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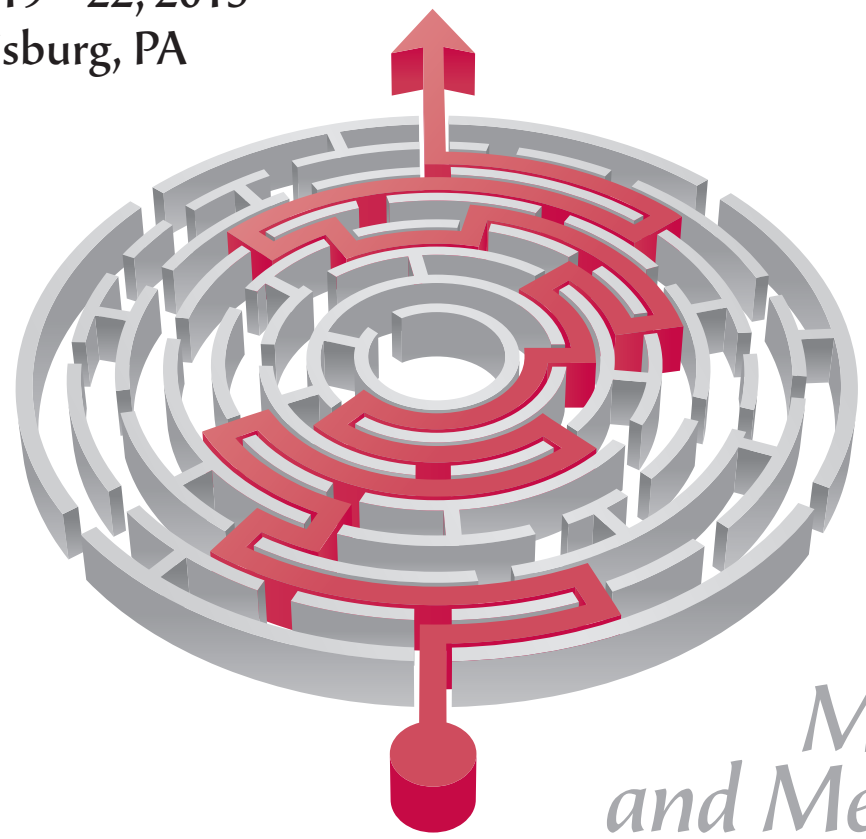
The Pennsylvania Psychologist

March 2013
QUARTERLY

ANNUAL CONVENTION

June 19 – 22, 2013
Harrisburg, PA



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Vol. 73 No. 3

The Pennsylvania Psychologist

Editor: Kathryn L. Vennie, MS

March 2013 • QUARTERLY

Pennsylvania Psychological Association
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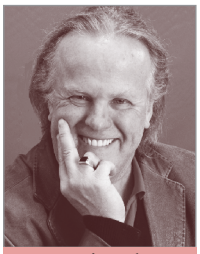
Help Us Increase Kids' Access to Mental Health Care

David J. Palmiter, Jr., PhD, ABPP



Dr. David J. Palmiter

This is a composite case sent to me by a colleague:

Little Lisa, just 9 years old, was my most recent referral. Until recently, Lisa would never have been referred for mental health services because she suffered from an anxiety disorder and was considered a model child by her parents or teacher. The well meaning parents did not realize how much anxiety she was feeling. They thought she would just "grow out of it." However, my pediatrician has agreed to screen all children for mental disorders and this screen, combined with my evaluation, showed that she suffered a great deal of anxiety, in silence. Now I am working carefully with her pediatrician to ensure she is getting the care she needs.

Those of you who have been following my presidential columns know about the Pennsylvania Pediatric Mental Health Task Force. In this column I'd like to provide a review, an update and an invitation.

Unfortunately, the literature that establishes that the mental health needs of our nation's youth is tragically neglected is both broad and deep. Let me cherry-pick a few findings here:

- More than 90% of juvenile suicide attempters suffer from a psychiatric disorder, with more than half suffering for two years or longer (AACAP, 2001).
- Depressed teens are no more likely to be referred for services than controls (Fonagy et al., 2002)
- About three-fourths of youth suffering from depression are not diagnosed. Of those that do receive a diagnosis 70% are not treated and fewer than 20% receive specialty mental health care. Similar numbers have been found with youth suffering from ADHD (50% who are diagnosed getting no care with less than a third receiving specialty care) (Pescosolido, et al., 2008).
- Almost three-fourths of adults do not perceive a child with daily problems as having a clinical problem (Pescosolido, 2008).
- The point prevalence rate for at least one class of mental health disorder falls decimal points shy of 50%, with 22% suffering severely. However, more than 60% of teens who meet criteria for a diagnosis receive no care (Merikangas, et al., 2010).
- Quoting the authors of a national longitudinal study appearing in JAACAP last year that found that from age 9 to 21 the rate of diagnosable mental health problems was over 90%: "...the experience of psychiatric illness (among youth) is not merely common but nearly universal...." However, these authors (i.e., Drs. William Copeland, Lilly Shanahan and E. Jane Costello and Ms. Adrian Angold) also noted "Only about one in three individuals with a well-specified psychiatric disorder received any treatment at all, and even when treatment was obtained, it rarely conformed to best practice recommendations."
- The adverse consequences of this profound social injustice clog the headlines of our 24/7 news cycle. This harsh reality of mental health underservice (and, as you know, it's true for adults too), together with evolving implications of the Affordable Care Act make both public education and collaborations with primary care our profession's life blood.

Recognizing these realities, PPA and the Pennsylvania Chapter of the American Academy of Pediatrics (www.paaap.org), have joined together to form the aforementioned task force. While we have 15 goals, our primary ones have been to get kids screened for mental health issues during pediatric well visits, to develop baseline evaluation standards for mental health evaluations when kids screen positive, and to establish collaborative and effective linkages between psychologists and pediatricians. As part of this work we are doing a six-month research trial examining a plethora of related issues and questions; we plan on giving a preliminary report on this study at PPA's annual convention and a full report at APA's annual convention. However, there are a two ways you can get involved in this work.

The first way you can get involved is to approach the pediatric practices in your area about doing mental health screens on well visits. The tools we are using are the Pediatric Symptom Checklist and the Pediatric Symptom Checklist-Youth Report; these tools are in the public domain (see http://psc.partners.org/psc_order.htm) and do a quick and psychometrically sound job of addressing whether a further mental health evaluation is indicated. I, or any member of our task force, would be happy to collaborate with you on strategies you might employ along these lines.

The second way you can get involved is to let us know that you'd like to receive referrals from pediatric practices that want to have kids and teens receive a mental health evaluation. The evidence-based evaluation standards developed and endorsed by the task force can be found as an appendix to this article.

So, join us as the future of integrative care comes into focus. Doing so stands to redress a profound social injustice, facilitate our profession's being at the table as the health care industry reshapes itself, and keep your practice or agency thriving. If the evaluation standards I just reviewed are acceptable to you, and you'd like to receive referrals from pediatricians in your region, e-mail Dr. Lauren Hazzouri (drlhazz@comcast.net) with your contact information and the forms of payment you accept in your practice or agency. Moreover, if you'd like to discuss strategies for approaching pediatric practices

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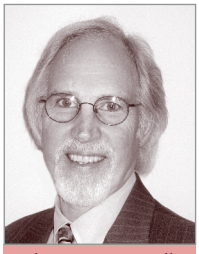
How PPA Became a Force in Harrisburg

Thomas H. DeWall, CAE



Thomas H. DeWall

My tenure as executive director at PPA is winding down after 26 years, with a planned August retirement. This column will reflect on the impact PPA has made on public policy during that span. At a time when psychology is under a lot of stress, it is easy to forget the great strides we have made over the years. In June my column will focus on advances that PPA has made as an organization over the 2½ decades. By then the Board of Directors will have selected a new executive director, whose tenure will overlap with mine by a few weeks.

I started with PPA in 1987, right after the revised Professional Psychologists Practice Act was passed establishing the doctorate as the entry-level requirement for licensure. Those who had terminal master's degrees were given until 1995 to become licensed at that level. Although PPA supported the change to the doctoral level we have always supported in relevant legislation those of our members who were grandfathered in at the master's level. In 1996, 28% of our members had terminal master's degrees. At present, due to retirement, relocation, or continued education, that figure is down to 16%.

Other than licensure the biggest challenges over the years have been third-party payment issues and the recognition to practice to the full extent that the Professional Psychologists Practice Act authorizes. Prior to my tenure, the "Freedom of Choice" law was passed (in 1978) which for the first time required psychologists to be eligible for insurance reimbursement for treating mental health problems. It was passed over the opposition of the psychiatrists and insurance interests (Knapp, Levin, & French, 1993). In 1988 we won new legislation enabling psychologists to be participating providers in Pennsylvania Blue Shield; it allowed direct payment to psychologists rather than having the patient pay and then get reimbursed.

PPA became a member of the Mental Illness Insurance Coalition in 1987. The coalition fought for years to pass legislation mandating mental health coverage in all health insurance contracts and later to require managed care organizations to accept any willing provider on their panels. Those efforts gradually turned into what we now know as mental health parity. These types of legislation were fought strenuously by the insurance lobby, which is very strong in Pennsylvania. Finally parity was enacted at the federal level in 2008 with a strong effort by PPA to secure the votes of members of Congress from Pennsylvania. This 20-year fight showed the necessity of persistence in advocating for progressive change. And still the parity law contains numerous loopholes, so future efforts will need to focus on eliminating them.

Medicare has been another contentious issue for more than 20 years. Psychologists were included as Medicare providers in 1990 (again over the objections of the psychiatrists), but only licensed doctoral-level psychologists were authorized to conduct psychotherapy. Despite advocacy by PPA those at the master's level were authorized only to conduct testing upon a referral by a physician. Ever since the late 1990s we have helped defeat or postpone constant attempts to lower the reimbursement rate under the aegis of the SGR formula, the 5-year rule, or another arcane regulation. These battles remain at the top of APA's and PPA's advocacy priorities.

PPA engaged in a prolonged legislative struggle, from 2006 to 2009, over the prior authorizations that several managed care companies and their subcontractors required. A PPA-backed bill passed the state House unanimously in 2007, only to be held up in the Senate despite the cosponsorship of 35 out of 50 senators. Nevertheless, because of PPA's advocacy with legislators and insurers directly, several managed care organizations stopped their use of prior authorizations.

Unlike many other state psychological associations, PPA also fought hard for the interests of school psychologists. In 1989 PPA mounted a campaign against corporal punishment in public schools, culminating in a victory 16 years later in 2005. In 1999 PPA helped derail a bill that would have limited the authority of school psychologists to discuss a variety of problems with students or to deliver health care services. In 2000 we successfully fought a proposed regulation that could have eliminated many school psychologist positions by opening the door to having lesser trained providers conduct psychological evaluations.

PPA has also had to fend off numerous attempts to restrict or impede the practice of psychologists. These efforts are often time-consuming and do not engender big headlines, but they have often been critical. Recent examples were attempts to impose a sales tax on psychological services, to change the rules on treating injured workers under Workers Compensation, and to restrict the ability of psychologists to provide supervision to psychologists-in-training.

Due to PPA advocacy psychologists have won statutory recognition in many other laws, some of which are enumerated below (and many of which were reserved only to physicians). Psychologists are authorized to:

- act as reviewers within managed care companies for behavioral health services;
- present expert testimony in civil cases pursuant to the Pennsylvania Rules of Civil Procedure;
- evaluate impaired physicians or nurses, pursuant to their respective licensing laws;
- present sentencing recommendations in court for drug offenders;
- be leaders of multidisciplinary treatment planning teams under the Mental Health Procedures Act;
- establish treatment plans for patients receiving drug and alcohol treatment;
- serve on the Drug, Device, and Cosmetic Board and the Sexual Offenders Assessment Board;
- develop treatment plans for children under Behavioral Health Rehabilitation Services;

Continued on page 4

Insanity Determination Bill Reintroduced

State Representative Glen R. Grell (R-Cumberland) has reintroduced the bill that authorizes psychologists to make insanity determinations. The bill this session is House Bill 21; it has been referred to the House Judiciary Committee, chaired by Rep. Ronald S. Marsico (R-Dauphin). HB 21 is a bipartisan bill that would clear up the ambiguity that currently exists whereby courts are permitted to appoint psychologists to do some insanity evaluations under the Rules of the Supreme Court, but are not permitted to appoint psychologists to do insanity evaluations when they also would like a determination of competency to stand trial. HB 21 would resolve this problem and allow the courts to appoint psychologists as evaluators of insanity.

