Vol. 74, No. 8

A PUBLICATION OF THE PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION • www.papsy.org

The Pennsylvania Psychologist

September 2014
QUARTERLY

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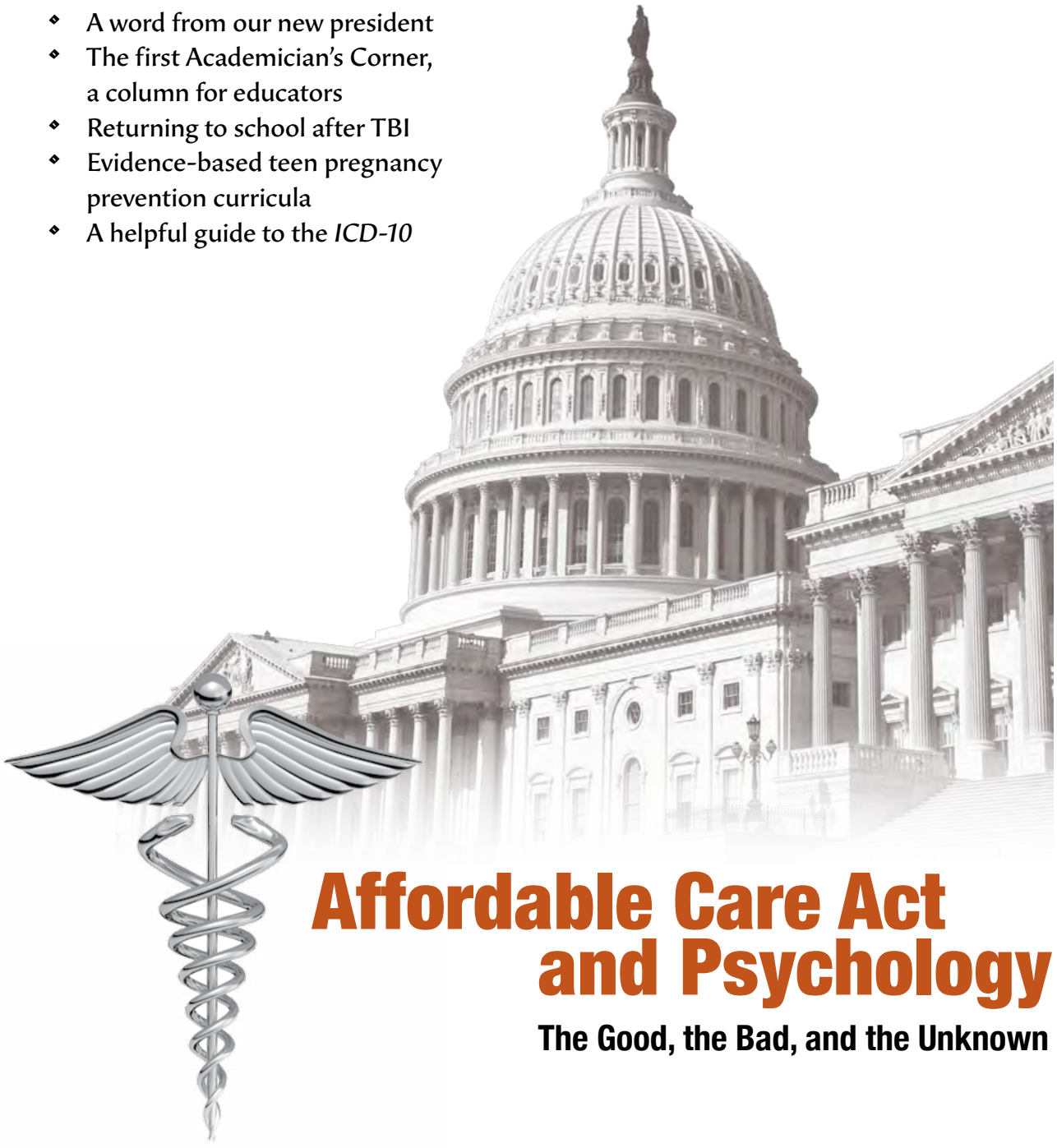

Affordable Care Act and Psychology

The Good, the Bad, and the Unknown

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

2014 ANNUAL CONVENTION

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Vol. 74, No. 8

The Pennsylvania Psychologist

Editor: Dea Silbertrust, PhD, JD

September 2014 • QUARTERLY

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Harrisburg, PA 17102
(717) 232-3817
www.papsy.org

The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in the *Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance or members or staff of PPA or PPF.

The Pennsylvania Psychologist Quarterly is published in March, June, September, and December. The copy deadline is the 15th of the second month preceding publication. Copy should be sent to the PPA Executive Office at Pennsylvania Psychological Association, 416 Forster Street, Harrisburg, PA 17102.

Copy Editor: Karen Chernyaev
Graphic Design: LiloGrafik, Harrisburg

REGULAR FEATURES

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ALSO INSIDE

Stepping Up to the Plate

Bruce E. Mapes, PhD

Dr. Bruce E. Mapes

The ripple effects of health-care reform will be felt by all psychologists. If psychology does not maintain prominence in health care, fewer young people will want to pursue a career in psychology. This will decrease the number of applicants to undergraduate and graduate programs and will ultimately impact the future of all disciplines. Psychologists can allow others to determine their destiny by doing nothing or individually confronting changes. Or psychologists can have greater control over their destiny by working together as a unified team. PPA is your team and is committed to the future of psychology, psychologists, and the people we serve in Pennsylvania.

Members of your team are working to expand internship opportunities for graduate students. Your team is committed to protecting current jobs through such efforts as successfully lobbying against the privatization of the Department of Corrections mental health services. PPA is expanding opportunities for psychologists through various initiatives, such as successfully lobbying for the recently signed legislation that allows courts to appoint psychologists to offer opinions on competency to proceed. Through the Integrated Care Committee, your team is sitting down at the table with insurance carriers to help ensure that psychologists are included in integrated care models.

In order for psychologists to be informed about emerging fields like telepsychology and such things as changes in the mandatory reporting laws for child abuse and elder abuse, there must be a means for psychologists to freely share ideas, to consult with peers, and to obtain information. Time and distance can no longer limit the participation of team members in such activities as committees or continuing education programs. Your team's technology has been brought into the 21st century this year. We now have expanded capabilities to more efficiently communicate and share information as it becomes available. In the near future, we hope all members will be able to participate on committees and to attend continuing education programs from anywhere in Pennsylvania.

Any team requires veterans and a good farm system to develop younger players who can replace the aging veterans. PPA's pool of volunteer veterans is aging, and there can no longer be a heavy reliance upon a few. We must recruit graduate students and early-career psychologists who can be groomed to provide the future leadership for your team. Just as any team needs skilled players, PPA requires psychologists from all disciplines. The more PPA is able to represent the interests of all generations and disciplines of psychology, the stronger your team will be.

Your team is a multifaceted organization that is positioning itself to help ensure the future of psychology, psychologists, and the people we serve in Pennsylvania.

All teams require an infrastructure to ensure the efficient and effective support of the current and future activities of the team. Although PPA is primarily concerned with the promotion of psychology, psychologists, and the people we serve in Pennsylvania, PPA is a business and must follow sound business, management, and fiduciary practices in order to implement our strategic plan. Several stalwarts of your front office will be retiring in the near future. Your team has developed a comprehensive plan to allow for seamless transitions in order to minimize disruptions in the efficient and effective support of your team.

All teams require a stadium in which to conduct their activities. Like our homes, stadiums age across time, and it is necessary to periodically explore options for remodeling, renovating, or relocating. Currently, a task force is exploring options to assure your stadium can meet the future needs of your team.

Since there is strength in numbers, your team is looking at ways to partner with social workers, psychiatrists, counselors, and others who make up the mental health league. Through cooperative efforts, we can more successfully pursue mutual interests.

Changes in health care, child welfare, the courts, and many other areas are stimulating new legislation. During the recent past, there has been an increase in the number of bills introduced that have an impact on the practice of psychology. In order to secure psychology's future, our team must be proactively involved in lobbying for the interests of psychology, psychologists, and the people we serve in Pennsylvania. For years, PPA has been by far the most responsive state association when it comes to American Psychological Association legislative alerts. We must maintain the same visibility in Pennsylvania. Every member of our team must be involved in communicating with their legislators. Because PPA cannot make political contributions, we need to support PennPsyPAC in order to maintain a visible presence at fundraisers for legislators who are favorable to our interests.

Through scholarships and other activities sponsored by the Pennsylvania Psychological Foundation, graduate students are introduced to the benefits of membership in PPA. Whether the foundation hits a home run or strikes out is determined by the support it receives from all team members.

Your team is a multifaceted organization that is positioning itself to help ensure the future of psychology, psychologists, and the people we serve in

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Here We Go!

Krista L. Paternostro, CAE

Krista L. Paternostro

It is hard to believe that August 15 marked my one-year anniversary with PPA. Just where does the time go? Looking back, the first year was filled with quiet learning, exciting changes, and many ideas and insights shared from our members around the Commonwealth. As you will read below, we are continuing along the road of change and invite you to continue to be a part of the growth and evolution of PPA!

Since the last issue of *PA Psychologist* was published in June, we embarked on a very successful PPA Annual Convention in Harrisburg. (Please take a moment to view photos of the award winners on pages 22–23 of this issue. We once again salute all of our award and scholarship recipients for their continued service to PPA!)

I would like to thank everyone who attended this year's annual event in Harrisburg. As those who attended can attest, we introduced some changes to the format and schedule that were very well received. In addition to combining the awards ceremony with the town hall plenary, we introduced new technology to gather instant, real-time feedback from our members on PPA initiatives during Friday's town hall. Please take a moment to see how your colleagues felt about our current and future offerings by visiting www.papsy.org and searching for poll results in the top left search bar. I salute the members of the PPA Convention Committee as well as our Board of Directors for their enthusiastic support as well as their important role in executing another successful event.

As for the future, here we go! We have many items on our plate for the fall, not the least of which is assessing our internal team and bringing new talent into the organization. As you know, Dr. Sam Knapp is set to retire from PPA on January 31, 2015. But, Sam will continue to work for PPA approximately 15 hours a week in his current role as consultant to PPA members on a host of issues including practice, ethical, and legal issues. In today's global world, we welcome the opportunity to continue to engage with Sam on a regular basis from his home in California. We have been assessing the other critical functions of his position to ensure that our members continue to receive the high level of service they have come to expect and deserve. Also, at right, you will read our tribute to Marti Evans, PPA's convention and communications manager, who retired from PPA on August 31, 2014. We wish Marti a happy and prosperous retirement.

