number	Percent
Bachelors			
First-time	1	0	0
Repeat	0	0	-
Total	1	0	0
Masters			
First-time	3	2	66.7
Repeat	7	0	0
Total	10	2	20
Clinical			
First-time	47	32	68.1
Repeat	38	11	28.9
Total	85	43	50.6
Advanced Generalist			
First-time	1	1	100
Repeat	0	0	-
Total	1	1	100

2023 school pass rate summary report

School: Virginia Commonwealth University
Date: June 2024

The table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total test-takers who passed the indicated exam categories during the year 2023. Note that test-takers who are unsuccessful may repeat the examination more than once.

Exam category and group type	Total number of examinations	Pass rate	
		Number	Percent
Bachelors			
First-time	0	0	-
Repeat	0	0	-
Total	0	0	-
Masters			
First-time	88	78	88.6
Repeat	13	7	53.8
Total	101	85	84.2
Clinical			
First-time	172	148	86
Repeat	70	21	30
Total	242	169	69.8
Advanced Generalist			
First-time	1	0	0
Repeat	0	0	-
Total	1	0	0

COMMONWEALTH of VIRGINIA

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

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

DATE: November 21, 2024

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

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

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

AO/EB
Enclosure

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

Preface

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

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

Contents

I. Executive Summary

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

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

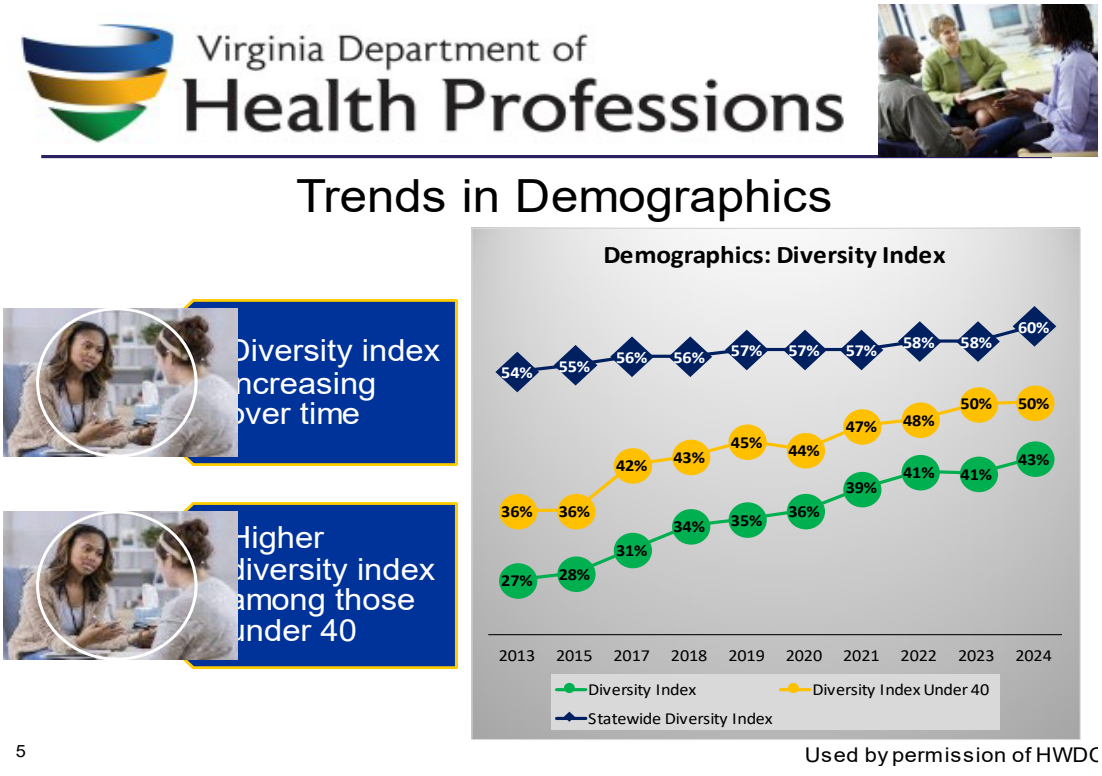
The mission of the Board is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to practitioners and the public. Within that mission, this report includes background on the current licensed clinical social worker workforce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

II. Background

A. Virginia Licensed Clinical Social Worker Workforce

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

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



Used by permission of HWDC

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

B. Current Licensure Requirements for Licensed Clinical Social Workers

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

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

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

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

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

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

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

III. Anti-Bias Measures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[4] *See* https://www.cswe.org/ for more detailed information on CSWE's initiatives.

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

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

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

V. Steps Taken by Other States Regarding Alternative Licensure Pathways

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

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

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

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

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

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

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

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

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

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

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

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

Likewise, supervision depends on the quality of the supervisor, and sometimes the dynamic between the supervisor and the supervisee. The Board ensures that the supervisor meets the requirements to be a supervisor but cannot ensure that the supervision is in fact occurring as reported. The Board lacks the personnel resources[7] to audit the supervision and relies on the honesty and the evaluative abilities of each supervisor. The Board recognizes that the Commonwealth has many wonderful supervisors, but a financial incentive to provide supervision exists because supervisees often must pay for their supervision. Additionally, the Board currently has no regulations governing the number of supervisees a supervisor can supervise, and some worry less about the quality of the supervision they provide and more about the quantity. The regulations only require that the supervisor have an active LCSW that has been in good standing for the last two years and have taken certain continuing education hours in supervision. In fact, the Board recently streamlined its regulations to reduce ongoing supervision requirements. If the Board adopts an alternative pathway to the examination, it will need to strengthen the regulations governing supervision to ensure greater accountability. Under the current requirements, applicants submit a Verification of Supervision form[8] that is signed and notarized by the supervisor and the applicant and lists the supervised hours and the type of supervision received. Staff reviews the forms for accuracy, but in actuality, must rely on the honesty and integrity of the applicant and the supervisor. If an alternative pathway does not change this review, additional staff would not be required. However, if supervision becomes the main competency measure and guardrail to protect the public, staff should audit the supervision, which would require additional staff.