New CPT (confusion, perplexity, and turmoil) Codes

The new CPT codes do not represent a mere change in the numerical designation of mental health procedures, but represent a more substantial change. These new codes have created at least three types of problems. First, insurers have not been clear or prompt in disseminating information about the codes. We know of no insurer who sent out information on these codes before January 1, 2013. Consequently, psychologists had no information to tell patients about how long the sessions would be or what their copays would be. Also, at least one insurer listed times for psychotherapy that differed from the times found in the CPT manual. At the PPA office we have tried to gather information on the new rates given by different insurers. However, different providers have received differing rates from the same insurers. It is not known whether this reflects differences in contracts, regional differences, or errors on the part of the insurer.

Second, the division of psychotherapy into two primary codes creates scheduling difficulties. While a psychologist may, for example, want to schedule all patients for 60-minute sessions, they may have one insurer who uses the codes in such an unusual manner that makes such scheduling impractical. That insurer may, for example, require authorizations for such 60-minute sessions, leaving psychologists at the mercy of the bureaucratic authorization process with all of the associated non-payment risks. As a result, it will take psychologists some time to learn what codes are practical for their practices given the companies that they deal with.

Finally, there are indications that some insurers have used this change as an excuse for rate reductions. As noted above, some of the rate information we are receiving is confusing and contradictory. Also, making comparisons is difficult considering that the length of time for the new codes differs from the previous 90806 code. Nonetheless, as we go to press, the net effect may be varying degrees of payment cuts for psychologists.

EXECUTIVE DIRECTOR'S REPORT

Continued from page 3

- receive direct referrals from Workers Compensation;
- diagnose emotional abuse according to the Child Protective Services Law;
- maintain privileged communications with patients on the same basis as attorney-client communications;
- evaluate impaired drivers – and are mandated to warn if drivers are impaired;
- conduct evaluations for carrying lethal weapons;
- conduct psychological evaluations of municipal firefighters and police officers;
- serve as evaluators for the Office of Vocational Rehabilitation and for disability in the Medical Assistance and Social Security Administration programs;
- conduct child custody evaluations without fear of licensing board complaints during the process;
- make return-to-play decisions for high school athletes experiencing concussions.

In addition, psychologists are the only non-medical profession mentioned specifically in the Health Care Facilities Act as eligible for hospital clinical privileges, and may serve on the medical staffs of private psychiatric hospitals. Other issues on which we have been successful advance the public interest directly but psychologists' interests only indirectly. Examples are laws promoting mental health courts and allowing minors over age 14 to consent to treatment.

These advances have occurred because the PPA and PennPsyPAC Boards of Directors, as well as PPA committees, have worked hard to establish enlightened policies for the organization and to raise the necessary funds for a robust advocacy program. The staff has been diligent in carrying out those policies.

Although some of the biggest challenges remain, PPA has followed a strategy of constructing building blocks, one at a time, to promote the profession of psychology throughout Pennsylvania law and to enhance the well-being of all Pennsylvanians.

Reference

Knapp, S., Levin, Z., & French, J. (1993). *A history of the Pennsylvania Psychological Association*. Harrisburg, PA: Pennsylvania Psychological Association.

PRESIDENT'S MESSAGE

Continued from page 2

by you, please don't hesitate to be in touch with me (palmiter@marywood.edu).

Evaluation Standards

This protocol is provided as a guideline for participating psychologists to follow when receiving referrals during the trial. However, participating psychologists maintain the right and ability to not adhere to a given standard when doing so is either not possible (e.g., after a discussion of the issues parents refused to allow teachers to fill out rating scales), clinically ill advised (e.g., a child's anxiety for meeting alone with the psychologist cannot be overcome), or otherwise contraindicated (e.g., a sole practitioner's treatment records won't be available for another month as she is on a leave of absence).

The psychologist will agree to:

1. *Let the pediatric practice know that the evaluation is underway (i.e., not the findings but just that the process is underway). This could occur at one of two points in time: (a) at the point that the initial evaluation appointment for the case is scheduled (assuming an oral release to do so has been granted during the phone call) or (b) after the family comes in for the initial evaluation appointment and signs a release of information to the pediatrician.*
2. *Complete a family interview with the child and at least one adult who lives with the child; ideally all parental figures would take part.*
3. *Complete an individual interview with the child.*
4. *Obtain parent, teacher, and child behavior rating scales, assuming that all involved possess sufficient reading skills and parents are willing to cooperate.*
5. *Screen caregivers the child lives with for mental health problems.*
6. *When they exist the psychologist will endeavor to review the following:*
   a. *The child's school records (i.e. report cards, state achievement testing, special education records, and discipline records)*
   b. *Previous mental health evaluation and treatment*
   c. *Medical records that could be relevant to the presenting concerns*
   d. *Forensic records*
   e. *Records from Children and Youth*
   f. *Other records that could be relevant to an evaluation of the presenting concerns*
7. *Within two weeks of finishing the evaluation, and assuming sufficient written releases have been executed, send a written summary to the pediatrician which includes at least the following elements:*
   a. *Sources of information for the evaluation*
   b. *Diagnostic impression*
   c. *Recommendations for either further evaluation or for treating the problem(s) that have been diagnosed*
   d. *Case disposition (i.e., what the family has agreed to do regarding the recommendations)*

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PPA Election Is Underway

PPA members have until March 15 to vote for PPA leadership using our easy web-based voting procedure. If you haven't voted yet please go to www.PaPsy.org now and vote for the candidates of your choice. The Nominations and Elections Committee has recruited excellent candidates for five positions on our Board of Directors. The offices being contested are president-elect, treasurer, and the chair of the Communications, Internal Affairs, and School Psychology Boards. You have been notified of it by e-mail with a direct link, but if you missed it you can still go to the website and vote.

The candidates' statements and the ballot are posted on the homepage of the PPA website. To visit it you will need your 4-digit member number (found on the mailing label of this issue). It's your organization! Please vote for the candidates you believe will provide the best direction for the association in the coming years. We are trying to make the process as easy for you as possible. If you have any problems with it you may e-mail the PPA office at ppa@PaPsy.org.

Please Vote!

Happy Anniversary, PPA!

Beatrice Chakraborty, PsyD, Chair, Program and Education Board,
ChakrabortyBH@gmail.com

Dr. Beatrice Chakraborty

My dear friends and colleagues, once upon a time (about 80 years ago) a group of well-meaning psychologists came together to form a volunteer organization (Pennsylvania Psychological Association; PPA) chartered "...to advance psychology in Pennsylvania as a means of promoting human welfare." Daily, PPA members carry out this mission through activities that advocate vigorously for public access to psychological services, that educate and support the professional development of our members, that educate the public through disseminating and applying psychological knowledge, and that maintain and build organizational strength.

This year, we aim to celebrate the 80th anniversary of what is now the second largest state psychological association affiliated with the American Psychological Association. On behalf of our PPA president, Dr. David Palmiter, the Board of Directors, the Convention Committee and PPA staff, I extend an invitation to psychologists and other mental health professionals across the Commonwealth to attend our Annual Convention.

PPA 2013 Annual Convention

June 19–22, Hilton Harrisburg

The PPA president's theme which characterizes the 2013 convention is: *Mission and Meaning: Using Psychology and PPA to Benefit Your Personal and Professional Life*. Under the very capable leadership of Convention Committee chair Dr. Mark McGowan, we have developed a stellar convention program that essentially demonstrates how our PPA-member psychologists practice and embrace the essence of the 2013 convention theme.

As this is a Pennsylvania state license renewal year, I urge you to register early to attend a variety of continuing education workshops that address the very latest in psychological science and practice. Look for more programs designed specifically for students and early career psychologists (e.g., "speed mentoring" is back). Spread the word that PPA is pleased to continue the free Psychology for Everyone Workshops for the public on Thursday and Friday. Of course, opportunities for learning and networking will be greatly enhanced and facilitated by the three main convention speakers: (1) *Keynote:* Ms. Mary Byers, CAE, renowned author (2) *Psychology in Pennsylvania Luncheon:* Dr. Donald N. Bersoff, 2013 APA President, and *(3) Mind-Body Health Breakfast Symposium:* Dr. Kareem J. Johnson, Assistant Professor, Temple University.

Venues for professional and social networking and fun include the mind-body river walk and the exhibitors' hall, where exhibitor giveaways and pretty amazing door prizes are just waiting for you. Yes, you have to visit to win. For pure delight, put on your dancing shoes and take a stroll down memory lane on Friday night with **Flashback**, the band that will provide some oldies-but-goodies live entertainment for those who remember when songs had words. Dr. Palmiter promised that the band would throw in some Motown, if I promised to leave Tina Turner and her hair in a closet.

Finally, the Board of Directors requests the pleasure of your company at the retirement party for our executive director, Thomas H. DeWall, CAE. Tom has given PPA members exemplary service for the last 26 of our 80 years. Way to go, Tom!!

Come on out and celebrate Tom and life with us! Renew your mind and body in the spirit of learning, fun and promoting human welfare ... yours and mine.

Invited Addresses and Workshops

Mark R. McGowan, PhD, Chair, Convention Committee,
Dr.Mark.McGowan1@gmail.com

Dr. Mark R. McGowan

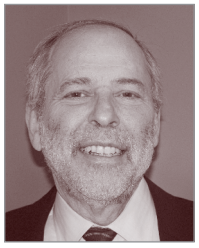
This year's convention theme encourages PPA members to explore their own sense of mission and meaning as they reflect on their relationship to our profession and our professional associations. Our speakers this year offer unique opportunities for gaining insight into how these relationships influence our personal and professional lives.

Mary Byers

Our keynote speaker, **Ms. Mary Byers**, will be engaging her audience in an interactive planning process that is designed to increase meaning and enhance productivity in her talk titled *Using a Mission Statement to Accomplish Meaning and Productivity*. Ms. Byers is an author of *Race for Relevance: 5 Radical Changes for Associations* (Coerver & Byers, 2011) and has more than 20 years of experience speaking on the subject of organizational change. This talk promises to be one you will not want to miss. Ms. Byers will also be facilitating a conversation with PPA leaders and the new executive director to identify future focus, common values, and guidelines to enhance operational effectiveness of our state association.

Dr. Kareem Johnson

On Wednesday morning, please join us at the Mind-Body Health Breakfast Symposium where **Dr. Kareem Johnson** will be offering a talk titled *Blurring Boundaries: The Effect of Positive Emotions on Perceptions of Race*. Dr. Johnson is a professor in the psychology department at Temple University who specializes in the emotional, cognitive, and psychophysiological factors that may influence how people perceive and respond to outgroup members. His work has appeared in recent publications such as *Are We Born Racist? New Insights from Neuroscience and Positive Psychology* (Marsh, Mendoza-Denton, & Smith, 2010).



Dr. Donald Bersoff

Finally, I am pleased to announce that the 2013 president of the American Psychological Association, **Dr. Donald Bersoff**, will be delivering the Psychology in Pennsylvania Luncheon address. Dr. Bersoff is also professor emeritus at the Earle Mack School of Law and adjunct professor of psychology at Drexel University. His talk will focus on how professional associations at the state level support the interests of its members through a shared mission to advance the profession of psychology. We are excited to be able to have several notable invited guests to speak with us at this year's convention. Please join us in benefiting from their knowledge and respective areas of expertise.

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Convention 2013 . . . A Preview

Marti Evans, Conference and Communications Manager, mevans@PaPsy.org

PPA's Annual Convention, June 19-22, is an excellent time to connect with colleagues and friends and learn the latest psychological knowledge in addition to the initiatives designed to enhance psychology as a discipline and profession in Pennsylvania. Celebrate with us!

PROGRAM TOPICS

The 2013 Convention Committee wishes to thank those who submitted proposals for this year's convention, and we encourage those whose programs were not accepted to send a proposal next year. The Call for Presentations form is available at www.PaPsy.org.

Program descriptions will be listed in the convention program booklet, which will be mailed in April. A preliminary schedule is available on our website.

The members of the Convention Committee (see page 9) and I will continue to work hard to ensure a quality convention. We look forward to greeting you in person in June!

REGISTRATION FEES

To help you properly plan and budget for the convention, the following convention registration fees will apply. If you need a preliminary convention registration form for employer's check-processing/approval, please contact Marti Evans at the PPA office by e-mail or phone (717-232-3817).