In addition to the happenings inside of the PPA office, there is one more important member update that I want to highlight in this month's column:

The Pennsylvania Psychologist Goes Virtual in June

In June 2015, we will issue the quarterly *Pennsylvania Psychologist* in an online-only format, and PPA members *will not* receive a printed copy in the mail. Using a digital format will allow us to enhance the overall publication by making it four-color throughout and including hyperlinks and dynamic content, giving you instant access to important information. The PPA Board of Directors' decision to produce one of our quarterly issues online is primarily motivated by the associated financial savings but also to gather your feedback as we continue to explore options related to this important member communication. Please continue to share your thoughts and suggestions with us.

We appreciate your continued membership in PPA and look forward to a bright future. Here we go . . .

Marti Evans

Convention & Communications Manager Retires After 20 Years of Service to PPA!

In recognition of Marti's contributions to the organization over the past two decades, we offer the following "top 10 impacts Marti has made on PPA since 1994" list, as compiled by those who know her best:

10 Marti secured more than $300,000 in exhibitor, sponsor, and advertiser income for PPA annual conventions between 1994 and 2014.

9 Marti was a member of APA's PEC Guidance Council from 2006 to 2014.

8 In 2008 Marti helped to launch the Free Public Workshops series.

7 Marti copresented several workshops on PPA's Public Education Campaign at the APA State Leadership Conference.

6 Marti staffed PPA's Leadership Development Committee for many years.

5 Marti helped to implement the public education e-newsletter used to educate the public about psychology.

4 Marti devised PPA's media directory to include a list of PPA members who are available to make presentations across Pennsylvania.

3 In 2000, Marti conceived PPA's Fall and Spring Conferences as 2-day events offering 12 workshops each.

2 At this year's convention, Marti coordinated the successful Learning Lounge for students and ECPs.

1 Marti developed meaningful relationships with many PPA members, staff, vendors, and exhibitors over the years that will long endure!

Congratulations, Marti!

We wish you all the best in your retirement.

STEPPING UP TO THE PLATE

Continued from Page 2

Pennsylvania. Every member of the team, including the front office and every committee and task force, is vital to the successful operation of the team. The larger and more cohesive the team is, the more effective it can be. On the other hand, the smaller the team and the more divided it is, the greater the chance of striking out. Some have argued they do not have the time to participate on the team. I ask you to consider how much time you will have if your team is unable to fully implement its strategic plan? In other words, can you afford not to participate and support your team?

As your general manager I am committed to expanding opportunities for graduate students and all psychologists. I will actively support the expansion of our technology to better serve the needs of all psychologists in Pennsylvania. Likewise, I am committed to identifying and implementing strategies to recruit and retain team members. Finally, I am committed to supporting changes in our team's infrastructure to ensure it can efficiently and effectively support your team in the future.

I hope I can count on each of you to step up to the plate and help us to hit a home run!

Introducing a New Column

Janet Etzi, PsyD; jetzi@immaculata.edu

Dr. Janet Etzi

Welcome to the Academician's Corner, a new column in the *Pennsylvania Psychologist*. Our hope is to provide a forum for addressing a broad range of topics that are relevant to psychologists working in colleges and universities, including the teaching and training of clinical psychologists; the science of psychology and process of doing research; and the relationship between research, data, and the practice of psychotherapy. But these are only some possibilities. We encourage *you* to share your ideas and contribute articles for this column.

The format of this column will vary from issue to issue. For example, we invite you to submit ideas for short articles addressing any aspect of the teaching, research, or scholarly work that you do. We are also interested in practitioners' questions *for* researchers and academicians. We will have various academic psychologists answering these questions, and we will include occasional interviews.

It's been said that the doing of science is inherently public; that knowledge evolves and accumulates the more it is shared and commented upon by peers and consumers of that science. This is the guiding principle of this column. Since I began teaching in Immaculata University's PsyD program, I have seen firsthand that what I learn contributes to my clinical practice and that clinical practice makes me a better educator in the program. In other words, theory and research inform practice, and practice can provide the questions for researchers to pursue and eventually answer.

There is an explosion of scholarly work in our field. For example, I have been incorporating the new research in affective neuroscience, which is corroborating much of what good clinicians have known for a long time about how emotions organize (or disorganize) a person's experience. Other areas of interest may include but are certainly not limited to nuts and bolts issues related to teaching and supervising; the science-practitioner model of training; integrative views of psychotherapy; evolutionary psychobiology; art and psychology; the validity and reliability of *DSM-5*; and many more.

Email me today with your ideas or questions regarding this new feature of the *Pennsylvania Psychologist*.

Informed Consent Forms for Adults and Minors

Samuel Knapp, EdD, ABPP; Director of Professional Affairs
Rachael Baturin, MPH, JD; Professional Affairs Associate
Allan M. Tepper, JD, PsyD; Legal Consultation Plan


Dr. Samuel Knapp


Rachael L. Baturin


Dr. Allan M. Tepper

The American Psychological Association (APA) Ethics Code contains a number of informed consent provisions related to clinical practice. For example, psychologists are required to inform patients of the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality (Standard 10.01(a)). When providing couples or family therapy, psychologists need to take reasonable steps to clarify at the outset which of the individuals are patients, as well as the relationship the psychologist will have with each person (Standard 10.02(a)). This clarification includes the psychologist's role and the probable uses of the services provided or the probable uses of the information obtained (Standard 10.02(a)). When services are court ordered or otherwise mandated, psychologists must inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated, and any limits of confidentiality (Standard 3.10(c)).

This informed consent process must take place at the start of treatment or as soon as feasible. Typically, the HIPAA-required privacy notice for HIPAA-covered entities is also discussed as part of the overall informed consent process.

During this informed consent process, psychologists provide sufficient opportunity for the patient to ask questions and receive answers (Standard 10.01(a)). For persons who are legally incapable of giving informed consent, psychologists strive, nonetheless, to provide an appropriate explanation, seek the individual's assent, and obtain the required permission from a legally authorized person (Standard 3.10(b)).

Psychologists *appropriately document* informed consent (Standard 3.10d). Such documentation can be contained in a typical progress note. In this way, the APA Ethics Code does not mandate the use of a written informed consent form. Such a written form is not prohibited, however, and thus many psychologists find that such written forms are a good means of fulfilling the informed consent requirement and introducing the patient to the parameters of treatment.

Typically, the HIPAA-required privacy notice for HIPAA-covered entities is also discussed as part of the overall informed consent process.

If a written informed consent is utilized, it must include the minimum information required by the APA Ethics Code, as well as any information mandated by Pennsylvania State Board of Psychology regulations. In addition to these minimum requirements, the length of the informed consent document will vary depending upon the number of topics that psychologists choose to include, coupled with the details related to these topics. For example, some psychologists may provide more detailed information related to their credentials or theoretical orientation. Given the prevalent use of email communication, cell phones, and text messaging, it is strongly recommended that the informed consent form cover if, when, and under what circumstances such forms of communication shall be utilized during treatment.

Often, psychologists believe that a lengthy informed consent form will provide greater protection against future liability. In the mental health field, however, such reliance upon a lengthy form may be misplaced. In addition, the longer the form, the less likelihood that the patient will read the form or understand the information, thereby defeating the clinical underpinnings of the informed consent process. For this reason, if a written informed consent form is utilized, it is recommended that a balance be struck between the amount of information contained in the form and the clinical utility of the form. See, for example, the sample form provided by the APA Insurance Trust that is comprehensive in nature but can be modified to conform to Pennsylvania State Board of Psychology requirements and to function as a good introduction to the clinical process (www.apait.org/apait/download.aspx).

The use of a written informed consent form is discretionary in nature, and psychologists have much latitude in deciding what information will be contained in the form. This article, therefore, will highlight the type of ancillary information that can be contained in a written informed consent form, including the role of the psychologist when treating children, payment for services not covered by insurance, and the boundaries of confidentiality.

The Role of the Treating Psychologist

Today, many children who enter therapy come from families at a high risk for a divorce or from families that are involved in a custody dispute. At the onset of treatment, therefore, it is important to distinguish between the psychologist's role as a therapist and as a custody evaluator. In addition it might be helpful

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to have a discussion regarding what, if any, role the psychologist might play in a future custody dispute. This information can be contained in the written informed consent form.

Once treatment is commenced, the psychologist might be requested to provide testimony at a future court hearing. Such testimony can be disruptive to treatment, and it can have a deleterious effect upon the child's well-being. For this reason, it might be helpful to discuss this issue at the beginning of treatment, as well as include this information in the written informed consent form. Later, if a parent wants to enlist the psychologist in the custody dispute, the psychologist can produce the written agreement, noting that the parent agreed that such involvement would be contraindicated. Although the psychologist still might be compelled to testify, this type of informed consent discussion might convince the parents, their respective attorneys, and even the presiding judge that the custody issues should be litigated without a disruption in treatment.

Payment for Noncovered Services

During treatment, some parents will request that the psychologist converse with collateral contacts, such as school personnel, physicians, or religious leaders. Often, these contacts have clinical significance. Third-party insurance companies, however, generally do not reimburse for such services. In this regard, if a psychologist wishes to be compensated for these services, it is advisable to include a statement in the written informed consent agreement indicating that such services are a billable expense. It further is advisable to include a specific fee structure related to these services, as well as other ancillary services such as travel time, report writing, and document review. Although the psychologist later can choose to waive these fees, this type of structured-fee agreement can help maintain appropriate boundaries during treatment, as well as prevent future fee disputes.

Another advantage of including this fee schedule in the written informed consent form is that it can reduce activities that are contraindicated or constitute frivolous demands upon the time of the psychologist. For example, a patient may insist that the psychologist speak to his attorney regarding custody issues, even though the psychologist has made it clear that the psychologist is unable to offer such custody recommendations. Once the psychologist reminds the patient of the fee associated with this collateral contact, the patient may withdraw the request.

At times, parents will give psychologists large amounts of material to read concerning their children. Often, this background material has clinical significance. Once again, however, third party insurance companies may not reimburse the psychologist for the time necessary to review these materials. For this reason, a statement in the written informed consent form indicating that such a document review is a billable expense, along with the fee schedule associated with this service, will clarify at the onset of treatment the parameters associated with such document review.

Confidentiality

The HIPAA privacy notice utilized by HIPAA-covered entities contains information related to the future release of confidential records. In the separate written informed consent form, however, it also is useful to outline a number of the more salient Pennsylvania rules concerning confidentiality, such as the reporting of suspected child abuse; the release of confidential information in the event of a threat of serious harm to self or others; and the release of confidential information of minors aged 14 or older.

Sharing Information With Parents

In Pennsylvania, the consent of a parent is necessary to treat a minor who is less than 14 years of age. In these situations, the parent generally can access the minor's confidential treatment information.

In situations where the minor is 14 to 17 years of age, the consent of a parent or the minor is necessary to institute treatment of the minor. In these situations, however, irrespective of the party that provides the consent to treatment, the minor generally controls access to the confidential treatment information.