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

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

[8] *Available at* https://www.dhp.virginia.gov/media/dhpweb/docs/sw/forms/ClinicalSupervisionVerification.pdf.

[9] Va. Code § 54.1-3703.

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

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

[11] Va. Code § 54.1-113.

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

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

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

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

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

[12] 18VAC140-20-50(B).
[13] Va. Code § 54.1-3705(8).

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

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

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

VIII. Impact on Social Work Licensure Compact

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

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

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

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

[15] *See generally* Va. Code § 54.1-3709.4, § 3.
[16] *See generally* Va. Code § 54.1-3709.4, § 4.

IX. Summary of ASWB Research Efforts

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

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

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

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

The ASWB has invested in a regulatory research agenda, in partnership with educational institutions and researchers, to consider alternative competence measurement formats, contextual factors impacting disparate outcomes, and other alternatives for regulators to have a voice in their licensure decisions. The ASWB awarded a grant to researchers at Western Kentucky University[17] to address three research areas: factors impacting disparity in pass rates for social work licensure;

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

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

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

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

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

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

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

[18] Joy Kim, MSW, PhD & Michael Joo, MSW, PhD, "The Profile of Social Work License Examinees: A Racially Patterned Educational and Training Journey Before the Exams," Rutgers School of Social Work (2024).
[19] https://www.aswb.org/wp-content/uploads/2024/08/1.-Kim-Joo-2024-Profile-of-Social-Work-License-Examinees-07-30-2024.pdf at 2.
[20] Joy Kim, MSW, PhD & Michael Joo, MSW, PhD, "The Determinants of Licensing Exam Outcomes: The Compounding Effects of Individual, Institutional, and Community Factors," Rutgers School of Social Work (2024).
[21] Joy Kim, MSW, PhD & Michael Joo, MSW, PhD "The Effects of Race/Ethnicity on Clinical Exam Outcomes: Diminished (Yet Persistent) Effects When Other Determinants are Controlled," Rutgers School of Social Work (2024).

X. Conclusions and Next Steps

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

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

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

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

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

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

Behavioral Sciences Regulatory Board

Survey of Social Workers

February 2024

Thank you for taking the time to participate in this online survey research project. We are an independent research organization hired by the American Foundation for Research and Consumer Education in Social Work Regulation. All of your responses to questions will be completely confidential and anonymous. This study is for research purposes only and we will not try to sell you anything.

SCREENERS

1. Have you ever worked as a licensed social worker?

    1. Yes – currently practicing
    2. Yes – not currently practicing
    3. No **TERMINATE**
    4. Not sure **TERMIANTE**

2. Which year did you become a licensed social worker?

    NUMBER ENTRY TO RECORD EXACT YEAR

3. In what state did you become a licensed social worker? **DROP DOWN LIST. SELECT ONE**

LICENSURE ATTITUDES

4. As you may know, there is a national effort to pass a social work licensure compact to make it easier to practice as a social worker in multiple states. Under the compact, social workers would be allowed to apply for a multi-state license that would allow them to practice in more than one state. Do you support or oppose the social work licensure compact?

    1. Strongly support
    2. Somewhat support
    3. Somewhat oppose
    4. Strongly oppose
    5. Don't know enough to say

[START BATTERY]
Now, you are going to read a list of statements about social work licensure. For each one, please indicate if you agree or disagree with the statement.

CODING FOR FOLLOWING:
1. Strongly agree
2. Somewhat agree
3. Somewhat disagree
4. Strongly disagree

[START BATTERY QUESTIONS]
SCRAMBLE
5. The licensing exam is an important measure of a social worker's competence to serve vulnerable clients
6. The licensing exam upholds professional standards among social workers
7. I believe new social workers should be required to take the exam to become licensed
8. It would be a mistake to remove the social work licensing exams as a requirement for licensure
9. People should be able to be licensed as social workers with just an educational degree
10. People should be able to be licensed as social workers with just an educational degree and supervised practice

[END BATTERY]

11. As you may know, some states are considering ending the requirement that social workers pass a licensing exam to become licensed to practice. In your opinion, should states (ROTATE) keep the licensing exam requirement or end the licensing exam requirement?

ROTATE 1-4;4-1

1. Strongly believe states should keep the licensing exam requirement
2. Somewhat believe states should keep the licensing exam requirement
3. Somewhat believe states should end the licensing exam requirement
4. Strongly believe states should end the licensing exam requirement
5. Don't know enough to say

12. Would you like to be contacted by the American Foundation for Research and Consumer Education in Social Work Regulation to receive further information about the social work interstate compact and the social work licensing exam?

1. Yes
2. No

Thank you for completing this survey!