	EARLY REGISTRATION *postmark by June*		REGULAR REGISTRATION *postmark after June 1*	
	All	**Daily**	**All**	**Daily**
PPA Member	$340	$200	$410	$225
Non-Member	$555	$300	$610	$335
First Year Post-Doc PPA Member	$65	$50	$70	$55
Full-Time Student Member	$65	$50	$70	$55
Full-Time Student Non-Member	$130	$90	$140	$95
Senior PPA Member	$225	$135	$240	$150
Senior Non-Member	$380	$225	$425	$240
Spouse/Family/Guest	$85	$55	$90	$65

HOTEL ACCOMMODATIONS

The Hilton Harrisburg will be the host for the 2013 Annual Convention. To make a reservation, call 1-800-HILTONS or 717-233-6000. When phoning for accommodations, please identify yourself as a participant in the PPA Annual Convention to obtain the group rate: $130 single/double (plus tax). The group rate is protected until May 28. If the room block is sold out before May 28, reservations will be accepted on a space availability basis only, and the rate you are charged will be higher. **Please make your reservation early! We expect the room block to sell out before May 28. NOTE: Last year the room block sold out in April.**

Clinical Workshops

Adam C. Sedlock Jr., MS, AdamSedlock@yahoo.com

Adam C. Sedlock Jr

This year's convention demonstrates PPA's strong clinical component with timely workshops offered by experts in their fields. Drs. Michael Crabtree, Mary E. Schaffer and Elizabeth A. Bennett offer workshops on *Understanding Military Culture* plus *Working with Veterans and Their Families*. *The Implications of the DSM-5 Revisions on the Diagnosis and Treatment of Eating Disorders* will be offered by Dr. Karyn Scher.

Offerings for family practitioners will include *Improving Behavioral Health Treatment for Older Adults Through Professional Collaboration* with Drs. Tod Marion and Carol Luce, and Jessica Strong and Diane Word. Dr. Joanne Wilson will present *Family Attachment Skills Training (FAST): A Clinically Significant and Expedient Treatment for Oppositional Defiant Disorder.* Dr. Lynne M. Kaplan and Johanna Kane from the Children's Hospital of Philadelphia will discuss compassion fatigue in their workshop, *Maintaining Resilience: Do As We Say, and As We Do.*

Treatment modalities for the practitioner will include *The Impact Factor of Anxiety in Bipolar Spectrum Disorder* with Cathy Petchel. Dr. Aaron Brinen will present *Recovery-Oriented Cognitive Therapy (CT-R) for Schizophrenia: Overview and Application*. Treatment modalities will also include a workshop by Dr. Farzin Irani, Matt Riley, and Stephen Sell on *Treating the Addicted Brain: Improving Outcomes Through Understanding Neurological Impairments*.

In line with treatment is *Money and Meaning: Our Psychological Relationship with Money* with Dr. Susan McGroarty, Judith Bijour-Leist, Jennifer Dagia-Edwards and David Lockley. The unmatched quality of all workshop presentations at this year's convention is bound to add to our general fund of knowledge.

Pennsylvania Psychological Association Board of Directors
request the pleasure of your company
at a Retirement Party for

Thomas H. DeWall, CAE

Wednesday, June 19, 2013
6:00 p.m. to 8:00 p.m.
Hilton Harrisburg

The event is FREE to all PPA members.
More details will be available in the convention booklet.

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Workshops on Children, Adolescents, and Schools

Gail R. Karafin, EdD, GRKarafin@gmail.com

Dr. Gail R. Karafin

This year's Annual Convention will provide many interesting workshops relating to children, teens, and schools. Danika Perry and Dr. Barbara Golden will present on the topical issue of assessment and interventions for childhood and adolescent obesity. They will describe key features and risks of the condition and review the empirically supported assessments and treatments, including the use of CBT. They will also address multicultural issues and ethical considerations relating to obesity.

In the clinical area, Dr. Mark McGowan will present on risk assessment and school safety planning. He provides guidelines for a multi-tiered approach for prevention and intervention. He will review best practices for risk assessments for violence and identify research-based intervention and treatment models. Dr. Peter Langman will round out this topic on violence in his workshop focusing on violence on college campuses. He is a renowned expert on school shootings, and he will describe the types of rampage shooters and their warning signs.

In the area of disabilities, Drs. Marie McGrath and Valerie Vogel Ross will address issues related to best practices for helping students with disabilities transition successfully to college. They will discuss the legal obligations of secondary and post-secondary institutions as they relate to students with disabilities, the most common disabilities that impact on college students. They will also discuss the assessment batteries that meet post-secondary requirements and link the results to empirically supported accommodations.

Steven Kossor will present on behavioral health rehabilitation services (BHRS) and will describe a model for psychologists to oversee treatment for effective service delivery and a variety of efficient tools for children's homes and schools to collect data and document effectiveness of treatment.

Dr. Jerry McMullen will address gender differences from "womb to tomb" in his workshop. He will discuss the impact of brain structure and hormones for shaping gender differences, and link these differences to developmental trends, communication differences, and coping differences for dealing with feelings and stress. Dr. McMullen will also present the implications for children in home school settings.

Briana Haut and Dr. Patricia Hillis-Clark will report on their three-year study of boys, ages 8 to 18, in a residential treatment facility. They will present the Trauma Informed Care Model, which functions for both the student as well as the organization. The model creates an organization-wide culture of acceptance. The results indicated that use of their model demonstrated improved coping skills, problem solving, safety, autonomy, and a greater sense of life control.

I hope to see you at the convention. I am sure you will be enhanced with new information and skills.

Diversity Workshops

Beatrice R. Salter, PhD, brsalter@verizon.net, and Stephanie Kim Phillips, PsyD, hiejin@zoominternet.net

Dr. Beatrice Salter

Dr. Stephanie Kim Phillips

PPA President Dr. David J. Palmiter has designated "positive multiculturalism" as a significant component of his presidency. Consistent with this, the Committee on Multiculturalism formed a subcommittee to identify and address issues relevant to this topic. This group will present a workshop titled *Psychology as an Inter-Cultural Profession: Developing Ethical Strategies for Bridging Differences*. Using the approach of positive multiculturalism, this workshop will examine the biological basis of bias, group perspectives on culture, and will include exercises on inter-group interactions. The workshop will encourage participants

Continued on next page

Assessment and Ethics Workshops

Molly Haas Cowan, PsyD, mhaas20@yahoo.com

Dr. Molly Haas Cowan

This year's convention will feature several workshops focused on ethics and assessment topics. With regard to assessment, Drs. Janet Etzi and Robert Gordon will present *Way Beyond Symptom Reduction: Enhancing Mental Functioning and Personal Growth*, which will look at tools to assess capacities including self-regulation, emotional experience, and coping. Dr. David Leaman will present *Developing Intimacy in Couples*, which will explore four dimensions of intimacy, as well as tools for assessing these dimensions in interventions with couples.

There will also be multiple workshops focused on different ethical domains. *Telehealth and Psychology: Ethical, Legal, and Clinical Issues*, presented by Dr. Sam Knapp and Rachael Baturin, will use case illustrations to examine the guidelines for engaging in electronic communication with clients. Additionally, Dr. Laurie Roehrich will present *Mindful Ethics in Treating HIV-AIDS Patients*, which will provide an examination of Kitchener & Anderson's Reflective Judgment Model of ethics, particularly as it applies to decision-making around HIV/AIDS issues.

Finally, Drs. John Gavazzi and Sam Knapp will present *Unlearning Ethics*, an interactive workshop that will apply professional standards and ethics to common risk management beliefs to see how well they stand up to scrutiny. As a reminder, three credits of ethics are required for each licensure renewal cycle – why not check out one of these quality workshops to fulfill that requirement?

DIVERSITY WORKSHOPS

Continued from previous page

to be self-aware, non-defensive, and engage in meaningful dialogue about cultural and racial differences.

Dr. Cheryll Rothery will present *Shades of Expression: African American Female Clients' Struggle for Affirmation*. She will seek to enhance psychologists' ability to identify factors germane to the clinical assessment and treatment of African American women, identifying factors that impede and enhance the therapeutic alliance. In *A Step Back to Diversity and Multicultural Training*, Dr. Rothery, along with Margarita Sáenz and Aliece Chen, will explore the development of cultural competence examining multiple dimensions that start with relationships with peers and professors at the beginning of professional training.

Dr. Audrey Ervin's workshop, *The Ethics of Working with LGBTQQ Youth: A Strengths-Based Approach*, will provide guidance in working with this population. Dr. Ervin will include research about LGBTQQ youth and their psychological well-being, as well as helping participants develop "an action plan for multicultural competence" with this population.

Dr. Maureen Osborne will address the "T" part of the LGBT acronym in her workshop *Culturally Competent Therapy: Across the Transgender Spectrum*. Participants will acquire information about the gender identity spectrum and become better able to distinguish between gender identity and sexual orientation and "create a culturally competent treatment plan for gender variant individuals seeking treatment."

In *Issues with Refugees after Resettlement: Intergenerational Issues, Intervention, and Ethical Considerations*, Drs. Takako Suzuki and Narrimone Thammavongsa, and Daisy Chebbet will share their knowledge of the impact of intergenerational conflicts among immigrant families due to acculturation and other psychological and multicultural factors. Participants will gain knowledge that can assist providers in servicing the increasing immigrant population of Pennsylvania.

Drs. Takako Suzuki and Jari Santana-Wynn will present *Acculturation Stress in Latina/o and Asian Immigrants*. They will discuss the complex process of acculturation by immigrants using case presentations. Addressing the unique stressors of Latina/o and Asian immigrants, participants will gain "effective strategies for facilitating adaptation and acculturation" in clients.

Dr. Walter R. Schamber will conduct a workshop entitled *Evaluating Spanish-Speaking Children Using the DAS-II, Early Years Spanish Supplement*. Participants will gain an understanding of populations that can benefit from this tool and understand the administration and interpretation of data obtained from the supplement.

We hope you will be able to join us!

Emerging Technologies and Practice Development

Charles LaJeunesse, PhD, clajeune@misericordia.edu

Dr. Charles LaJeunesse

Please come to this year's convention! It has so many great workshops and terrific presenters it will no doubt be one of our best in years. I have the pleasure of informing you about the workshops that will deal with emerging technologies and practice development.

Drs. Rachel Daltry and Kristin Mehr have a great workshop entitled *Being a Supervisor: Training and Self-care*. They urge those who are supervisors to get training at regular intervals to keep up-to-date and refreshed with new ideas. Next, Dr. Sam Knapp and Rachael Baturin present an ethical workshop entitled *Telehealth and Psychology: Ethical, Legal, and Clinical Issues*. If you are engaged in, or thinking of engaging in telehealth, you may want to attend this workshop.

Next, Drs. Pauline Wallin and Jeffrey Zimmerman plan to inform us on *Building a Thriving Practice Inside and Outside the Box: Understanding Your Professional Goals and Values*. They will address achieving a good fit with your core values, setting up a sound business plan, and how to ethically market your practice.

Dr. Shawn Blue has prepared a superb workshop entitled *Digital Communication Considerations in College Counseling Centers*. In this workshop she will discuss the role of the Internet and other electronic media in counseling centers. Next, two attorneys from the Collaborative Professionals of Central PA, James Demmel and Dawn Sunday, and Dr. Nicole Hiltz will collaborate to present us with an exciting workshop entitled *Collaborative Process for Resolution of Family Disputes: Role of Psychologists*. This workshop serves as an introduction to collaboration, suggesting much more training would be required to engage in this practice.

Drs. Christopher Royer, David Zehrung, and Bradley Norford will present *Top Ten Techs for Psychologists*. The authors assert that attending this workshop will help one's practice through the employment of the technologies discussed in the workshop.

Academia and Supervision Workshops

Cathy Petchel, MA, baywood260@yahoo.com

Cathy Petchel

Our Annual Convention for 2013 will prove to be a wonderful opportunity to connect with our friends and colleagues. The selection of workshops and training possibilities provide diverse and exciting topics. We are pleased to report that the ever-growing realm of academia and supervision will be represented with a handful of relevant and timely sessions that clearly address undergraduate and graduate training.