Despite these minor's consent to treatment requirements, the psychologist does have the option of proposing conditions at the beginning of treatment that are predicated upon genuine clinical concerns. For example, if the psychologist believes that the treatment of the 14- to 17-year-old will be most successful if the parents periodically are updated regarding the course of treatment, the psychologist can propose that such updates be a condition of treatment. This agreement can be contained in the written informed consent form. If the minor later asserts the right to confidentiality, the issue can be discussed during the course of treatment.

Often, following such a discussion, the minor will agree that the information in question can be shared with the parents. If the minor continues to refuse to provide the necessary consent, the psychologist then may need to reconsider whether treatment can continue to be effective. In more extreme cases, the psychologist may need to terminate treatment and transfer the case if the refusal to share the information is inconsistent with the clinical needs of the minor.

If there is an agreement that information will be shared with the parents, psychologists differ regarding what information should be conveyed to the parents. Generally, there is consensus that if there is imminent harm to self or others, such information will be shared with the parents. The emergence of such threats during treatment also may trigger a legal duty to protect by warning requirement.

In the grayer areas, there may be less agreement regarding what information should be shared with the parents. These issues include such activities as truancy, sexual activity, or drug use.

Once again, in an attempt to establish clear clinical boundaries, it is advisable to discuss with the parents and the minor at the initiation of treatment the type of discretion that shall be afforded to the psychologist regarding the sharing of information with the parents. In addition, the inclusion of this information in the written informed consent form can help clarify the terms and conditions of treatment, as well as avoid or help resolve future confidentiality questions.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of August 8, 2014

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 300 **HB 300**	Adds sexual orientation to the Human Relations Act re: discrimination in employment and public accommodations - Sen. Patrick M. Browne (R-Lehigh) - Rep. Dan Frankel (D-Allegheny)	For	In State Government Committee	In State Government Committee
SB 980	Updates the psychologist licensing law, eliminates certain exemptions, and modernizes the experience requirements - Sen. John R. Gordner (R-Columbia)	For	In Professional Licensure Committee	None
SB 998	Limits retroactive denial in insurance reimbursement - Sen. David G. Argall (R-Schuylkill)	For	In Banking and Insurance Committee	None
SB 1025 **HB 1011**	Prohibits the outsourcing of prison psychologist positions - Sen. Timothy J. Solobay (D-Washington) - Rep. Michael E. Fleck (R-Huntingdon)	For	In Judiciary Committee	In Judiciary Committee
SB 1164	Prohibits criminal charges against a person seeking medical help for a drug overdose or against someone helping that person - Sen. Dominic Pileggi (R-Delaware)	For	Passed 12/1013, 50–0	Passed by Appropriations Committee, 6/25/14. On House Calendar
HB 336	Authorizes licensing boards to expunge disciplinary records for certain technical violations after 4 years - Rep. Kate Harper (R-Montgomery)	For	Passed by Professional Licensure Committee 5/7/14. On Senate calendar	Passed 2/13/13, 195–1
HB 430	Allows reports of child abuse to be submitted through advanced electronic communications - Rep. Katharine M. Watson (R-Bucks)	For	In Aging and Youth Committee	Passed 6/20/13, 184–6
HB 2190	Establishes fair contracting standards between physicians and insurers (needs amendment adding other providers) - Rep. Nick A. Miccarelli (R-Delaware Co.)	Under Review	None	In Insurance Committee

Information on any bill can be obtained from www.legis.state.pa.us/cfdocs/legis/home/session.cfm

Like a Bridge Over Troubled Water: Health Care in America

Patrick DeLeon, PhD, former APA President

Dr. Patrick DeLeon

The Congressional Budget Office (CBO): In December 2008, just prior to the inauguration of President Barack Obama, the CBO issued its biennial compendium of budget options to help inform federal lawmakers about the implications of various policy choices. In retrospect, in many ways, CBO's deliberations provided the foundation for the eventual enactment of President Obama's landmark Patient Protection and Affordable Care Act (PPACA) [P.L. 111–148]. It also raised a number of critical policy issues that are being passionately debated today.

Highlights: Because of the major fiscal and policy challenges associated with health care, CBO expanded its work in this area in order to issue two reports, the first volume focusing solely on budget options related to health care—including financing, delivery, and access—within federal programs and the larger health-care system. The second volume, which will consist of options not related to health care, was to be released in 2009. In addition, CBO provided a companion report, *Key Issues in Analyzing Major Health Insurance Proposals*.

Addressing health-care issues will be crucial to closing the nation's looming fiscal gap, which is caused to a great extent by rising health-care costs. Spending on health care has consumed an ever-increasing share of the gross domestic product (GDP) over the past 45 years, and its share will continue to rise unless changes occur to slow the trajectory. If tax revenues as a share of GDP remain at current levels, additional spending for Medicare, Medicaid, and Social Security will eventually cause future budget deficits to become unsustainable. Without any changes in federal law, CBO projected that the total spending on health care will rise from 16% of GDP in 2007 to 25% in 2025 and close to 50% in 2082; net federal spending on Medicare and Medicaid will rise from 4% of GDP to almost 20% over the same period. Many of the other factors that will play a role in determining future fiscal conditions over the long term are seen as pale by comparison to the challenges of containing growth in the cost of federal health insurance programs.

CBO noted that concerns about the rising cost of health care would be less pressing *if* there were unambiguous evidence that greater spending meant better health outcomes or a higher quality of care—a position strenuously advanced by many health-care providers. The evidence, however, suggests that the nation's increasing spending on health care may not be improving the quality of that care or health outcomes. In addition, the fact that clear geographical variations in health-care spending lead to no corresponding differences in measured health outcomes suggests that the potential exists to reduce health-care spending without affecting the quality of health care.

The amount of spending involved is quite large. One credible report indicated that Medicare spending would fall by 29% if spending in medium- and high-spending regions were the same as that in low-spending regions. CBO also observed that another challenge facing policymakers was the fact that at that time roughly 45 million Americans lacked health insurance. Trying to improve access to, and the quality of, health care while simultaneously constraining spending would be a difficult challenge, and the existence of millions of individuals without health insurance added an extra layer of complexity to such efforts. This conundrum represents a very difficult public policy "balancing act," around which there are strongly held conflicting views.

Addressing health-care issues will be crucial to closing the nation's looming fiscal gap, which is caused to a great extent by rising health-care costs.

In its report CBO also focused upon the issue of the quality and efficiency of health care. The quality of health care in the United States has long been of concern to policymakers. Despite spending more per capita than other nations, the United States lags behind lower-spending nations on several vital metrics, including life expectancy and infant mortality. In addition, many experts believe that the health-care delivery system of today is ill suited to meet current and future health-care needs, particularly with respect to the treatment of chronic conditions. Although many treatments undoubtedly save lives and improve health—and the aggregate benefits from health-care spending probably exceed the costs—evidence indicates that much spending is not cost effective and in many cases does not even improve health. These concerns have generated calls to increase the efficiency of the health-care system.

Together, Medicare and Medicaid account for a large share of the total health-care costs and are thought to influence health-care delivery in the broader health-care system. Therefore, changes in these two programs would have a ripple effect throughout the system. In recent years, interest has grown in reducing incentives for providers to perform services of marginal benefit and increasing incentives for them to improve quality. Evidence that these approaches would lead to long-term changes in the rate of growth in health-care costs is, however, lacking in many cases. In addition, the process of converting innovative ideas into successful programmatic change would probably require some experimentation and would take a number of years. Medicare, which is largely financed by the federal government within mostly uniform national policies on coverage and payments, offers opportunities to develop and test strategies to reduce costs and improve the quality of care. In the case of Medicaid, states have the primary responsibility for administering the program, so improving the quality of care that Medicaid provides can be more challenging. CBO further noted that policymakers have expressed a

strong interest in encouraging providers to adopt health information technology (health IT) to improve both the quality of care and the efficiency with which it is delivered. (Health IT refers to information technology applications specifically designed for the practice of clinical medicine, including electronic health records, personal health records, health information exchange, computerized physician order entry, clinical decision support systems, and electronic prescribing.)

In all, the 2008 CBO report presented 115 specific options, encompassing a broad array of issues related to the financing and delivery of health care—more than double the number of health-related options included in their 2007 edition of *Budget Options*. In keeping with CBO's mandate to provide objective, impartial analysis, the report made no recommendations. A review of the subsequently enacted ACA indicates that a number of these options are now public law and that they could have provided psychology with an exciting opportunity to position itself as a bona fide *health* profession. For example, in the Medical Home initiative for the chronically ill, psychology is not expressly recognized in the underlying statute or implementing regulations, notwithstanding the clinical importance of psychological care for the beneficiaries. Similarly, in the CBO report on creating incentives in Medicare for the adoption of health information technology, once again psychology is not expressly recognized. CBO also addressed the possibility of making home- and community-based services a mandatory benefit under Medicaid, with the clinical and policy goal of allowing older adults and individuals with disabilities and other health needs to remain in their home and community, instead of having to receive care in institutional settings such as nursing homes—an administration priority.

Those of us trained in the behavioral sciences and psychology in particular should be very pleased with CBO's visionary recognition of the importance of Health Behavior and Health Promotion, a definite priority of the ACA, as it was for Marc Lalonde, who was minister of National Health and Welfare of Canada in 1974. In the CBO's view, health insurance—and the access to care it can provide—is only one determinant of an individual's overall health status. Health status largely depends on an individual's decisions and behaviors regarding, in particular, diet, exercise, smoking, and the use of preventive services. The CBO report noted that federal policy can encourage or discourage behavior that affects health through several channels. For example, Medicare coverage of and payment for a given service can encourage wider use, both within the Medicare program and more generally. In the same way, if Medicare decides not to cover a particular intervention or limits coverage to certain populations, that decision can have an adverse impact beyond the Medicare program.

CBO also addressed the critical issue of providing Medicare coverage for preventive services based upon evidence of effectiveness. Interestingly, this data-driven decision-making process was the underlying theme supporting the inclusion of psychological services under Medicare back in 1978, when former APA president Nick Cummings, Russ Bent, and Joan Willens testified before the U.S. Senate Finance Committee, which has jurisdiction over Medicare and Medicaid.

Health status largely depends on an individual's decisions and behaviors regarding, in particular, diet, exercise, smoking, and the use of preventive services.

The Importance of Developing Health Policy Expertise

At this year's exciting APA State Leadership Conference (SLC), Practice Directorate Executive Director Katherine Nordal emphasized:

> The way the Affordable Care Act is unfolding reminds us that no single advocacy strategy for psychology can address the diverse legislative, regulatory and marketplace environments we see from one state to another. A combination of professional, marketplace, legislative and regulatory developments encourages more collaborative, multi-disciplinary practice models. As the landscape shifts towards more integrated care, new reimbursement mechanisms will emerge. The demand for evidence-based practices and use of quality measures related to process and outcome, including behavioral health measures, will grow. And the increasing use of technology for electronic health record keeping and telepsychology service delivery will continue to evolve.