As we reflect on the diverse membership of PPA, not only focusing on our individual backgrounds and cultural components but on our own particular fields of practice, I am struck by the fact that we are all teachers and supervisors of sorts. Whether we work with clients, students, staff, business development, and/or service projects we bring to the table our expertise and our ability to teach and guide. For those of us actively working within colleges and universities we welcome learning opportunities that equip us with current information and training as it relates to not only the interaction with each student but communication process within the institution. With the growing number of graduate students matriculating into the field and needing sound supervisory guidance, we need to be equipped with clear guidelines and expectations.

The following programs will enhance your understanding of working in the academic setting and supervisory role:

- *The Nuts and Bolts of Postdoctoral Supervision* by Dr. Samuel Knapp and Rachael Baturin
- *Effective Mentorship for Diverse Graduate Students: A Didactic and Experiential Analysis* by Drs. Ruth Benns-Suter and Jeanne DiVincenzo
- *The Elements of Clinical Supervision by Dr. Maria Somova*
- *Being a Supervisor: Training and Self-Care* by Drs. Rachel Daltry and Kristin Mehr
- *Digital Communication Considerations in College Counseling Centers* by Dr. Shawn Blue

The "Other" Workshops

Mary Pat Cunningham, MA, mpc380@verizon.net

Mary Pat Cunningham

Over the years, a tradition of the Convention Committee has been to write articles for the March issue of the *Pennsylvania Psychologist*. Our goal is to whet the appetite of those psychologists attending the convention in June. We typically group newly chosen workshops into categories such as child, clinical, and ethics, to name a few. This year we selected a few workshops that fell slightly outside our time-honored categories hence, the "other" workshops. I'm excited to highlight these workshops and to add them to our lineup for June.

Two workshops will focus on the collaboration between psychologists and physicians. First, Drs. Heather Hoover, Shelley Hosterman and William Gianfagna, MD, will present *Enhancing Psychology's Relationships and Relevance to Primary Care Physicians*. Their mission is to identify free screening tools that PCPs can utilize to identify developmental, behavioral, and emotional concerns in children and adolescents. They will discuss the pros and cons of physician use of behavioral health screening tools. Additionally, Drs. Paul Kettlewell and Lauren Hazzouri, along with Lisa Hutton, MD, and graduate student, Kylie McColligan, will present a workshop entitled *Effective Collaboration Between Psychologists and Pediatricians: Research Review and Strategies*. This program reviews outcomes from the Pennsylvania Pediatric Mental Health Task Force, a collaboration between PPA and the Pennsylvania Chapter of the American Academy of Pediatrics. It also teaches pediatricians how to screen for mental health concerns during children's well visits in a way that is cost effective.

Spirituality Across the Life Span: From Identity to Gerotranscendence will be presented by Dr. Gail Cabral. While borrowing concepts from Erikson and Kegan, she will identify dimensions of spirituality in psychosocial tasks at different points in the lifespan.

Lastly, Drs. Ellen Adelman, Marianne Intoccia and Gail Vant Zelfde will help us deepen our compassion and insight for patients in *Mind Body Intelligence: Compassion-based Psychotherapy and Clinician Self-Care*. Those attending will acquire tools to be able to use some self- healing practices for mind, body and spirit.

These interesting and unique "other" workshops promise to pique our interest and complement the convention's strong tradition of excellence. See you there!

Attention Students and Early Career Psychologists!

Allyson L. Galloway, PsyD, drallysongalloway@gmail.com, and George Herrity, MSW, gherrity@live.carlow.edu

"I have attended every year since 2005," says Dr. Galloway, "and I am already looking forward to June to see the many friends I've made!"

There is so much to look forward to at the annual convention! Friday, June 21, is Student and Early Career Psychologist Day, but the whole convention offers programming relevant for us.

First, the research poster session offers an excellent opportunity to get your feet wet presenting your research to an interested crowd of professionals (it's great for your CV, too).

Then there's the student and ECP awards ceremony, where you can show your support for your colleagues, and you'll definitely want to stay around for the student and ECP networking reception on Friday night! The wine and cheese reception is free for students and ECPs, and offers speed mentoring with seasoned professionals in a relaxed and informal setting. There are also plenty of opportunities to socialize and there are usually groups heading out for dinner or drinks nightly throughout the convention.

Dr. Allyson L. Galloway

George Herrity

One presentation that is particularly relevant for students and ECPs is *The Nuts and Bolts of Postdoctoral Supervision*, which is being presented by Dr. Sam Knapp and Rachael Baturin.

The discounted registration fee is very reasonable, only $65 for the whole convention, for student PPA members and first-year post-doctoral residents. And for those on a tight budget the registration fee is waived entirely for students willing to volunteer to help out for a few hours during the convention.

If you are debating whether attending the convention is feasible for you, or even trying to decide whether PPA or APA is the right choice, we strongly suggest attending PPA's annual convention. In our experience it is invaluable, especially for those planning on remaining in Pennsylvania, for informative learning opportunities and many wonderful networking experiences.

Now THAT's What I Call "Icing on the Cake!"

David A. Rogers, Ph.D., HersheyPsychSvcs@aol.com

Dr. David A. Rogers

When I started crafting this article, Christmas was in full swing and New Year's was on the horizon. As I reflected on what I wanted to communicate about the convention's slate of "fun" I was struck by two immediate thoughts.

The first was that my home was permeated by the delicious smell of my wife Nancy's renowned chocolate cherry cake which was in the final stage of baking before the "crown jewel," a rich and gooey fudge icing, is applied.

The second was that we would soon be saying goodbye to 2012 and hello to 2013. New Year's and our Annual Convention have a lot in common. For most of us, the Annual Convention is a cost- and time-efficient way to accrue many of our necessary licensure CEs and to network with our colleagues. And, our Annual Convention is both the end and the beginning of an organizational year. It is the time when we applaud and highlight the accomplishments of the current leadership team and subsequently welcome and celebrate the start of the new leadership team.

The 2013 Annual Convention will be both familiar and unique in many ways. As expected, the event will offer our customary "menu" of fun and relaxation but we are going to start with "the icing on the cake!" More specifically, on the first day of the convention there will be a retirement party for our executive director, Thomas H. DeWall, CAE, which will be free to PPA members. Tom has served PPA for over 26 years, and there will be a celebration to thank him for the years that he has blessed us with his time and talents.

As the convention continues, so do the opportunities to "have your cake and eat it too!" On Thursday we will again be offering the Mind-Body River Walk where you can join your colleagues for a fun morning walk along the beautiful Susquehanna River. Then you can join us at the Annual Banquet where the "gavel is passed" from outgoing President Dr. David Palmiter to his successor, Dr. Vincent Bellwoar. Later that day is the Annual Exhibitors' Networking Cocktail Party (free to registered attendees) at which time you may browse the exhibitor booths (free stuff) while partaking nourishing (free) food!

The convention fun wraps up on Friday with an evening reception for ECPs and graduate students, followed by a dance by Flashback Band from Harrisburg performing "flashbacks" from the 60s, 70s, 80s, and 90s! And, there will be selections which could be considered more "flash-forwards" with hits by Adele, Duffy, and Maroon Five!

While I cannot give you the recipe to Nancy's chocolate cherry cake, I can assure you that the recipe for fun being served up by this year's Convention Committee at the Annual Convention will not leave you disappointed! Come join us as we celebrate the past, thank Tom for his service, and look expectantly to the coming year! Now THAT's what I call "icing on the cake!"

What Impact Will the Affordable Care Act Have on the Practice of Psychology in Pennsylvania?

Samuel Knapp, EdD, Director of Professional Affairs

Dr. Samuel Knapp

These are times of extraordinary change and stress for psychologists with several major changes occurring at around the same period of time. In addition to changes in the CPT codes, the DSM, Medicare, and electronic medical records, we are anticipating the implementation of the major provisions of the Affordable Care Act (ACA) in 2014.

What change will the ACA have on the practices of psychologists? My best guess is to think of the impact of the ACA on psychology in terms of 40-40-20 (40% of psychologists will be impacted little, 40% impacted somewhat, and 20% impacted a lot). But I could be wrong; ultimately it may be 40-20-40 or some other configuration. Nonetheless, here is my reasoning.

According to PPA surveys, about 15% of our members work full-time in an institutional setting that does not rely on third-party reimbursement (public schools, college counseling services, or prisons). About 15% of psychologists have independent practices that are primarily self-pay (either in psychotherapy, forensic work, coaching, or some combination of these). Finally, about 10% of psychologists have practices that largely depend on funding streams that will be impacted very little by the ACA (such as Medicaid/BHRS, Workers Compensation, auto insurance, vocational rehabilitation, Social Security disability evaluations, or Medicare). Of course, the ACA will have some impact on many of these psychologists. For example, many psychologists employed in institutions have part-time practices that use commercial insurance; some self-pay patients of psychologists submit bills to insurers for third-party reimbursement; and many psychologists have mixed sources of income so that a psychologist who relies primarily on Medicare, for example, may have some patients covered by commercial contracts. However, these psychologists will be able to continue to practice with relatively little disruption caused by the ACA.

The ACA is more likely to impact the 60% of psychologists who rely heavily on commercial third-party reimbursement. It remains to be seen whether the overall impact of these changes will be positive or negative. On the positive side, the ACA will increase demand for services because insurance policies will be paying for preventive services (such as programs to reduce excess weight or smoking cessation). Also the ACA will increase coverage for the 12% of Pennsylvanians who are currently uninsured. About half of the currently uninsured Pennsylvanians will be covered by health care exchanges, which must cover mental health services. The other half will be eligible to be covered by an expanded Medicaid program if Pennsylvania approves such an expansion. (As we go to press Pennsylvania has not yet made a decision whether to accept the Medicaid expansion, although Governor Corbett has come out against it.) At a minimum the existence of the health exchange will increase the number of patients with commercial third-party reimbursement by more than 10%.

The economics of health care are that a few patients account for a disproportionate amount of health care costs.

On the uncertain side, the practices of psychologists will be impacted by the spread of accountable care organizations (ACOs) or medical homes. Medicare is beginning to use ACOs, but no federal law requires commercial insurers to do so, although insurers can get financial incentives for starting them. Consequently, the extent to which health insurers will adopt ACOs or medical homes is uncertain.

The economics of health care are that a few patients account for a disproportionate amount of health care costs. About 5% of patients are responsible for 50% of all health care costs (Kuehn, 2012) and 10% of patients are responsible for 64% of all costs (Emmanuel, 2012). About three-fourths of the high-cost patients had seven or more major chronic conditions (Emanuel, 2012). It is believed that the rate of increase in health care costs can be reduced substantially if more efficient and effective treatment were provided to these patients with serious medical conditions. The functions of the ACOs and medical homes are both to improve care and to reduce costs for these patients with serious illnesses.

It is unknown how extensively commercial insurers will adopt ACO models or medical homes or, if they do so widely, how much psychologists would be impacted. It is possible that psychologists heavily dependent on insurance will be located in an area where there is enough of a market outside of ACOs and medical homes so that their practices will not be impacted a great deal. On the other hand, some psychologists may find traditional referral patterns change substantially if the insurers in their areas adopt ACOs or medical homes on a widespread scale. It is possible that psychologists with outpatient practices heavily dependent on health insurance could lose a substantial portion of their referrals if the local hospital or health insurer invests heavily in an ACO or medical home and use their own mental health staff. On the other hand, it is possible that the same psychologists could see an increase in practice opportunities if they convinced the ACO that they could provide these services effectively and efficiently.

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How Psychologists Function in the Canadian Health Care System

Kathryn L. Vennie, MS

Kathryn L. Vennie

As we contemplate vast changes in health care delivery under the Affordable Care Act, it is worth looking at how psychologists function in our neighbor to the north. The author investigated this mainly through interviews and e-mail correspondence with two Canadian psychologists. Larry S. Fong, PhD, a psychologist in private practice in Calgary, specializes in forensic issues. John Pearce, PhD, is a psychologist employed in a hospital-based practice at the Alberta Children's Hospital in Calgary. Members of the Bulletin Committee submitted a number of questions to our Canadian colleagues. The responses of Drs. Fong and Pearce are summarized in this article.

Questions about education, licensing, and levels of practice were of great interest. Each Canadian province, except for the Yukon Territory, has its own governing board for the licensing or registration of psychologists. There is no legislation governing the practice of psychology in the Yukon. Doctoral programs are accredited by the Canadian Psychological Association. The accreditation process is much more recent than the APA process in the United States. APA has no accrediting or licensing authority in Canada, but some Canadian psychologists have graduated from U.S. programs that are APA-accredited. PsyD programs are notably absent in Canada. There is one French-language PsyD program in Montreal. All Canadian training programs in psychology are university-based. There are no "professional schools."

While all provinces license or register psychologists at the doctoral level, many also credential at the master's level. British Columbia, Manitoba, and Ontario grant master's-level psychologists the title of "psychological associate," but the scope of practice is "independent practice." Prince Edward Island grants the title of "psychologist" at the master's level, but restricts "independent practice" to within an institution or agency. New Brunswick is currently implementing a grandfather clause: persons studying for a master's degree will be eligible to practice independently as psychologists if their degrees are granted before July 1, 2014. Quebec is currently the only province to mandate the doctoral degree. Many provinces do not require the EPPP (see www.cpa.ca/education/accreditation/PTlicensingrequirements/).

Hospital-based practice

Both Dr. Pearce and Dr. Fong said many psychologists are practicing in Canada, especially within hospital-based teams. Offering a typical scenario, Dr. Pearce described a multidisciplinary team in medical settings such as a fetal alcohol clinic in which the psychologist mostly does evaluations. In other clinics, such as pain management or disease management, psychologists on the team may provide more therapy. He stresses that Canadian physicians appreciate psychologists' contributions to good patient outcomes. Within hospital settings, psychologists are employees with salaries and full benefits. Psychologists are organized under the Health Alliance, which is a union. According to Dr. Pearce, the hospital provides all services with funds provided by the provincial Health Services, not private insurance. These funds are provided through a general "medicare" fund. Each family pays a premium or "tax" and the medical care they receive, including psychology, social work, and speech/language, are provided at no additional cost.

When asked about Canadian psychologists' response to DSM-5, Dr. Pearce replied that hospital-based psychologists do no billing and do not need diagnostic codes for their routine work. The response to DSM-5 has been minimal. Dr. Fong said controversy regarding the DSM-5 is not as intense as in the U.S.

With regard to ethical concerns within the hospital, psychologists must work hard to make their voices heard at upper-management levels. The chief of psychology may sit on many management committees. The issues of conflicting and competing interests are similar to those in any large organization, including U.S. hospitals and large agencies. Each province has its own ethics code, but they are quite similar. The provinces also have voluntary membership organizations similar to PPA.

Because hospital records are centralized, hospital-based psychologists do not have to contend with subpoenas for record releases. When a request for records is received by a psychologist, it is forwarded to a central office, where a records specialist determines what is to be released. The psychologist then approves the information being released.

Each family pays a premium or "tax" and the medical care they receive, including psychology, social work, and speech/language, are provided at no additional cost.

Cultural diversity is increasing in Canada due to a liberal policy toward refugees and a long history of working with Aboriginal peoples (First Nation). At the Alberta Children's Hospital, an Aboriginal psychologist is on staff. The hospital also maintains a cultural diversity committee and a full range of translators. Dr. Pearce notes that the increasing diversity in the population is challenging, but the philosophy is definitely to accommodate.

Due to the expansive rural areas of Canada, Dr. Pearce states that telehealth is utilized extensively to facilitate

consultation between hospital staffs and rural health clinics and other rural agencies. At the Alberta Children's Hospital, however, all initial evaluations are done on an in-person basis. Much of that work involves evaluations for child abuse. Dr. Fong describes some experience with Skype, but does not use it extensively. Colleagues who work with business executives and sports psychologists tend to use it more, because their clients may be anywhere in the world. Telehealth standards and guidelines for ongoing therapy are still evolving in Canada as in the United States, but the concept has long been accepted.

Canada's private practitioners

In a private practice such as Dr. Fong's, important differences exist. For each province, the College of Psychologists issues standards and guidelines for practice, rather than the uniform guidelines of APA in the United States. While the ethical guidelines are similar, variations can occur in specific standards such as those governing child custody evaluations or dealing with dependent adults.

Dr. Fong points to the variation in the types of ethical quandaries that may be seen in a private practice. The nature of ethical issues differs with the type of work done, but the work must follow the standards published by the provincial College of Psychology (see www.cap.ab.ca for examples). He also notes that communication with a psychologist in Canada is not privileged as it is in the States. This limits the confidentiality of files and records and causes special concern when names of others or similar references are mentioned in a file.

Another issue is that of informed consent. In the U.S., a distinction exists between a client under a court order to participate in an evaluation and a client doing so under personal informed consent. The former may not simply withdraw from the proceeding, and doing so would typically result in additional court action. According to Dr. Fong, in Canada a client may withdraw consent even in the middle of a court-ordered process such as a child custody evaluation. An individual in Canada is entitled to claim as a medical expense the fee paid for a psychologist to testify in court.

Diagnostically, Dr. Fong states that the DSM-IV-TR and the ICD-9 are used in private practice because some clients have private insurance such as Blue Cross, so the codes are necessary for billing. Most clients pay their private practitioners, get a receipt for income tax purposes, and collect their own reimbursement. Dr. Fong notes that some billing might be done directly to EAP services.

In Canada the Aboriginal people receive psychological services from the same psychologists who serve the general population, so cultural sensitivity to diagnosis is essential. In the United States we have the Indian Health Service, which employs psychologists on reservations. Consequently, most psychologists in general hospitals or private practices here do not become familiar with the cultural nuances of the Native American population. Dr. Fong strongly believes economics should not influence diagnosis, but that cultural issues may be very important.

Private mental health services are also provided by social workers. Reimbursement is available for fees paid to licensed social workers covered under Canada's Health Professions Act. Counselors, however, are not covered, and it would be unlikely that extended insurance (Blue Cross) would reimburse for their services. Nurse practitioners are covered by health care funding if they are employed by the government or work at an agency funded by the government. Psychologists in private practice are not unionized.

Dr. Fong notes that at one time there were more psychologists per capita in Calgary than in California. In his experience, there has not been much competitive pressure from other providers, although physicians and chiropractors may do some counseling. The title "psychologist" and its derivatives are protected under the law. Most private practice psychologists get their referrals from a wide range of sources, and practices seem to be doing well. Some aspects of private practice may be subsidized, such as in areas of child welfare. In those cases, the government agency can limit the services provided. Most extended insurance companies tend to have annual limits rather than specific code-related fees. This eliminates the need for authorizations for services such as testing. Health spending accounts are also available in Canada.

As in the U.S., a leading cause of licensing board complaints involves child custody evaluations. Boundary violations are another major cause of complaints. Each provincial college provides statistics regarding complaints on its website. Only cases are mentioned, not names.

As we in the United States look to the future, we can learn much from our Canadian colleagues about how to function in a more unified health care system. We also need to make our voices heard in the shaping of our system. We have to keep our focus on the needs of our future clients as well as maximizing emerging technologies. We must be prepared to "meet our clients where they are."

Thank You

Many thanks to our Canadian colleagues, Drs. John Pearce and Larry Fong, for their generous help with this article.

Larry S. Fong, PhD, is a psychologist, mediator, and arbitrator in Calgary, Alberta, since 1982. Dr. Fong is a member of APA and is on the board of directors of the Association of Family and Conciliation Courts. More information on Dr. Fong can be found at his website: www.FongMediate.com.

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The Importance of Health in Universal Health Care: A Social Justice Perspective

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Joy B. Krumenacker

Universal health care has been an ongoing topic of discussion in our country for many years, and for many years politicians were unsuccessful in reaching an agreement that would help bring some resolve to the health care crisis in the United States. Until last year the last significant health care change was made in 1965 when Medicare and Medicaid were implemented. In July 2012, the Patient Protection and Affordable Care Act (PPACA) was passed and will be fully implemented beginning in 2014. The PPACA aims to implement a mandated system of universal health care in the United States that will decrease the number of uninsured citizens and also decrease overall health care costs.

Universal health care is a system in which all citizens of a nation have access to affordable, high-quality medical care. Until PPACA was passed, the United States remained the only industrialized nation in which citizens are not guaranteed the right to health care, leaving approximately 46 million Americans uninsured. Reports from the Physicians for a National Health Care Program state that the U.S. spends twice as much (over $8,000 per capita) as other industrialized nations on health care, but also having the highest chronic disease rates of all industrialized nations. The World Health Organization (WHO) reported that 88% of deaths in the US are due to chronic diseases such as cardiovascular disease, cancer, and diabetes. It is projected by 2015, 87% of men and 83% of women will be considered to be "overweight" – a considerable factor in the prevalence of chronic disease. Data from the WHO demonstrates that countries such as the United Kingdom, Japan, and Germany that have adopted universal health care have less chronic disease, hence, fewer health care related costs (WHO, 2013).

PPACA will bring changes to our health care system and in theory we will see a decrease in the uninsured and a decrease in the overwhelming costs that are incurred each year. However, as we place energy and emphasis into health care, we cannot ignore the more important factor which is health. Are we, as citizens of an industrialized nation, able to take our health – both physical and mental health – seriously enough to prolong our lives? The WHO (2013) estimates that 80% of premature heart disease, stroke, and type II diabetes could be avoided as well as 40% of cancers within the U.S. with proper prevention. Prevention is something that is easier for some than others. As childhood obesity rates skyrocket, we see how improper nutritional practices as well as limited physical activity in our children have become much too common. As the future of this country, these children deserve the opportunity to live a life of health and well-being. Yet without examination of the conditions in which they are given to grow and develop, they may never have that opportunity.

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As psychologists, it is of utmost importance that we take a more active role by becoming more cognizant of disparities in our communities and examining our current approaches and the research around them. Through a social justice examination, we will have a clearer understanding of factors such as the impact of culture, gender, race, age, and class (income, occupation, education, wealth) when assessing health needs. We will become more aware of the availability of resources, as well as the attitudes of members of our communities when assessing health and disease. The disparities that are seen across our communities are quite evident and we know that persons with a lower socioeconomic status have a higher probability of negative health status such as early disease, infectious disease, and malnourishment. I also believe it is fair to say that these persons have had a lack of knowledge and/or access to quality foods and resources that promote healthy living.

Social class is the core of living: it is both our physical and social environment, comprised of supports, violence, resources. Social class also dictates much of our personality and mood as well as our behaviors – including our behaviors surrounding health (Adler, et al., 1994). Research has demonstrated that social class has an inverse relationship with neonatal adjustment (Field, et al., 2002), adolescent physical and emotional well-being (Brady & Matthews, 2002), adult health risk behaviors (Lynch, Kaplan, & Salonen, 2002), and mortality, quality of life, and cognitive functioning in seniors (Bassuk, Berkman, & Amick, 2002). Clearly this demonstrates that across the lifespan, social class has an impact on our overall health and well-being. This construct is important to psychologists because without integration into practice, problems and assumptions cannot adequately be addressed and therefore we move further from the notion of prevention.

Having the knowledge of how social class can impact health, wellness, and development will allow us to become strong advocates for community members and the need for inclusion of quality psychological services in the upcoming health care reform. Significant cuts to the mental health and substance abuse budgets in Pennsylvania this year demonstrate that we need to be able to ensure that our citizens, especially our

most vulnerable citizens, are granted a health care approach that encompasses a biopsychosocial philosophy that encourages less disease and more longevity and overall life satisfaction. Universal health care will not solve all of our health care problems; there are many pros and cons that will continue to be debated beyond its implementation in the upcoming years. However, it is an enormous change to watch our nation move towards a system that supports whole health integration and quality care to all individuals, regardless of race, age, gender, and social class. And after all, a healthy individual is part of a healthy community, and healthy communities are the foundation of a healthy society. And we all deserve that.

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Leader of the Pack

As in the past dozen years Pennsylvania has received far more votes in the APA apportionment balloting for 2014 than any other state, provincial, or territorial association (SPTA). Each year APA members vote to apportion seats on the Council of Representatives to SPTAs or divisions. The voting took place in the fall with results released in late December.

PPA retained its two seats on the council, as did New York, California, and New Jersey. All other SPTAs were awarded just one seat. The top vote-getters were:

PA	4.21%	NJ	2.71%
NY	3.08%	MA	2.16%
CA	2.88%	IL	2.14%

Four SPTAs received between 1.3% and 1.5% of the vote, and all others got less than 1%.

The APA governance system is skewed toward divisions rather than SPTAs. The undemocratic nature of the representation on the APA Council is reflected in the fact that 5 divisions were each awarded 3 seats while earning only less than 2.8% of the votes. Another 2 divisions got 4 seats while attracting fewer votes than PPA got.

WHAT IMPACT WILL THE AFFORDABLE CARE ACT HAVE...?