And, as Katherine indicated at last year's SLC conference:

> Our practitioners increasingly will need to promote the value and quality they can contribute to emerging models of care. If we are not valued as a health profession, it will detract from our value in other practice arenas as well. Health care reform is a marathon—we're in it for the long haul. New models of care and changes in health care financing won't take shape overnight.

Le Ondra Clark, a colleague who is actively involved in shaping health policy as a consultant for the California Senate Standing Committee on Business, Professions and Economic Development, stated:

> I have recently had some conversations with students and colleagues about the lack of training that we as psychologists receive in policy. I often speak about how it was difficult for me to forge a path into the policy arena with no psychology mentors who were doing work in policy and no models for how to get into the policy arena. As the healthcare system and models of care become more and more integrated, it is incumbent that psychologists be prepared to work in inter/multidisciplinary settings and also learn about how to interact with and impact the policy arena.

Health policy ***is*** a required educational competency within schools of nursing, where more than 100 doctoral level programs have stand-alone required courses, with numerous other programs incorporating health policy content into related courses. As former APA president Frank Farley, who hosted a meeting on behalf of APA and the National Association of Social Workers with the First Lady during the midst of the Clinton Administration national health insurance debates, well knows: "A billion here, a billion there, and pretty soon you're talking about real money."

Aloha.

The ACA and Pennsylvania Psychologists

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Dr. Samuel Knapp

After attending a health-care conference recently, a psychologist called me up in great distress because the speaker announced that "the private practice of psychology will soon be dead." Another psychologist at a different conference was told that "any psychologist who does not join a medical home will be unemployed in 5 years." The kindest thing I could say about these statements is that they are grossly inaccurate. But I am also bothered by the fact that these comments focus on the potential negatives of the movement toward integrative care and fail to address the opportunities that it opens up.

Independent Practice Will Continue as an Option

Despite the dire predictions of imminent demise, predictions of the death of independent practice are simply wrong. Let me explain why. First, many psychologists in independent practice have income streams (such as educational evaluations, life or executive coaching, forensic work, or health service on a cash-only basis) that do not depend on third-party sources. Second, other psychologists have practices that largely depend on third parties that will be impacted very little by the Affordable Care Act (ACA), such as Medicaid/BHRS, workers' compensation, auto insurance, vocational rehabilitation, Social Security Disability evaluations, MHMR contracts, or Medicare. Third, any health-care reform is unlikely to diminish the high demand for psychological services in rural areas because of the great shortage of psychologists in those areas. The most rural counties in Pennsylvania have 1 psychologist for every 4,800 Pennsylvanians (compared to 1 psychologist for every 2,500 Pennsylvanians statewide). Furthermore, the ratio of psychologists to citizens is misleading because many of these rural psychologists work primarily in state universities or prisons and do not provide fulltime health services to the public.

Psychologists working in independent practices that rely primarily upon commercial insurance will experience some change in referral patterns, although the extent and direction of the change is unclear. About two years ago I wrote that my best *guess* is to think of health-care reform in terms of 40-40-20 (40% impacted a little, 40% impacted somewhat, and 20% impacted a lot). I still think that this ratio is about as accurate as anyone can get. This is a guess, and I could be wrong; ultimately it may be 40-20-40; 40-50-10, or some other configuration. Furthermore, the direction of the change is uncertain as well. It is possible that the impact could be positive (or very positive) for many psychologists. To explain my reasoning, I need to review basic information about the ACA and other long-term trends in health care.

Long-Term Health-Care Trends

The essential goals of the ACA are to create near universal health-care coverage and to reduce the rate of growth for health-care spending.[1] The ability to sustain near universal health care depends, to a large extent, on the ability to control medical inflation. Medical costs are driven by a few patients with serious conditions. Currently, about 1% of patients are responsible for 20% of costs, each averaging $51,000 a year (Kuehn, 2012);[2] 5% of patients for 50% of costs (Emanuel, 2012); and 10% of patients for 64% of costs. About three fourths of the high-cost patients had seven or more major chronic conditions (Emanuel, 2012). About 40% of medical patients have a comorbid mental health disorder and about 75% of seriously mentally ill patients have comorbid physical disorders (Johnson, 2013).

To save money and improve treatment, the health-care system needs to move from one that responds to patient-initiated treatment for acute conditions to one where providers take initiative to manage chronic conditions. Medical homes and accountable care organizations (ACOs) were designed to do just that through better coordination of care and integrating behavioral health into the overall plan for the treatment of the patient.

No one knows for certain how medical homes and ACOs will impact the overall delivery or cost of medical services or the practices of psychologists in Pennsylvania. It is possible that the impact will vary considerably across the state because some insurers might be able to create, maintain, or expand medical homes that reduce costs; while other insurers may be unable to do so. To date the data on medical homes is mixed. Some have reduced the rate of medical spending (or even reduced costs), while others have not. Most result in some improvement in health-care outcomes (Robert Wood Johnson Foundation/ Consumer Union, 2013).

Although medical homes typically promote behavioral health interventions, they can deliver those services in any number of ways. They may hire psychologists (or other health-care professionals) directly, contract with them, refer services to professionals in the community, or use some combination of those options. Also, medical homes can pay for services in a number of ways. They may pay a fixed amount for a unit of service, pay dependent on outcomes, or pay according to a formula that includes both the units of service and outcomes. In a medical-home model, some patients who formerly sought therapy from the outpatient office of a psychologist will now receive treatment from psychologists or other mental health professionals directly connected with that medical home. The extent to which this will occur is the unknown that makes predictions uncertain.

1 Sometimes this is expressed in terms of "saving money," which means "bending the curve," or reducing the anticipated rate of medical spending growth.

2 Other researchers have found the same general trend that a small percentage of patients use a great deal of health care. Brenner found that 1% of the residents of Camden, New Jersey, accounted for 30% of hospital costs (targeted interventions reduced those costs by 40 to 50%; Gawande, 2011).

Finally it is unclear as to the extent to which medical homes will rely on psychologists or other mental health professionals to deliver the behavioral health.[3] Some psychologists worry that the medical homes will hire less trained professionals to provide services to save money. Of course, some ill-informed administrators will do just that, and it is up to psychologists to promote our unique skills and expertise. However, I resist the perception that some kind of invisible hand of history will make the marginalization of psychologists inevitable.

The fact that other mental health professionals can do some of the same work as psychologists does not necessarily mean that we are doomed to extinction. Certainly case workers with master's degrees or less can do some of the monitoring and outreach for persons with chronic health-care problems. Also, psychologists as well as psychiatric nurses, marriage and family therapists, social workers, and counselors can all provide outpatient psychotherapy.

Nonetheless, medical homes and ACOs have several reasons to involve psychologists. First, the scope of practice of social workers, licensed professional counselors, and marriage and family therapists requires them to get consultation when they treat a person who presents a danger to die from suicide or who has an apparent biologically based disorder. No such restrictions exist on the licenses of psychologists. Second, Medicare recognizes psychologists and licensed clinical social workers (but not other professionals) for direct reimbursement for psychotherapy. Also, most psychologists (especially recent graduates) are well qualified to treat patients with comorbid medical problems because of their extensive education in the biological basis of behavior. Furthermore, psychologists may be preferred by medical homes or ACOs because only psychologists can conduct psychological and neuropsychological testing, and only psychologists and physicians can perform health and behavior codes (psychological interventions for medical problems).

3 Within one clinic the most common activities were screenings (27%), consultation (50%), individual therapy (16%), diagnostic evaluations (3%), child screens (3%), smoking cessation (2%), and family/group therapy/drug treatment/combined (1%; Auxier et al., 2011); numbers do not equal 100 because of rounding). Of course the distribution of work may vary according to the idiosyncrasies of each practice.

Most importantly, however, psychologists can do really good work in an integrative care setting. There is both hard evidence (Brooke & Axelrod, 2013; Knapp, 2012) and anecdotal support for viewing psychological services as integral toward providing high-quality and efficient care for patients with serious and chronic conditions. Many psychologists I know like the collegiality of working in medical offices, perceive that they are treated with respect, and know that they are making a difference in the lives of patients.

Of course the impact of medical homes and ACOs will be moderated by other changes in the overall health-care environment. As part of the ACA, most policies will cover preventive care (weight loss or smoking cessation) and mental health. In addition, the ACA increases coverage for the 12% of Pennsylvanians who were uninsured in 2013. About half of the previously uninsured Pennsylvanians can be covered by health-care exchanges.[4] The other half of those will be eligible to be covered by an expanded Medicaid program if Pennsylvania agrees to accept such an expansion.[5] Finally, our ability to predict the overall success of psychological practices will depend on other trends such as the payment rates for services under Medicare and Medicaid.

Psychologists can do really good work in an integrative care setting.

In conclusion, I believe that the ACA will have little impact on 40% of psychologists and some (yet to be determined) impact on the other 60%, depending on the confluence of many concurrent changes in the health-care system. Older psychologists with established independent practices will probably have a sufficient source of referrals that they could survive any major change in the health insurance market until they retire. Early- and mid-career psychologists who have independent practices dependent on commercial third-party reimbursement may, depending on a variety of factors, find changes in the way that outpatient independent practice has been conducted. Those psychologists who want to take advantage of interesting opportunities in medical homes or with integrative care will have an easier transition if they have (a) established a relationship with physicians or health-care systems; (b) expertise in treating high-cost patients, such as patients with comorbid medical disorders; and (c) an outcomes system in place. However, the biggest impetus to become involved in integrated care is, in my opinion, not so much to avoid disaster but to embrace the chance to expand practice opportunities where they are badly needed.

4 Some of the health exchange policies have high deductibles, so health care is not as accessible as one would hope. Deductibles have been increasing even for long-standing commercial insurance policies (in the last 4 years deductibles raised from $680 and $1,000 in-network and out-of-network respectively to $1,230 and $2,110). As of April 2013, half of the Pennsylvanians eligible to enroll in health exchanges had done so. Most had no previous insurance coverage.

5 Although Governor Corbett has proposed a Medicaid expansion program, it is unclear whether the federal government will approve it. Democratic gubernatorial candidate Thomas Wolfe has promised to expand Medicaid. Several independent reports have claimed that Pennsylvania will benefit from the Medicaid expansion.