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The manner in which health providers would be paid by ACOs or medical homes may vary. Some may be paid on the regular basis of a fixed payment for a unit of service. Others may be paid on the basis of patient outcomes. Some may be paid on the basis of a combination of these plans.

Psychologists who are dependent heavily on insurance will be more likely to benefit from these changes in health care delivery if they (1) have established a relationship with physicians or health care systems; (2) have expertise in treating high-cost patients, such as patients with co-morbid medical disorders; (3) are willing to consider greater integration or coordination of their services with medical health care delivery systems; (4) have an outcomes system in place; and (5) have an interest in delivering preventive services, such as in controlling excess weight or smoking cessation.

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PennPsyPAC Contributors, 2012

Many PPA members went above and beyond the call of duty to help ensure the viability and effectiveness of the Pennsylvania Psychological Political Action Committee (PennPsyPAC). We are listing here those who contributed at least $100 during the last calendar year. Many others contributed amounts less than $100; they are not listed here but will be listed in the pamphlet distributed at the annual convention. Thanks to each and every one of you!

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How to Properly Opt Out of Medicare

Rachael L. Baturin, MPH, JD, Professional Affairs Associate


Rachael L. Baturin

Generally, doctoral level psychologists (called "clinical psychologists" by Medicare) must accept assignment for all Medicare claims for their services. However, psychologists may decide that they want to opt out of Medicare and create private contracts with patients. Psychologists who wish to sign private contracts with their Medicare patients (opt out of Medicare) can do so on the first day of each calendar quarter. In order to opt out of Medicare, psychologists need to follow the specific procedure described in Chapter 4 of the Medicare Part B Reference Manual (https://www.highmarkmedicareservices.com/refman/chapter-4.html).

Psychologists who are licensed with terminal master's degrees (called "independently practicing psychologists" by Medicare) are reimbursed by Medicare only for outpatient psychological testing based on a physician's referral. When providing psychotherapy for Medicare beneficiaries, psychologists at the master's level can develop private fee arrangements without having to go through the opt-out process (described below).

To opt out of Medicare, psychologists need to send an affidavit to all Medicare carriers where they submit claims stating that they want to opt out of Medicare. In Pennsylvania, the local Medicare carrier is Novitas Solutions, Inc., attn: Provider Services Enrollment, P.O. Box 890157, Camp Hill, PA 17089-0157. The affidavit must be submitted at least 30 days prior to the beginning of the calendar quarter. Thereafter, on the first day of the calendar quarter the provider's participating agreement will be terminated and all services performed on or after the first day of the calendar quarter fall under the opt-out provisions. Psychologists may not provide services under private contracts with beneficiaries earlier than the effective date of the affidavit.

To be valid, the affidavit must:

- Be in writing and be signed by the psychologist.
- Contain the physician's or practitioner's full name, address, telephone number, national provider identifier (NPI) or billing number (if one has been assigned), uniform provider identification number (UPIN) if one has been assigned, or, if neither an NPI or a UPIN has been assigned, the psychologist's tax identification number.
- State that, except for emergency or urgent care services, during the opt-out period the psychologist will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §3044.8 for services that would have been covered by Medicare (for their provision under a private contract).
- State that the psychologist will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will the psychologist permit any entity acting on his/her behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in §3044.28.
- State that, during the opt-out period, the psychologist understands that he/she may receive no direct or indirect Medicare payment for services that he/she furnishes to Medicare beneficiaries with whom he/she has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare + Choice plan.
- State that a physician/practitioner who opts out of Medicare acknowledges that, during the opt-out period, his/her services are not covered under Medicare and that no Medicare payment may be made to any entity for his/her services, directly or on a capitated basis.
- State an acknowledgment by the psychologist to the effect that, during the opt-out period, the psychologist agrees to be bound by the terms of both the affidavit and the private contracts that he/she has entered into.
- Acknowledge that the psychologist recognizes that the terms of the affidavit apply to all items covered by Medicare and services furnished to Medicare beneficiaries by the psychologist during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom he/she has not previously privately contracted) without regard to any payment arrangements the psychologist may make.
- With respect to a psychologist who has signed a Part B participation agreement (participating provider agreement), acknowledge that such agreement terminates on the effective date of the affidavit.

To opt out of Medicare, psychologists need to send an affidavit to all Medicare carriers where they submit claims stating that they want to opt out of Medicare.

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HOW TO PROPERLY OPT OUT OF MEDICARE

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- Acknowledge that the psychologist understands that a beneficiary who has not entered into a private contract and who requires emergency or urgent services may not be asked to enter into a private contract with respect to receiving such services and that the rules of §3044.28 apply if the psychologist furnished such services.
- Identify the psychologist sufficiently so that the carrier can ensure that no payment is made to the psychologist during the opt-out period. If the psychologist has already enrolled in Medicare, this would include the psychologist's Medicare UPIN, if one has been assigned. If the physician/practitioner has not enrolled in Medicare, this would include the information necessary to be assigned a UPIN.
- Be filed with all carriers who have jurisdiction over claims the psychologist would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into.

In addition, psychologists must enter into a private written contract with the Medicare beneficiary. In the private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the psychologist and to pay the psychologist without regard to any limits that would otherwise apply to what the psychologist could charge. Chapter 4 of the Medicare Part B Reference Manual lists the requirements for each private contract. The requirements of a private contract are as follows:

- Be in writing and in print sufficiently large to ensure that the beneficiary is able to read the contract.
- Clearly state whether the psychologist is excluded from Medicare under §§1128, 1156 or 1892 of the Social Security Act.
- State that the beneficiary or his/her legal representative accepts full responsibility for payment of the psychologist's charge for all services furnished by the psychologist.
- State that the beneficiary or his/her legal representative understands that Medicare limits do not apply to what the psychologist may charge for items or services furnished by the psychologist.
- State that the beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the psychologist to submit a claim to Medicare.

When psychologists opt out, they have opted out of Medicare for **ALL** *of their patients.*

- State that the beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the psychologist that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- State that the beneficiary or his/her legal representative enters into the contract with the knowledge that he/she has the right to obtain services covered by Medicare from psychologists who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other covered Medicare services furnished by other psychologists who have not opted out.
- State the expected or known effective date and expected or known expiration date of the opt-out period.
- That the beneficiary or his/her legal representative understands that Medigap plans do not (and other supplemental plans may elect not to) make payment for items and services not paid for by Medicare. (As a practical matter, psychologists should be aware that the terms found in many commercial health insurance policies state that these policies automatically become Medigap policies after a specific period of time. Some patients who believe that they do not need to bill Medicare because they also have a commercial health care policy may not be aware that their commercial policy has reverted to a Medigap policy).
- Be signed by the beneficiary or his/her legal representative and by the psychologist.
- Not be entered into by the beneficiary or by the beneficiary's legal representative during a time when the beneficiary requires emergency care services or urgent care services.
- Be provided to the beneficiary or to his/her legal representative before items or services are furnished to the beneficiary under the term of the contract (a photocopy is permissible)
- Be retained by the psychologist for the duration of the opt-out period (original signatures of both parties required).
- Be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.
- Be entered into for each opt-out period (2 years).

In order for a private contract with a beneficiary to be effective, psychologists must file an affidavit with all Medicare carriers to which they would submit claims, advising that they have opted out of Medicare. The affidavit must be filed within 10 days of entering into the first private contract with a Medicare beneficiary. Once psychologists have opted out, they must enter into a private contract with each Medicare beneficiary to whom they furnished covered services (even where Medicare payment would be on a capitated basis or where Medicare would pay an organization for the psychologist's

services to the Medicare beneficiary), with the exception of a Medicare beneficiary needing emergency or urgent care.

If psychologists have opted out of Medicare, they must use a private contract for services that are, or may be, covered by Medicare (except for emergency or urgent care services). Opt-out psychologists are not required to use a private contract for a service that is definitely excluded from coverage from Medicare.

Only individuals can opt out; businesses cannot. When psychologists opt out, they have opted out of Medicare for **ALL** of their patients. That is, a patient can sign a private contract with one of his or her doctors, but the doctor is either in Medicare completely or out of Medicare completely. If psychologists opt out with one Medicare carrier (i.e. Pennsylvania), they are then opting out with all other carriers.

Psychologists must opt out for a two-year period, and they have to renew the opt-out every two years if they choose to continue to opt out. Psychologists may renew an opt-out without interruption by filing an affidavit with each carrier, provided the affidavits are filed within 30 days after the current opt-out period's expiration. If psychologists fail to renew their opt-out, they will automatically become a Medicare provider again and they will be reassigned the same UPIN that they used before opting out.

If psychologists decide that they no longer want to opt out of Medicare after their affidavit has been approved by Medicare, the opt-out may be terminated within 90 days of the effective date of the affidavit. To properly terminate an opt-out, a psychologist must:

- Not have previously opted out of Medicare.
- Notify all Medicare carriers with which he/she filed an affidavit of the termination of the opt-out no later than 90 days after the effective date of the opt-out period.
- Refund to each beneficiary with whom he or she has privately contracted all payments collected in excess of:
  - The Medicare limiting charge; or
  - The deductible and coinsurance.
- Notify all beneficiaries with whom the psychologist entered into private contracts of the psychologist's decision to terminate opt-out and of the beneficiaries' right to have claims filed on their behalf with Medicare for services furnished during the period between the effective date of the opt-out and the effective date of the termination of the opt-out period.

Under the opt-out provisions, psychologists are not permitted to submit claims for Medicare payment except for emergency or urgent care services rendered to a patient with whom a private contract has not been signed. If an opt-out psychologist submits a claim for payment that is not an emergency or urgent care situation, the psychologist will have been deemed in violation of the opt-out provisions and his private contracts with any and all beneficiaries will be deemed null and void. Thereafter, psychologists must submit all Medicare claims to the carrier for the duration of their opt-out period (though payment will not be made by the carrier). In addition, the psychologist must abide by the limiting charge provisions, thus collecting payment from only the beneficiary up to the limiting charge amount.

Developing Interventions for Gifted Students With ADHD and Executive Function Difficulties

Timothy King, PhD

Dr. Timothy King

There are probably no learning disabilities that are without cost. Educators and psychologists are not always in agreement, but few would dispute the reality that having a learning disorder almost always carries with it at least some emotional toll. However, stating that the emotional consequences of one learning problem are higher than those of another would likely generate a stormy debate, to say the least. The purpose of this article is not to settle a potential controversy regarding prioritization of emotional problems, but rather to raise the awareness of psychologists to understand that gifted students with ADHD and executive function difficulties can struggle with unique emotional consequences, likely due to the cognitive dissonance experienced by teachers who work with them as well as the students themselves.

George McCloskey (McCloskey, Perkins & Van Divner, 2009), school psychology researcher and one of many individuals involved in the development of earlier versions of the WISC, has clarified the reality that an individual can have executive function problems without ADHD but not have ADHD without executive function problems. We learned, in our trials of the use of ADHD medications, from researchers such as Russell Barkley (Barkley, 2006), that stimulant medications may temper some of the impulsivity and disruptive behavior of ADHD students, but they do not improve their ability for interpersonal/reciprocal sensitivity and engagement. Thus, we were educated into the reality that these students still had to be "taught" and guided into practicing ways to become more sensitive/attuned interpersonally and more effective in interpersonal problem-solving.

Unfortunately, the above-outlined ADHD medication lesson has not uniformly found its way into the minds of parents and educators working with gifted students with ADHD and executive function problems. Very often gifted students with executive function problems can be actively engaged and even be leaders in classroom discussions (Fiedler, 2007). Their elevated cognitive competencies often aid them in quickly discerning conceptual connections and insights that their classmates fail to grasp or overlook.

As Fiedler (2007) notes, gifted students can sometimes feel that organization requires mundane work that their brains simply are not set up for.

Yet, there can still be a reaction of "surprise" by some parents and teachers when some newly medicated gifted students with ADHD and executive function problems stop staring off into space and disturbing other students, yet they still may not suddenly start completing classroom assignments or homework. One of the many contributions that McCloskey and his colleagues (2009) made to the field is to help us to understand that the reason why some students do not modify their production patterns after being placed on medication has to do with the reality that ADHD medications treat only several of the 23 executive functions. As the aforementioned authors note, "... these are self-regulation capacities that are used to varying degrees and in varying combinations to direct and cue our sensing, thinking, feeling and acting" (p. 40). Thus, as psychologists and therapists, we may need to help parents and teachers understand that executive functions such as initiation, persistence, monitoring, and organization may all have to be addressed for a student to initiate a task, sustain engagement and, ultimately, complete an academic task.