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Health-Care Reform Creates Opportunities for Psychologists and Patients

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Psychologists can expect to experience an increased demand for their services due to the enactment of the Patient Protection and Affordable Care Act (PPACA). The ACA, as it is commonly referred to, has set in motion aggressive reforms aimed at normalizing the provision and receipt of mental health and substance abuse services in the United States. New rules mandating parity with medical benefits, coupled with removal of barriers to care, are projected to result in an influx of persons seeking mental health treatment. Although the health-care industry as a whole is projected to experience a swell of consumers, the mental health field is especially rife with opportunity.

Increased Access to Health Insurance

An overarching goal of the ACA is the expansion of health insurance to millions of uninsured Americans. The act seeks to accomplish increased access to coverage, in part, through the imposition of the individual mandate, which requires that all Americans (with limited exception) obtain minimum essential health coverage in lieu of paying a penalty. Drafters of the law aimed to facilitate access to minimum essential coverage through three primary methods: (a) the expansion of Medicaid, (b) the creation of Health Insurance Exchanges with attendant subsidies, and (c) the employer mandate.

Expansion of Medicaid

Prior to the ACA, Medicaid coverage was generally available only to certain groups of low-income individuals, including children, parents, pregnant women, disabled persons, the blind, and*DSM*older adults. Individuals of limited means not falling within one the foregoing categories had few options to otherwise obtain affordable health insurance. To reconcile this gap, the ACA was drafted to expand the reach of Medicaid eligibility to all unincarcerated Americans between the ages of 19 and 65, earning up to 138% of the federal poverty level (FPL), or approximately $15,800 for individuals and $32,400 for families. Doing so was intended to provide access to health coverage to nearly half of America's uninsured. In 2012, the U.S. Supreme Court drastically curtailed the reach of the Medicaid expansion, however, by holding that the states could not be required to expand the same. Instead, they have to be given the option to expand. Faced with the choice, the majority of states have expanded Medicaid, compared with 20 that have declined as of the writing of this article. Providers in expansion states can expect an upsurge in Medicaid patients. Currently, the expansion of Medicaid in Pennsylvania is the subject of ongoing debate. Although an alternative expansion plan has been proposed by the Commonwealth, federal approval remains pending. A final ruling is expected by the end of the year.

New rules mandating parity with medical benefits, coupled with removal of barriers to care, are projected to result in an influx of persons seeking mental health treatment.

Health Insurance Exchanges and Subsidies

Health insurance exchange (HIE) is defined by the Centers for Medicare & Medicaid Services as "A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage." By way of analogy, HIEs are reminiscent of the travel websites wherein you can compare prices from different vendors (only they are heavily regulated, and their use largely will be a matter of necessity).

Beyond the opportunity to shop and compare prices, persons earning between 100 and 400% of the FPL, who do not otherwise have an offer of affordable coverage, are eligible to receive a "premium tax credit" to defray the cost of purchasing a qualified health plan (QHP) in an HIE. Americans had their first opportunity to enroll in insurance via HIE between October 1, 2013, and March 31, 2014. Over 8 million Americans enrolled in QHPs, with approximately 85% receiving governmental assistance. The number of HIE enrollees is projected to grow into the future.

However, a recent Federal Circuit Court opinion has called the longevity of subsidies provided in federally facilitated exchanges (and incidentally federally facilitated exchanges) into question. The Circuit Court for the District of Columbia has ruled that subsidies provided through federally facilitated exchanges are not supported by the ACA. Instead, the Court opined that the law was written to provide for subsidies in state-facilitated exchanges only. This issue will likely make its way to the U.S. Supreme Court, as the Court of Appeals for the Fourth Circuit has held oppositely. If it is ultimately ruled that subsidies are no longer available in federal-run exchanges, enrollment in health insurance through HIEs will likely dramatically decrease, seriously undermining the ACA.

Employer Mandate

Although many employers offered health insurance to their employees prior to the passage of the ACA, moving forward "large employers" (meaning those with 50 or more fulltime-equivalent employees) must offer health insurance that is "affordable" and of "minimum value" to their fulltime employees to avoid paying considerable fines. The employer mandate is intended to serve as the third mechanism to close the uninsured gap. Its operation has been temporarily

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ACA Opportunities and Challenges

Allen Miller, PhD, MBA

Dr. Allen Miller

The Affordable Care Act (ACA) provides opportunities and challenges for psychologists. An opportunity is that it puts us in a prominent position at the table of providers who treat a variety of health conditions. A challenge will be in treating some patients who have conditions for which we have established protocols. Why should those conditions pose challenges to us? Under the ACA, payment models will shift from being primarily fee-for-service to include some variety of bundled payments or capitation to provide population management. Under the new payment models, the providers will be at financial risk for the total cost of health care for the population of people being cared for. Because medical conditions can be treated more effectively and for less cost when patients also receive psychological treatment, there will be strong incentives for providers to engage patients into effective psychological treatment even if the patients do not want treatment.

How can we finesse our way into providing care to patients who do not want it, and how can we make a difference for patients who are not psychologically minded? These were questions we set out to answer when accepting a certain referral from a primary care physician. The patient had been cast into the unsavory category known as "superutilizers" of medical treatment.

Josh (pseudonym) was a 30-year-old single male who had been laid off from his engineering job several years previous. He was referred to me with the diagnosis of somatic disorder. He had previously had heart surgery, had his thyroid removed, and more recently had experienced multiple physical complaints of unknown origin. During the previous two-year period, he had made numerous visits to the emergency department(ED), his primary care physician, and medical specialists including cardiologists, neurologists, endocrinologists, and a rheumatologist. Although he accepted the referral to me he quickly stated that there was no psychological component to his problems. He said that the medical professionals just needed to find out what was wrong with him physically and treat him for it. Without seeming to make any connection to his physical complaints he acknowledged that he had anxiety. His thought was that his anxiety would go away when his physical symptoms were treated.

In the years prior to his referral to me, Josh had experienced medical problems that generated great concern in him. He developed the pattern of automatically going to the ED when he had physical discomfort. Part of the reason for going to the ED was that he made catastrophic misinterpretations about minor symptoms. Seeing a doctor, getting an EKG, and finding that nothing was seriously wrong with his heart relieved his concerns. Medical doctors repeatedly reinforced that coming in to see them was the safest route—just to be sure.

A major fear Josh had when he was first referred for psychological treatment was that he had developed cancer as a result of radiation exposure from the many imaging tests he had undergone. His physicians had already assured him that he did not have cancer, but he had trouble accepting their assurances. He was won over by our evaluation of his beliefs. Together we considered the difference between the possibility of his having cancer versus the probability of having cancer. He concluded that he most likely did not have cancer, and he experienced relief. In retrospect, something he has repeatedly mentioned as being important is that the psychologist never told him that he did not have physical problems or that it was "all in (his) head."

During the initial phase of treatment, we constructed a conceptualization to understand how his pattern of making frequent visits to medical providers developed and was maintained. One thing we learned was that he had become hypersensitive to any physical discomfort. He came to require reassurance that he was okay. Reassurances provided by physicians offered temporary relief from his worry and suffering. I spent much time educating the patient about the mind-body connection, teaching guided discovery to help him to evaluate his thoughts, and used motivational techniques to engage him in treatment. I eventually used additional cognitive-behavioral techniques to teach him alternative thoughts and behavioral reactions to physical discomfort.

A challenge will be in treating some patients who have conditions for which we have established protocols.

During the treatment phase, I used standard cognitive-behavioral techniques to address his varying concerns. Relaxation techniques, exposure techniques, and alternatives to cognitive misinterpretations were used to help him better tolerate his physical symptoms and to reduce his reactions to the symptoms. As initially stated, a major reason for Josh's referral for psychological treatment was related to his extensive use of medical services. In the year prior to his referral, he utilized laboratory services 364 times, radiation imaging 39 times, and EKGs 32 times. He made a total of 73 visits to the ED and 104 visits to his primary care doctor and medical specialists to seek the reassurance he desperately needed.

By participating in treatment, he learned to tolerate the discomfort of his physical symptoms (thereby reducing his discomfort) and found that most symptoms quickly reside even if left unattended. Upon reflection he recognized

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ACA OPPORTUNITIES AND CHALLENGES

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that even if labs or EKGs were done in the ED or a physician's office, he could not remember a time when a treatment or intervention was given other than reassurance that everything was okay. After a medical visit, he would return home the same day without having received any medical treatment per se. By increasing his activity level in my office he learned that he could experience an increased heart rate and quick breathing and that those symptoms would soon subside without an intervention. These exercises challenged his belief that these physical symptoms posed a danger to him. By not interpreting each symptom as being potentially dangerous and by using relaxation and exposure techniques he learned to tolerate the symptoms and manage his discomfort. When he learned to manage his discomfort, he increasingly found it unnecessary to go to the ED or medical specialists for reassurance.

During the current year, Josh's utilization of medical services has been drastically reduced. His medical record shows that he has had fewer labs (17), no radiology, only biweekly appointments with his primary care physician, monthly (or less often) appointments with medical specialists (14), and fewer ED visits (7).

As psychologists venture into the future of being providers of care for medical patients and as we are included in models for providing population health care, we will find it necessary to find effective ways to establish rapport, to identify and utilize treatment techniques as quickly as possible, to deliver them as efficiently as possible, and to achieve positive outcomes while improving satisfaction for entire populations of patients (whether or not they seek out our services). The challenges are great, but the opportunities have never been better for psychologists to move into the mainstream of being general health-care providers.

HEALTH-CARE REFORM CREATES OPPORTUNITIES

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postponed, however, rendering its ultimate impact yet to be seen.

Overall, the three aforementioned statutory constructions have resulted in increased access to coverage for millions of Americans. Significant to psychologists, these newly insured individuals will be operating according a new set of rules that requires equal treatment of mental health services by payors, ending longstanding disparate treatment.

Reforms in the Mental Health Field

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that group health plans and insurers treat coverage of mental health and substance abuse (MH/SA) disorders equally to medical and surgical benefits, if the former are covered services. In other words, although not required to offer MH/SA benefits, if applicable employers (generally, those with 50-plus employees) decide to do so, they must be offered with the same cost requirements and treatment limitations applicable to medical and surgical benefits. Moreover, if an insurer denies MH/SA benefits, a written explanation must be provided to the participant explaining the decision.

The ACA expanded the parity requirement to plans offered in the small group and individual markets. Consequently, only certain local government and self-insured employers have the choice to opt out of MHPAEA requirements. Even more significant, the ACA *requires* that all HIE individual and small group plans offer mental health services as an "essential benefit" (large group plans and small group and individual plans offered outside of an HIE have no similar requirement), greatly expanding access to MH/SA services.

Together, the ACA and MHPAEA have effectuated access to mental health services to approximately 62 million Americans, incidentally creating new opportunities for psychologists to both earn a livelihood and shape the well-being of their communities. These opportunities are bolstered by additional health reforms enacted by the ACA, including: the elimination of preexisting condition exclusions and the removal of annual and lifetime limits. Overall, psychologists and their patients can expect to see a new landscape in the mental health field.

Ms. Martin wishes to express her sincere thanks to Nicole Radziewicz, JD, also a member of the Health Law Group, for her assistance with this article.

Health-Care Changes and Psychology: A Student's Perspective

Kylie A. McColligan, MA

Kylie A. McColligan

Students are continually faced with headlines about how health-care reform will impact the field of psychology. For example, according to the National Alliance on Mental Health (NAMI) more than 11 million individuals affected by mental illness do not have health insurance (National Alliance on Mental Health, 2013). The health reform law, entitled the Patient Protection and Affordable Care Act (PPACA), is designed to target the disparity between individuals in need of mental health services and the number who receive them by offering more choices for health insurance for people living with mental illness. Thus, one may speculate that health-care reform will have a positive impact on the field of psychology by allowing more individuals to receive mental health services.

In reality, little is known regarding the specific effects of the ACA on psychology. Although the ACA became law on March 23, 2010, its effects on psychology are just beginning to be understood. A May 30, 2013, article by the American Psychological Association (APA) indicates that the ACA poses unique challenges for psychologists. The difficulties psychologists are most likely to face are centered on the Affordable Insurance Exchange, the online health insurance marketplace where individuals can view and compare various health insurance plans. According to the APA, psychologists who are in-network providers need to consider assignability provisions, provider notifications, network directories, cost-sharing requirements, and complaints and appeals processes (APA, 2013). For a more detailed overview see APA, 2013.

Health-care reform also emphasizes primary care and integrated health care teams. This emphasis has a direct impact on psychologists, especially psychology students, as they will be expected to work in integrated health-care settings. In an effort to prepare future psychologists for their broadening role, the APA established the Primary Care Training Task Force. The main focus of the Primary Care Training Task Force is to determine what doctoral training programs are already doing to prepare students for work in primary care settings. This information will then be used by the APA to ensure future psychologists are prepared to work in integrative health-care settings (Clay, 2011). Therefore, it is crucial that doctoral training programs design their curriculum to encompass the impact of health-care reform. Furthermore, it is equally important that as professors learn about the impact of health-care reform they pass this information along to their students. As a means of addressing health-care reform, this author's doctoral program includes a course dedicated to the practice of psychology.

In reality, little is known regarding the specific effects of the ACA on psychology.

Given that training programs cannot be all encompassing, students should seek opportunities to learn about health-care reform and integrative care models outside of the classroom. For example, students can educate themselves about health-care reform by attending conferences where workshops are held specifically targeting integrative care; several were offered at this year's PPA annual convention. Furthermore, associations such as NAMI offer webinars about health-care reform and its implications for mental health. In addition, students can glean valuable information from practica supervisors about how health-care reform has impacted their practice of psychology. Opportunities for involvement in integrative care projects also exist. For example, graduate students at Marywood University were eligible to be a part of the Pennsylvania Pediatric Mental Health Task Force, which was established by the PPA to better integrate pediatric primary care and mental health throughout Pennsylvania.

Graduate students should consider how health-care changes will impact their training and career options as well. Health-care reform provides additional training and employment opportunities for future psychologists, such as working in integrated care settings and with geriatric populations. For example, as a result of health-care reform, the federal Health Resources and Services Administration established three training programs for providers for the aging in which psychologists are eligible to work (Clay, 2011). Students may also want to consider seeking specialized training through predoctoral internships in integrated or primary care settings.

Current psychology students represent the first generation of psychologists who will be practicing in a fully integrated care environment. Thus, it remains to be seen how health-care reform will impact future psychologists. As health-care reform continues to unfold, its impact on psychology and future psychologists will become clearer.

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Brain Injury and School Reentry

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Dr. Stacie A. Leffard

Traumatic brain injury (TBI) is the most common cause of death and disability in children (Gotschall, 1993). Approximately 75% of brain injuries are mild, with the other 25% being moderate or severe (Comstock & Logan, 2012). In children, these injuries are most common from birth to age 4 and from ages 15 to 19. When a child is discharged from inpatient or outpatient rehabilitation, families often look to schools to provide support and help with this transition between hospitalization and the return to a typical routine. It is important for school personnel to be familiar with recovery from all severities of acquired brain injury and to understand the importance of a student's adjustment to recovery.

Concussion

Concussion, as defined by the Fourth International Conference on Concussion in Sport (McCrory et al., 2013), is a complex pathophysiological process affecting the brain that may be caused by a blow to the head, face, neck, or other part of the body with force transmitted to the head. Symptoms typically occur immediately after injury but may develop over the next several hours. Loss of consciousness may or may not occur. Mental status change (e.g., disorientation, memory loss) is a common indication of concussion. Other common symptoms of concussion include headache, attention difficulties, fatigue, mental fogginess, irritability, and sleep disturbance. Dizziness and balance difficulties can also occur. Recovery is attained when a child returns to his or her baseline of cognitive functioning and physical symptoms have resolved at rest and with exertion.

Given the propensity of media coverage for this topic, it is important to maintain familiarity with typical recovery patterns of concussion to set appropriate expectations. In a study of concussed high school and collegiate athletes, 90% of athlete's recovered from concussion within 7 days. Of the remaining 10%, only 25% continued to endorse symptoms at 6 to 12 weeks (McCrea et al., 2013). These results indicate that most concussions resolve quickly and without complication.

Though most people recover quickly, there are cases in which recovery is quite extended in duration. Predictive factors for protracted recovery include loss of consciousness, amnesia, and initial symptom severity (McCrea et al., 2013; Yeates et al., 2012). Dizziness at the time of injury has also been found to be related to protracted recovery (Lau et al., 2011). Psychosocial functioning is commonly thought to have a moderating effect on recovery. Based on recent findings, children from higher functioning families may report more postconcussive symptoms than children from families with more adversity (Yeates et al., 2012).

The need for accommodations is typically brief in duration, with most, but not all, students functioning without accommodations by 6 weeks postinjury.

With regard to school return, students with concussion may return to school immediately or after several weeks. Common school accommodations provided include reduced schedule (e.g., half days), preferred seating, testing in a quiet environment, and breaks in instruction as needed. The type and duration of accommodations needed depends largely on symptoms, severity, and duration of recovery. Again, the need for accommodations is typically brief in duration, with most, but not all, students functioning without accommodations by 6 weeks postinjury. The mechanism for providing these accommodations varies by school district and may involve a formal 504 plan or informal communication among school staff for consistency.

Moderate and Severe TBI

Severity of brain injury is determined based on duration of loss of consciousness, duration of posttraumatic amnesia, and the Glasgow Coma Scale (GCS), which represents the level of responsiveness after injury. Moderate brain injury is typically classified by less than 6 hours of unconsciousness and a GCS of 9 to 12 at hospital admission. Severe brain injury is classified as greater than 6 hours of unconsciousness with a GCS of less than 9.

Moderate and severe brain injuries differ from concussions in many ways, including duration of recovery and range of associated impairment (Taylor et al., 2008; Trenchard, Rust, & Bunton, 2013). Children with moderate and severe TBIs typically recover over the course of years rather than weeks. Injuries may include specific or diffuse cognitive difficulties as well as motoric impairment. Each injury is unique and must be approached as such. Generalizations should not be made from concussion to moderate and severe TBIs to avoid minimizing the consequences of injury and duration of recovery.

In terms of outcomes, younger age at injury, particularly ages 2 through 7, is a predictor of more negative outcome and potential for longer-term cognitive difficulties (Anderson, Catroppa, Morse, Haritou, & Rosenfeld, 2005; Taylor et al., 2008). In contrast with concussion in which higher functioning families may report more symptoms, premorbid family adversity is associated with more negative outcomes in severe TBI (Taylor et al., 1999; Taylor et al., 2008).

For children with moderate and severe TBI, return to school can be a complex process that may involve both accommodations and modifications through a 504 plan or Individualized Education Program. Related services, such as physical, occupational and speech therapies, and vision and hearing support may also be necessary. These programming changes may be temporary or permanent depending on extent of recovery from the injury.

School Reentry

Two primary factors that need to be considered during school reentry for a child with any type of brain injury are communication and adjustment. In the medical community, school is considered an extension of rehabilitation therapies for ongoing cognitive stimulation and support of recovery. From the school perspective, giving the child access to a free and appropriate public education in the least restrictive environment is the primary goal. These different perspectives can cause communication difficulties at times as both environments have different criteria for needed services. Medical providers focus on restoration of function, whereas school personnel focus on ensuring as much access to the regular education environment as possible. Both of these perspectives are important for recovery, but communication difficulties can result as families attempt to navigate these two perspectives.

In order for school reentry to be successful, communication needs to be consistent and comprehensive among all systems (Farmer, Clippard, Luehr-Wiemann, Wright, & Owings, 1996; Semrud-Clikeman, 2010; Sharp, Bye, Llewellyn, & Cusick, 2006). Medical settings and parents benefit from communication about the special education process, and schools benefit from communication regarding a child's medical condition, current needs, and known recovery expectations. The school psychologist is an ideal person to assist with this communication, based on consultative skills and role in special education programming.

In addition to communication, consideration of a child's adjustment is also important for successful school transition. Regardless of injury severity, children coping with brain injury experience a number of changes to their environment and social experience. A child with a concussion may not attend school or participate in athletics for a period of time. Children with a moderate or severe brain injury may return to a different environment entirely. School personnel, including school psychologists, can assist with adjustment in many ways. For concussion, it is important for schools to reinforce expectations of recovery and provide encouragement during interactions with these students. For more severe injuries, a step-wise approach to assisting children with adjustment, such as a meet-and-greet with a few peers and a tour of the building prior to return, is suggested. Additionally, providing opportunities for quality social interaction with peers is helpful for all levels of injury.

Resources

Kirkwood, M. W., & Yeates, K. O., Eds. (2012). *Mild traumatic brain injury in children and adolescents*. New York, NY: Guilford.

Dise-Lewis, J. E., Calvery, M., & Lewis, H. C. (2006). *BrainSTARS: Brain injury—strategies for teams and re-education for students*. Wake Forest, NC: Lash.

Pennsylvania-specific resources:

BrainSTEPS (www.brainsteps.net)

Brain Injury Association of Pennsylvania (www.biapa.org)

References Available Online

Teen Pregnancy Prevention and the ACA

Katherine Piselli, MSEd, Kerry Schutte, MSEd, Rachael L. Hoffman, MSEd, and Ara J. Schmitt, PhD; Duquesne University

Katherine Piselli

Kerry Schutte

Rachael L. Hoffman

Dr. Ara J. Schmitt

The Patient Protection and Affordable Care Act (PPACA) of 2010 considers schools a primary location for the delivery of health services, including prevention services. Under the ACA's Preventive Services Mandate, children and teens can gain access to preventive services, such as screenings for sexually active teens, contraception counseling, and sexually transmitted infection (STI) prevention counseling (Pilkey et al., 2013), with no out-of-pocket expenses. In 2013, the Family and Youth Services Bureau of the Department of Health and Human Services (DHHS) distributed $41.7 million to fund states through the Personal Responsibility Education Program (PREP). PREP's mission is to provide comprehensive sex education to teens in order to prevent pregnancy and STIs (Family and Youth Services Bureau, 2013) and fund evidence-based programs "that have been proven to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth" (Family and Youth Services Bureau, 2013, p. 1). School psychologists who also hold a license to practice independent psychology are in a prime position to seek federal funds and deliver such prevention services as a "qualified provider[s]."