Effectively communicating such understandings could offer parents and teachers important tools for beginning to more effectively assist the children they are working with who are not producing in school.

So, why is the emphasis in this article on gifted students with ADHD and executive function difficulties? The principal reason for this focus is this author's concern that gifted students with these issues often "stay under the radar." Further, it is their intelligence that often persuades parents and teachers to conclude, "They could do it if they tried" or "They did it last week, why not today?"

Unfortunately, as Kane (2009) outlines, these students may: have nonexistent study skills, problems in written expression, difficulties in subject areas such as mathematics because they cannot convey how they arrived at an answer, and have time management problems, particularly with long-term projects. As Fiedler (2007) notes, gifted students can sometimes feel that organization requires mundane work that their brains simply are not set up for. She also found that these students are typically internally driven and thus likely to resist external efforts to re-direct them.

So, here are some of the directions psychologists can explore for possible solutions:

a) Utilize alternative behavioral measures such as the BRIEF (Gioia, Isquith, Guy, & Kenworthy, 2000) to gain more specific data if a student you are working with appears to be exhibiting symptoms of executive function problems.

b) Help parents and teachers to become better educated and less judgmental about students with

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School Vouchers, Education, and Psychologists

Julie Meranze Levitt, PhD

Dr. Julie Meranze Levitt

I believe that traditional public school education is being undermined. As psychologists we consider good education one of the necessary building blocks for the development of competencies and skills leading to productive lives. As mental health practitioners, we are aware that poverty is linked to poor education and then to the absence of skills and eventual jobs, contributing to the continuing cycle of disempowerment and feelings of shame and despair. Undercutting traditional public education disproportionately affects the poor and therefore, must be of concern.

One way that public education may be undermined is through tax credits and voucher programs. What may not be generally known are the facts and ramifications associated with the move to publicly fund private education (Doerr, 2012; Tabachnick, 2012). Moreover, funding of private schools, most of which are religious in orientation, through public funds is becoming more the norm despite a 2:1 opposition of Americans in referendums to support such plans (Doerr, 2012). Presently, 15 states and the District of Columbia have voucher programs.

The National Alternative Education Association (http://the-naea.org/NAEA/) maintains that there is no link between vouchers of any kind and gains in student achievement. Dramatic improvements in student successes occur in places where voucher programs do not exist, such as Texas, North Carolina, Connecticut, and in the city of Chicago. Public monies in these sites go to enhancing teacher quality and providing extra help to students in need of services to keep up with demands of curricula. Test results for the two oldest voucher programs in the country, Milwaukee and Cleveland, are disappointing (Richards & Hetzner, 2011), as cited in Tabachnick (2012).Voucher programs have reduced accountability because private schools, unlike public schools, have less governmental oversight. In addition, "choice" vouchers ironically do not give students and parents more options. Private programs are free to choose which children they admit or dismiss. Children from poor, diverse, underserved ethnic groups may not be chosen or only admitted in limited numbers. And vouchers transfer moneys from public to private schools. For more about a possible national movement to undercut public education, see Sirota (2012).

Charter schools, including cyber schools, are the new public schools. They also may have less stringent oversight than traditional public schools and the money allocated for traditional public schooling follows the child to his/her new school. For more on charter schools and their effectiveness, see the Stanford University study from 2009, in which it is reported that 17% of children in charter schools reported academic gains that were significantly better than traditional public school, 37% showed gains that were worse than traditional public schools, and 46% do about the same (Credo, 2009).

The National Alternative Education Association maintains that there is no link between vouchers of any kind and gains in student achievement.

Undermining of public education has occurred through the No Child Left Behind Act of 2001. As a result of this act, teachers and school programs are subjected to evaluations that may have no bearing on how and to what extent children master academic skills. Teachers may be maligned and fired when children do not perform well in state-mandated testing. Schools may be closed, only to be replaced with other schools that are private, or children may be relocated to other schools where their familiar surroundings are no longer present. Inadequate standardized testing results do not take into account the problems besetting children, including limited access to necessities and blighted, unsafe neighborhoods. These factors may affect how a child scores on group tests. Replacement schools may be less suitable to meet educational and psychological/social needs of children and families because the new curricula and school culture may fail to take into account the customs and beliefs of families.

The Pew Charitable Trusts Philadelphia Research Initiative (2011) argues that the long-term consequences of school closings on student performance are negligible. A vast collection of case studies may be found in Peace and Conflict, *Journal of Peace Psychology* (Fine, 2012); Michelle Fine, special editor, explores the impact of school closings on students, parents, and educators. Topics discussed include a wide range of issues presented by a number of authors.

In one of the articles, Schwebel (2012) argues for steps that would raise the academic achievement level of those who attend schools in under-resourced areas. He calls for:

- a solid social safety net for families in or near poverty, such as exist in other countries that excel on international tests;
- coaching for new teachers, at least for one year, to help them through their early teaching experience, like an apprentice system;
- classrooms with one or more full-time teaching assistants, because many in poor-performing schools need individual (or small group) instruction;
- making available national funds for education to states where there is need;
- school budgets that include libraries, labs, computers, and classes in the

Continued on page 26

SCHOOL VOUCHERS

Continued from page 25

arts, sciences and physical education;
- salaries for teachers in low-income communities that are on par with those in high-income population areas;
- review of curricula to ensure that content is relevant to the lives of the students.

Of course, a significant blow to traditional public education comes from diminished funding in state budgets. The children affected most by this are poor and living in districts that cannot adequately support public schools. Consider what is happening in Pennsylvania where there was a cut of $860 million in 2011-12, with a restoration of $49 million in 2012-13 (Elliott, 2013). The largest school district, Philadelphia, is ravaged by debt.

As psychologists we should work with our colleagues in educational specialties and parents to press for fundamental changes in how federal and state funds are channeled and volunteer in programs designed to improve educational levels. We can testify about the needs of children and families. We can work with parents and children to find their voices, to become proactive, and to develop skills for confronting powerful and entrenched systems.

Of course, a significant blow to traditional public education comes from diminished funding in state budgets.

The literature on this issue is vast. To learn more, go to the National Education Association's website, http://www.nea.org/, and for more information about steps being taken in states and localities, see http://www.edweek.com/ and for Pennsylvania, http://www.researchforaction.org and the Pennsylvania State Education Association (PSEA) at http://psea.org .

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DEVELOPING INTERVENTIONS FOR GIFTED STUDENTS WITH ADHD

Continued from page 24

executive function problems. Guide them to websites such as www.cognitiveconnectiontherapy.com to obtain resources for structure, monitoring and planning. Reading material, timing devices, and planners are among the many resources at that site.

c) Help parents and teachers to understand that executive function problems with all students, but especially those who are gifted, require long-term solutions, not just brief interventions. Consider the use of ongoing tutorial support, not to address learning issues but to address executive function problems in initiation, planning, organizing, and management of their academic responsibilities.

d) McCloskey and his colleagues (2009) provide a comprehensive and thorough analysis of executive function issues as well as a CD that provides a host of suggestions, interventions, and analyses for parents, teachers and clinicians.

If psychologists are able to guide gifted students with ADHD and executive function problems to the support, understanding, and interventions they need, their prognosis for success, in this author's experience, has tended to be quite favorable. For once the cognitive dissonance between what they know and what they do starts to resolve. It is replaced by emotional energy and elevated motivation because they feel more understood and strategically supported. As a result, an elevated production and achievement cycle often begins to evolve.

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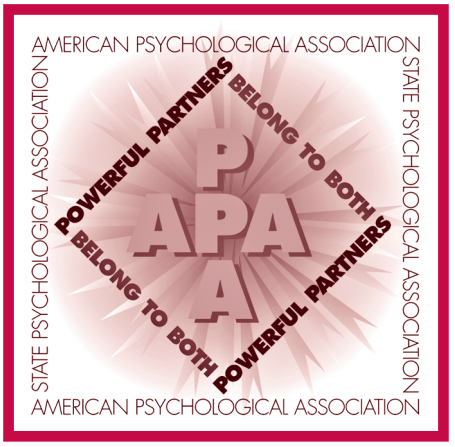
Welcome, New Members

We offer a magnificent, monumental welcome to the following new members who joined the association between November 1, 2012, and January 31, 2013.



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CE Questions for This Issue

The articles selected for one CE credit in this issue of the *Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period, then you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the test at home and return the answer sheet to the PPA office. Passing the test requires a score of at least 70%. If you fail, you may complete the test again at no additional cost. We do not allow more than two attempts at the test.

Complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. For each question there is only one right answer. Be sure to fill in your name and address, and sign your form. Allow 3 to 6 weeks for notification of your results. If you successfully complete the test, we will mail a confirmation letter to you. The response form must be submitted to the PPA office on or before March 31, 2015.

Return the completed form with your CE registration fee (made payable to PPA) for $20 for members ($35 for non members) and mail to:

Continuing Education Programs
Pennsylvania Psychological Association
416 Forster Street
Harrisburg, PA 17102-1748

Learning objectives: The articles in this issue will enable readers to (1) assess and explain current issues in professional psychology, and (2) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Palmiter

1. One of the tools being used by the PMHTF is:
   a. the Symptom-Checklist-90-Revised
   b. the Pediatric Symptom Checklist
   c. the Beck Depression Inventory
   d. the Beck Anxiety Inventory

2. Which of the following was NOT an evaluation procedure included in the evaluation standards of the PMHTF?
   a. review of school records
   b. use of behavior rating scales
   c. screening for parental psychopathology
   d. cognitive testing

DeWall

3. PPA was successful in getting legislation passed authorizing psychologists to do all of the following except:
   a. conduct insanity determinations in criminal cases
   b. act as reviewers within managed care companies for behavioral health services
   c. maintain privileged communications with patients on the same basis as attorney-client communications
   d. be leaders of multidisciplinary treatment planning teams under the Mental Health Procedures Act

Knapp

4. According to the author, accountable care organizations:
   a. will pay all providers on the basis of patient outcomes
   b. will pay providers according to a fixed fee for unit of service
   c. have the flexibility to pay providers according to different formulae including fixed fee per unit or service, patient outcomes, or some combination thereof
   d. will pay all mental health providers at the same rate

5. According to the author, the Affordable Care Act:
   a. will not impact psychology
   b. will result in greatly reduced incomes for psychologists
   c. may impact the practices of psychologists very differently
   d. will impact most psychologists the same, regardless of their area of specialty or income source

Vennie

6. Both hospital-based and private practice psychologists are unionized throughout Canada.
   True
   False

7. Telehealth services are widely used in Canada:
   a. for initial evaluations
   b. for ongoing therapy
   c. because the rules are now clearly established for all telehealth applications
   d. for consultations with rural health facilities

Krumenacker

8. Chronic disease is the cause of almost____ of deaths in the United States:
   a. 75%
   b. 50%
   c. 15%
   d. 90%
   e. 25%

King

9. ADHD medications effectively treat executive function problems.
   True
   False

10. Gifted students with executive function problems are usually quite responsive to suggestions and interventions because of their superior intelligence and creativity.
    True
    False

Levitt

11. Charter schools operate under the same regulations as traditional public schools.
    True
    False

Zuckerman

12. Which one is NOT an advantage of using programs to store data in the cloud?
    a. accessibility without a high-speed Internet connection
    b. files are useless to anyone else because they are encrypted
    c. protection from physical threats
    d. protection from forgetting to create backups

Continuing Education Answer Sheet
The *Pennsylvania Psychologist*, March 2013

Please circle the letter corresponding to the correct answer for each question.

1.	a	b	c	d		**7.**	a	b	c	d	
2.	a	b	c	d		**8.**	a	b	c	d	e
3.	a	b	c	d		**9.**	T	F			
4.	a	b	c	d		**10.**	T	F			
5.	a	b	c	d		**11.**	T	F			
6.	T	F				**12.**	a	b	c	d	

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

_____

Please print clearly.

Name _____

Address _____

City _____ State _____ZIP _____ Phone ( ) _____

I verify that I personally completed the above CE test.

Signature_____ Date_____

A check or money order for $20 for members of PPA ($35 for non-members of PPA) must accompany this form.
Mail to Continuing Education Programs, PPA, 416 Forster Street, Harrisburg, PA 17102-1748.

Disaster-Proofing Your Computer With Online Backups

Ed Zuckerman, PhD, EdZucker@mac.com


Dr. Ed Zuckerman

I am going to assume that, as educated professionals, you already have some method of creating copies of your computer's files in case one of the dozens of threats to their integrity or existence actually happens. However, your plan may not be sufficiently consistent (do you forget?), timely (every few minutes when you are working), complete (applications and operating system as well as files), or even safe (protected from physical as well as electronic threats) enough. What is needed is the use of several tools.

Different kinds of backup for different goals

The simplest and most frequent type of backup use is to restore the latest version of a document you recently changed (were working on) from a spare copy of the current file. This is simple redundancy. Changes made to a currently open file are stored in active memory – RAM – which allows the use of "undo" to recover the most recent changes. The number of "undos" can be set by the user and setting 10 or 15 will not slow current computers. These changes will be lost if power were lost to the computer or some glitch occurred. Programs also make a copy of the current state of a file and store it in stable memory on the hard disk. The time interval between storing copies can be set by the user, usually in a Preferences file. On current computers setting this interval at three minutes does not slow the operations and so, at worst, only a few minutes' work would be lost.

With the above-described process the latest version of a file overwrites and destroys the earlier versions. If a file is being opened and modified repeatedly, such as an ongoing case record or drafts of a complex document there may arise the need to recover those earlier or intermediate files called versions. To store them by date and time and then to access them later requires a backup program. Windows and Macs have such programs built into their operating systems so they must simply be set in motion.

However, storing such copies on the same hard drive as the originals is a recipe for disaster. Adding a separate external hard drive is both simple and inexpensive. The current standard is a tiny (size of a deck of cards), one terabyte drive connected to the computer with a USB cable and requiring no other power source. Even two and three terabyte drives like this cost around $100 and take only a few minutes to employ. The backup programs included with the operating systems operate fully automatically for those of us with other life projects and numerous distractions. If you choose not to use one of these, several of the commercially available backup programs allow the creation of these local backups as well as storage in their cloud servers.

Backup programs can also record these files to DVDs or CDs, which is the least expensive option but with two limitations. First, these disks hold much less than your hard disk and so are not suitable for storing more than your word processing files (which are tiny) and some application created data. When many disks are required they must be linked by the program, and this can get complicated. The second disadvantage is that this approach requires regular attention. DVDs must be supplied, changed, and protected, tasks which most of us tend to delay or forget resulting in unusable infrequent backups. For more on this see http://www.backblaze.com/backup-comparison-chart.html.

Sadly, these local internal and external backups remain vulnerable to threats like water, power surges, and burglary and so offsite backups are desirable. Because of the burden imposed by physically moving these media and especially remembering to do so, online backup programs have become popular. There are many, they are highly efficient, and they are inexpensive ($50-$100 per year). A disadvantage may be that they are accessible only with a high-speed Internet connection.

Advantage of using the cloud for storage

- Cheaper because there is only one free and simple program to use to store and access your data. Storage space is bought only as needed. Updates are free and even invisible to us.
- Automatic and therefore reliable. When we forget we lose the value in having backups.
- Easy to use. You don't have to decide which files to upload and save; the program finds the appropriate ones no matter where/how you have organized your folders. All your data, documents, photos, video, music, financial records, etc. will be in one place. The interfaces are often completely transparent, familiar, and foolproof.
- Secure. Their encryption and procedures are as invulnerable as well-funded, trained, full-time professionals can make them. We are amateurs at this.
- Reliable. Their datacenters are a million times safer than your home or office from floods, fire, power loss, and a million kinds of accidents. Most guarantee 99.99% and 365/7/24 availability of your data.
- Scalable. When you add more computers or more persons using them you don't need new programs, to train staff, revise procedures, etc.
- Convenient because your data is available to you from anywhere with an Internet connection.

- Greener because of less use of electricity and better life-cycle use of hardware. They use your Internet connection only when you aren't.
- At the standard of care and so safer from legal threats. For a few dollars a month we individuals have access to the same personnel, tools, and procedures that government agencies, lawyers, and big businesses use.
- Because the data is carried over the Internet and stored centrally these programs easily provide other benefits. If you have several locations or use multiple devices such as laptops, tablets and smartphones, all of them have instantaneous access to the same data. This syncing prevents "charts unavailable" problems in other offices, allows you to work on your records even in transit, and lets all authorized users see the identical and current version of any record. Syncing supports collaboration – the ability of multiple persons to communicate and to modify documents and other records in real time. This, in turn, could enhance training and supervision, improve workflow, and spur innovation and creativity.

Sites with lists of programs with links and information about each

- **Consumer Rankings at www.consumer-rankings.com/online-backup/**

  Very useful information in their approximately 3-page reviews of 10 programs on the topics of pricing, features, storage space, ease of use (with screen shots), security, customer support, and some simple summary points. Not critical and no comparative reviews but some minimal consumer feedback for some programs.

- **CloudBackuping at http://www.cloudbackuping.com/**

  Mauricio Prinzlau has put his heart into providing information and reviews of these programs (at http://www.cloudbackuping.com/top-10-online-backup-services/) and also offers guiding essays (at http://www.cloud-backuping.com/online-backup/). They are all extensive yet easy to read and understand, very well illustrated, and current. The site also offers about 70 thumbnails to relevant videos for those who would rather watch than read to learn how to use backup programs and techniques. There are two free downloadable books: "The Definitive Guide to Backing Up Your Data" and a similar "Online Backup 101 – The Definitive Report." An advantage is his coverage of several programs not well known or advertised and smaller topics such as backing up smartphones. The reviews are not critical nor comparative but do offer some user comments and discussion for most programs.

- **A program-choosing program at http://www.thetop10bestonline-backup.com/chooser**

  Answer six questions and it presents a number of suitable programs (from at least 50) with a rather large checklist of functions for each. Clicking reveals moderate-sized, non-critical reviews and customer reviews, often negative. The educational articles are too tiny to be helpful.

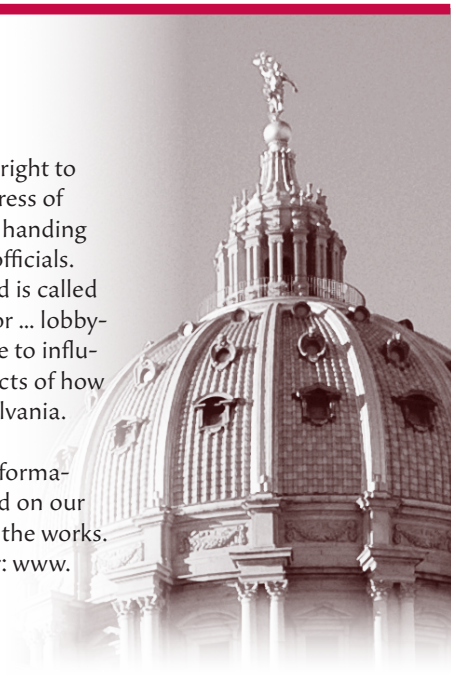
In future columns I will address options for permanently storing files you might someday want to access – "cold storage" from an archive and recreating your whole computer after unrepairable damage or theft by regularly cloning its entire hard drive.

Plan to Attend Advocacy Day

The PPA leadership has selected Monday, April 15, 2013, as our Harrisburg Advocacy Day this year. PPA members are urged to attend. It will again be at the state Capitol Building. The schedule will consist of registration at 9:30 a.m., an issue orientation session from 10:00 to 11:30, and meetings with legislators after that. We will be addressing several new legislative proposals for dealing with child abuse reporting and a bill making numerous changes to the Professional Psychologists Practice Act.

We often shy away from the word "lobbying" because it has developed negative connotations. But the state and federal Constitutions guarantee citizens' right to petition the government for a redress of grievances. It's not all sleazy guys handing money under the table to public officials. Doing it honestly and above board is called government relations, advocacy, or ... lobbying. At any rate, this is your chance to influence the process of deciding aspects of how psychology is practiced in Pennsylvania. No room for social loafers here!

We will be providing more information about the event by e-mail and on our website. Plans for CE credit are in the works. Please visit our website to register: www.PaPsy.org.



Record-Copying Charges for 2013 Announced

Under Pennsylvania's Act 26 the Secretary of Health is directed to adjust annually the amounts that may be charged by a health care facility or health care provider upon receipt of a request or subpoena for production of medical charges or records. Because the law specifically references "health care providers," as opposed to just physicians, PPA believes that the law applies to psychologists. The amounts for 2013 vary only slightly from last year's amounts.

Effective January 1, 2013, the following payments may be charged in response to a subpoena:

	Not to Exceed
Search and Retrieval of Records	$21.08
Amount charged per page for pages 1-20	$1.42
Amount charged per page for pages 21-60	$1.05
Amount charged per page for pages 61-end	$0.35
Amount charged per page for microfilm copies	$2.09

In addition to the amounts listed, charges may also be assessed for the actual cost of postage, shipping, and delivery of the requested records.

In addition, a flat fee that can be charged by a psychologist for a claim or appeal under the Social Security Act or any federal or state financial needs-based benefit program is $26.70 plus charges for the actual cost of postage, shipping, and delivery of the requested records. The flat fee that can be charged for a request made by a district attorney is $21.08 plus charges for the actual cost of postage, shipping, and delivery of the requested records. Requests from independent or executive branch agencies of the government are exempt from the record-copying fee requirements. This law does not apply to copying required by insurance companies to monitor services under an insurance contract. The rate is increased annually according to the Consumer Price Index.

The law does not alter the requirement that psychologists must have a signed release from the patient or a court order before releasing the information to a third party.

Classifieds

POSITION AVAILABLE

PART-TIME Fee for Service – **DOCTORAL LEVEL PSYCHOLOGIST** positions available in nursing homes and rehabilitation facilities in Montgomery, Bucks, and Chester counties. If you are a Medicare provider or Medicare eligible and are interested in a rewarding experience, please contact: Dr. Lynne Freeman or Dr. Robert Mabel at LMF Psychological Services, LLC, P.O. Box 237, Hatfield, PA 19440; 215-362-1420 or e-mail lmfpsych@hotmail.com

OTHER

PSYCHOLOGY BOOKS, including hardcover books by S. Freud (Volumes 1 through 5). Call Joanne Buzzetta, 215-636-0336. Leave message.

OFFICE SPACE CENTER CITY, NEAR RITTENHOUSE SQUARE. Share with other mental health professionals. Bright well-appointed offices with waiting room in secure, hi-rise building. Near parking, shops, dining, transportation. Available by day, evening or weekend. Reasonable rates. Contact: Joanne Buzzetta, 215-636-0336.

EXPANSION OFFICE SPACE! Share quiet, professional suite near suburban Philadelphia area (Bala Cynwyd), furnished, conference room, fax/copier, etc. Flexible hours, friendly rates. 610-664-3442.

MOTIVATION CARDS by Dr. Julie Ann Allender; they are designed to help motivate everyone to have a better day. Each card is created with a photo chosen from an extensive photo library & includes a motivational saying. The deck of 54 cards comes with a purple collapsible desk holder for portability. $15 per set. Quantity discounts available. Cards can be viewed & ordered from www.pettherapyparadisepark.com or office: 215-799-2220.

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2013 CE Calendar

The following programs are being offered either through co-sponsorship or solely by PPA.

April 4 and 5, 2013
Spring Continuing Education and Ethics Conference
Monroeville, PA
Marti Evans (717) 232-3817

April 15, 2013
Advocacy Day
State Capitol Building
Harrisburg, PA
Rachael L. Baturin, MPH, JD
(717) 232-3817

June 19-22, 2013
Annual Convention
Harrisburg, PA
Marti Evans (717) 232-3817

October 31/November 1
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

Podcast
A Conversation on Positive Ethics with Dr. Sam Knapp and Dr. John Gavazzi
Contact: ppa@PaPsy.org

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/index.php/collaboration-communication/.

Registration materials and further conference information will be mailed to all members.

If you have additional questions, please contact Marti Evans at the PPA office.

HOME STUDY CE COURSES – *also available at www.PaPsy.org*

Excess Weight and Weight Loss – NEW!
3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer and Meditation Can Help You Pay Attention to What Really Matters
5 CE Credits

*Competence, Advertising, Informed Consent and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Confidentiality, Record Keeping, Subpoenas, Mandated Reporting and Life Endangering Patients**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations and Ethics**
6 CE Credits

**This program qualifies for three contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.*

For all Home Study CE Courses above contact: Katie Boyer (717) 232-3817, secretary@PaPsy.org.