Prevalence and Outcomes of Teen Pregnancy

Although teen pregnancy rates have been steadily decreasing since 1990 with a 51% decrease from 1990 to 2010 (Kost & Henshaw, 2014), the pregnancy rate during that time period for teenagers aged 15 to 19 was 29.4 births per 1,000 teenagers (Martin, Hamilton, Osterman, Curtin, & Mathews, 2013). That said, a 2009 survey from the Centers for Disease Control found that 72.7% of pregnancies by teenagers were unintended (Centers for Disease Control, 2012).

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TEEN PREGNANCY PREVENTION

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Teenage pregnancies place an economic burden on taxpayers, costing an estimated $9.4 billion in 2010 (The National Campaign, 2013). Teen pregnancy has numerous negative social outcomes, including increased risk for school dropout and need for public assistance (Hoffman & Maynard, 2008). Furthermore, children born to teenage mothers are more likely to have medical or behavioral problems and are also more likely to drop out of high school, become incarcerated, give birth as a teenager, and be unemployed as an adult (Centers for Disease Control, 2011).

School and community involvement were found to be protective factors against risky sexual behaviors.

Teen Pregnancy Prevention

Kirby and Lepore (2007) conducted a review of more than 400 studies that identified protective factors that may reduce the risk of pregnancy and STIs. School and community involvement were found to be protective factors against risky sexual behaviors. However, the strongest factors were related to the teens' beliefs, attitudes, and values related to sexual activity. For example, a teen is more likely to use contraception if the teen believes that both young men and women are responsible for preventing pregnancy, and the teen believes that his or her partner will anticipate safe sex. A teen is also more likely to use contraception if the negative consequences of pregnancy and STIs are considered and if he or she possesses the skills to insist on the use of contraception.

*DSM*Although a multitude of factors may influence teens' decisions to participate in sexual activities, the link between these decisions and teens' beliefs and attitudes provides an avenue for intervention. Community- and school-based pregnancy prevention programs allow teens to become more educated on the risks related to sexual activity, allow for the development and practice of decision-making and assertiveness skills, and help foster a sense of personal responsibility. The following is an overview of two evidence-based prevention programs school psychologists might consider for their districts.

Safer Choices: A Classwide Curriculum

Safer Choices is a high school sexual education program that received a high effectiveness rating by the DHHS. *Safer Choices* is a structured 2-year curriculum for 9th- and 10th-grade students that can be administered in the classroom by trained teachers (Basen-Engquist et al., 2001; Coyle et al., 1999). Each grade level of the program includes 10 lessons that provide information about STIs, HIV, and condom use. Additionally, student leaders facilitate activities that aim to help their peers learn to refuse pressure to have sex and use responsible decision making. A primary goal of the program is to emphasize partnership between the school and the community. *Safer Choices* is designed to include collaboration between a council of teachers, parents, administrators, students, and community members. The complete *Safer Choices* curriculum, including the training manual, student workbooks, role-playing cards, and pamphlets, is available for purchase online from ETR Associates.

An initial study on the *Safer Choices* program using the grade nine curriculum found positive postintervention effects on the use of condoms for sexually experienced students in the experimental group when compared to the control group (Coyle et al., 1999). Following the intervention, students in the *Safer Choices* group also demonstrated significantly increased knowledge about STIs and HIV and more positive attitudes regarding safe sex. Subsequent research has shown similar positive outcomes when the effects were compared across ethnicity and gender (Kirby et al., 2004).

17 Days (*What Could You Do?*): An Individual Intervention

The *17 Days* DVD, formerly known as *What Could You Do?,* is a pregnancy prevention intervention program that has been implemented in health clinics in Pennsylvania, Ohio, and West Virginia. The DHHS advocates that *17 Days* is an evidence-based program that is highly effective for preventing pregnancy in adolescents (U.S. Department of Health and Human Services, 2014). The program aims to teach sexually active females between the ages of 14 and 18 about STIs and contraceptives and effective decision making. In order to complete the program, participants must watch a DVD that contains four hypothetical scenarios, three brief documentaries, and a condom demonstration. The hypothetical scenarios included on the DVD are considered to be interactive and provide viewers with opportunities to cognitively rehearse appropriate responses to imaginary at-risk situations. The brief documentaries included on the DVD present real-life situations and teach participants about STDS, male and female anatomy, and contraceptives, including correct condom use.

Participants are expected to complete the program over the course of four sessions. Sessions are intended to be completed in privacy with each participant having the opportunity to watch the DVD alone. During the first session, a participant watches a scenario of his or her choosing and then watches the condom demonstration as well. The following three sessions are then delivered 3, 6, and 18 months after the first session. During these additional sessions, participants select one of the remaining scenarios and one documentary to watch. According to Downs et al. (2004), young women reported significantly more instances of abstinence after the 3-month session in the *17 Days* program compared to participants in control programs. Furthermore, after receiving the 6-month session, participants were significantly less likely to report being diagnosed with an STD.

Teenage pregnancy can have a number of repercussions for teen mothers, fathers, and their children. Schools are in a unique position to intervene with teens to help them make educated choices regarding safe sex and better understand the risks associated with sexual activity. The ACA intends to strengthen the role of school districts by specifically considering schools a primary location for the provision of preventive health services.

References Available Online

Using *ICD* as It Is InTENded

Edward L. Zuckerman, PhD; edzucker@mac.com

Dr. Ed Zuckerman

Health care is changing rapidly, including the diagnostic code we will be required to use. The whole world has used the *International Statistical Classification of Diseases and Related Health Problems* (10th ed.), or *ICD-10,* since 1994. As of October 1, 2015, all health-care providers in the United States must use it too. Here is a guide to the *ICD-10*, which has a different philosophy and layout than the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), or the *DSM-5*.

The Lay of the Land

You want to use the *ICD-10-CM* (Clinical Modification) version of 2015 (which is the same as for 2014) from the National Center for Health Statistics of the Centers for Disease Control and Prevention. You can download the whole shebang from www.cdc.gov/nchs/icd/icd10cm.htm#icd2015, but it will take you hours of work to make it user friendly. Note that you want all the F codes, most of the Z codes, and some R, T, and other codes (see below for why these are valuable).

Implementation: Use *ICD-9* codes (numbers) and diagnoses (labels, names) for recording and billing all services performed before October 1, 2015, even if you bill later. Use *ICD-10-CM* codes after that date. Remember that we are catching up: The rest of the world has been using *ICD-10* since 1994.

While there are 10 times as many codes in the *ICD-10* than the *ICD-9* or *DSM-IV* most of this increase is because of the substance use and abuse codes (see below). Do not be intimidated by the number of codes and do not fall for the criticisms that the huge number is burdensome (everyone will use only a few familiar codes) or that many codes are irrational (e.g., V91.07XA "Burn due to water-skis on fire"). In fact, the finer grained diagnoses of *ICD-10* will be very helpful (e.g., specifying which trimester of pregnancy or which artery is bleeding).

These are diagnostic codes and not treatment, procedure, or service codes. We will still use the CPT (Current Procedural Terminology) codes from the American Medical Association, although inpatient services have used the *ICD-10-PCS* (Procedure Coding System).

The mental health codes rarely change. While *ICD* is designed to expand for finer distinctions (using more decimal places) and can be modified each year (many numbers are not presently used), the codes in mental health changed little with *ICD-9*, and I expect that to continue. There is a moratorium on changes for now but the American Psychiatric Association is expected to

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lobby to include some of *DSM-5*'s unique diagnoses. Tune in each summer for updates that will take effect on October 1.

As with *DSM-5*, each code can have several diagnoses associated with it. You can use any of these in your documentation. *DSM-5* has adopted about half of the codes available in *ICD-10* and also renamed about a quarter of these so the labels will not match exactly.

The disorders are clustered in familiar groups but arbitrarily sequenced (whereas *DSM-5* uses a rough developmental sequence), which makes looking up a diagnosis more difficult. You may have to search for locations to find the diagnosis you need.

Where have all the axes gone? Neither *DSM-5* nor *ICD-9* or *-10* use axes (although they may come back in *ICD-11*). Just list all the appropriate diagnoses from Axes I, II, and III. Axis IV ("problems" in functioning) is much more extensively addressed by the Z codes of *ICD-10*. Axis V—the arbitrary GAF—has been replaced by a much more reliable and extensive WHODAS (World Health Organization's Disability Assessment Schedule 2.0) in *DSM-5* and can be used with *ICD-10* as can other measures from WHO or elsewhere for assessing functioning and disability (see section 4).

Large differences between the approaches to mental health issues exist between *DSM* and *ICD*. First, the *ICD* bluebook (World Health Organization, 1993) states the following:

> Descriptions and guidelines carry no theoretical implications, and they do not pretend to be comprehensive statements about the current state of knowledge of the disorders. They are simply a set of symptoms and comments that have been agreed, by a large number of advisors and consultants in many different countries, to be a reasonable basis for defining the limits of categories in the classification of mental disorders (p. 9).

This stands in sharp contrast with *DSM*'s approach. The table below summarizes more of the differences.

DSM-5	*ICD-10*
American	Multinational
Unicultural	Multicultural, multilingual, diverse
Psychiatry	Multidisciplinary
Expensive	Free
Only for use by the most trained	Usable at all levels of expertise and service delivery
Some research basis	Just used by clinicians
Low reliability	High reliability (by design)
Little if any validation	Not relevant to purpose

Identifying the (Closest) Disorder

Although not well known, there is a manual commonly known as the "bluebook" that contains the diagnostic criteria for each diagnosis. The "bluebook," or *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*, is published by the World Health Organization and available free as a 267-page download from: www.who.int/classifications/icd/en/bluebook.pdf. It offers only the diagnostic criteria although the introductions to several categories of disorders offer educational and thoughtful explanations. The lists of symptoms and the numbers needed for a diagnosis are much less rigid in *ICD* than *DSM* and clinicians are allowed to use their judgment. The book is 20 years old and so a few of the code numbers are different in the current *ICD-10-CM* list.

Currently you can choose to use diagnostic criteria from the bluebook or *DSM-IV* or *DSM-5* or even other standard sets (like for the sleep disorders) and then record the diagnosis with the *ICD* code numbers. To be consistent, I suggest including the label from the publication you used for the criteria, although there is not, at present, such a requirement.

Selecting the Recording Code

The familiar psych diagnoses (mainly *ICD-10* F-codes) and medical diagnoses are given equal but separate status. Some conditions in *DSM*, such as Parkinson's (G20) and Alzheimer's (G30), are considered "underlying" medical conditions in *ICD* and should be listed before their "manifestations," such as dementia (F02.80 or .81) or wandering (Z91.83).

Substance use codes (F10–F19) are extensive but logically organized, first by substance and then by use, abuse, or dependence. Additional decimals allow finer distinctions like intoxication, withdrawal, or with amnestic, anxiety, or sexual dysfunction.

Use all the codes available for a good diagnostic workup, not just the symptom codes (F-codes), and especially consider the Z codes for a biopsychosocial understanding.

The G codes are for neurological conditions and so include some relevant to us such as Parkinson's (G20), all the sleep disorders (G47), and movement disorders.

The R codes are very varied and quite psychological: "Signs and symptoms involving cognition, perception, emotional state and behavior." They illustrate a strength of the *ICD* system: The "signs and symptoms" can be recorded when a full diagnosis is not (yet) available or when additional but undiagnosed information should be recorded. Thus these codes are ideal referral reasons. For example, R44 is hallucinations without assuming their cause or relationship to other disorders. They were designed this way so a front-line health worker without much knowledge of psych could assign a code to be followed up by more sophisticated workers. Included here are learning disabilities (R48) and chronic fatigue syndrome (R53.82), as well as old age and frailty (R54).

The T codes include both adverse effects of medications and codes for abuse—physical, sexual, and psychological—and neglect and abandonment of children and adults, suspected and confirmed.

Many familiar codes removed from *DSM-5* are retained in *ICD-10*: Asperger's (F84.5), substance dependence (many codes), somatization (F45.0), conduct disorder, undersocialized, aggressive type.

No diagnosis fits? F99 for Mental Disorder, NOS, or when no diagnosis is made: Z71.1.

Record the medical diagnoses first and then in the order of importance or which you will address first; there is no rule. Incidentally, *ICD* capitalizes only the first word of a diagnosis, for universality and simplicity.

Qualifiers

While *DSM-5* offers dozens of specifiers, varying with diagnoses, *ICD* offers only Confident (fully meets all criteria), Provisional (partially meets criteria and more information is to come), and Tentative (partially meets and no additional information is anticipated).

"It is more important to know the patient who has the disease than the disease the patient has," said Sir William Osler in 1904. If you take this to mean personality is primary, the *Psychodynamic Diagnostic Manual* is for you. If you interpret this as the necessity of a comprehensive biopsychosocial evaluation, the Z codes are what you need. This is where *ICD* shines. The Z codes address the context in which we provide care.

All the "problem" areas of Axis IV are all here: education, employment, family, and so forth but with much more detail. For example, education (Z55) includes illiteracy (Z55.0), inadequate teaching (Z55.8), and discord with teachers (Z55.4), as well as underachievement (Z55.3).

Z56 codes address employment ranging from threat of job loss (Z56.2), to stressful work schedule (Z56.3), through sexual harassment on the job (Z56.81), and military deployment (Z56.82). I found the latter to be an invaluable addition when diagnosing a spouse with major depression.

The Z59 codes allow detailing housing problems such as homelessness (Z59.0), foreclosure (Z59.8), low income (Z59.6), and extreme poverty (Z59.5).

Social stressors in Z60 include acculturation difficulty (Z60.3), living alone (Z60.2), retirement problems (Z60.0), and being the target of discrimination and persecution (Z60.5).

Problems with upbringing (Z62) include being in welfare custody (Z62.21), living in a group home (Z62.22), being scapegoated (Z62.3), as well as several parent-child conflicts (Z62.82), and sibling rivalry (Z62.891).

The codes in Z63 concern family issues of well-recognized relevance such as absence of a family member (Z63.3), separation, divorce, or estrangement (Z63.5), substance dependence in the family (Z63.72), as well as having a dependent relative needing care at home (Z63.6), and high levels of expressed emotion (EE) (Z63.8), which has been implicated in psychosis.

Other codes address criminal and legal issues such as imprisonment (Z65.1), lifestyle (Z72), including high-risk behaviors, gambling (Z72.6), "antisocial behavior without manifest psychiatric disorder"(Z72.810), and life management and difficulty (Z73), which includes stress, burnout, and insomnia.

A large set of codes allows description of the context of care. Treating victims or perpetrators of child or partner abuse or rape is under Z69. Providing counseling or education for sexual attitudes, orientation, or behavior is coded under Z70. Providing counseling and advice (Z71) allows coding for services ranging from dealing with the "worried well" without a diagnosis (Z71.1), alcohol, drug abuse, and HIV counseling for family members, and spiritual counseling (Z71.81). Other codes that concern our work include problems related to dependency on a care provider (Z74), malingering (Z76.5), noncompliance with treatment (Z91.1), and discord with counselors (Z64.4).

I am looking forward to using the *ICD-10* and hope I have shown some of its benefits. I am happy to talk or text more at edzucker@mac.com.

Reference

World Health Organization. (1993). ***The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.*** **Retrieved from http://www.who.int/classifications/icd/en/bluebook.pdf**

Convention 2014

❶ Anthony Dimitrion from Kings College is presented the Undergraduate Research Poster Session Award by Dr. Allyson Galloway.

❷ At the Annual Banquet, outgoing president Dr. Vincent Bellwoar (*left*) passes the gavel to incoming president, Dr. Bruce Mapes.

❸ Dr. John Gavazzi (*left*) presents the Public Service Award to state Rep. Glen Grell.

❹ Dr. Samuel Knapp presents the Public Service Award to Thomas E. Sweeney, Esq. (*right*) .

❺ During the Annual Banquet, PPA president, Dr. Vincent Bellwoar, presents PPA's Professional Affairs Associate, Rachael M. Baturin, MPH, JD, with her 15-year Service Award.

❻ PPA past president Dr. Steven R. Cohen is recipient of the 2014 Distinguished Service Award.

❼ This year's Graduate Research Poster Session Award recipient is Sharon Jung, MA (*right*), from Indiana University of Pennsylvania. The award is presented to her by Dr. Allyson Galloway.

❽ Dr. Charles LaJeunesse (*left*) presented the Science-Practice Research Poster Session Award to Dr. Joseph V. Lambert and Dr. G. David Smith (*right*).

❾ Eight graduate students receive the Pennsylvania Psychological Foundation Education Awards. *Left to right*: Dr. Richard F. Small, award sponsor; Abby E. Costello, MS; Michelle Chu, MA; Amanda L. Sellers, MS; Shay Selden, BA; Kameelah M. Mu'Min, MEd; Joelle Bazaz, MA; Sharon M. Jung, MA; and Drs. Dianne Salter and Beatrice Salter, award sponsors. Not pictured are Stella Hyuna Kim, MA, award recipient, and Dr. David A. Rogers, PPF president.

❶ On June 19, three Pennsylvania companies were recognized for being psychologically healthy workplaces. Caitlin Gubich (*third from left*) accepts the Best Practices for Employee Involvement recognition for Avantor Performance Materials. Psychologically Healthy Workplace Awards are presented to Maura Cermak (*fifth from left*) from MedExpress Urgent Care and to Stephanie Doliveira (*fourth from right*) from Sheetz Inc.

❷ Incoming president, Dr. Bruce Mapes, delivers his presidential address.

❸ Margarita Sáenz, MS, PPAGS chair, presents Brooke E. Garwood, BS (*center*), and Christina A. Schneider, BS (*right*), of Arcadia University, with the PPAGS Community Service Project Award. Not pictured is winner Lisa M. Brutko, BA.

❹ Dr. David R. Kraus, president and chief scientific officer of Outcome Referrals Inc. in Framingham, Massachusetts, gives a stimulating keynote address on June 19 on the role of outcome measurement in health-care reform.

❺ Dr. Timothy Barksdale presents the Student Multiculturalism Award to Kameelah M. Mu'Min, MEd, from Chestnut Hill College. Dr. Cheryll Rothery (*right*), chair of CHC's Graduate Program, is also pictured.

❻ Linda and Chris Hosterman accept the Early Career Psychologist of the Year Award on behalf of their daughter, Dr. Shelley J. Hosterman, from Dr. Patricia J. Fox (*left*).

❼ Dr. Marie C. McGrath presents the Award for Distinguished Contributions to School Psychology to Dr. Cathy A. Fiorello (*right*).

❽ Dr. Donna D. Pinter is presented the Psychology in the Media Award by Dr. Bradley Norford.

❾ APA's director of Legal and Regulatory Affairs, Dr. Stacey Larson, speaks about the various aspects of mental health parity at the Psychology in PA Luncheon.

❿ Drs. Walter J. Clark Jr. (*left*) and Jeffrey Lee Peters from the VA Pittsburgh Healthcare System discussed the integration of primary care with behavioral health during the Psychopharmacology Symposium on June 18.

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 you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of $20 for members ($35 for nonmembers) and mail to:

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

To purchase and complete the test online, visit our online store at www.papsy.org. 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.

Allow three to six 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 September 30, 2016.

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

Knapp, Baturin, & Tepper

1. The authors suggest that the most effective way to educate patients about informed consent is by providing a lengthy, in-depth form outlining the details of the agreement.
   True
   False

DeLeon

2. Evidence suggests that the nation's increased spending on health care is, in fact, improving the overall quality of health care and outcomes.
   True
   False

3. The following are determinants of an individual's overall health status:
   a. Health insurance and the access to care it can provide
   b. Diet
   c. Exercise
   d. Use of preventive services
   e. All of the above

Knapp

4. According to the author, which of the following is the best way to save money and improve treatment?
   a. Patients initiating treatment for acute conditions
   b. Removing provider coordination of care entirely
   c. Providers taking initiative to manage chronic conditions
   d. None of the above

Martin

5. The Affordable Care Act mandates that all Health Insurance Exchange individual and small group plans provide mental health services as an "essential benefit."
   True
   False

Miller

6. Psychologists can do which of the following as they increasingly provide care for medical patients and are included in the provision of population health care:
   a. Effectively establish rapport with the patient
   b. Deliver treatment techniques efficiently
   c. Achieve positive outcomes while improving satisfaction for entire populations of patients
   d. All of the above

McColligan

7. The APA encourages in-network providers to consider the following:
   a. Provider notifications
   b. Cost-sharing requirements
   c. Assignability provisions
   d. All of the above

Leffard

8. Which age range is correlated with a more negative outcome and potential for longer term cognitive difficulties postinjury?
   a. 8–13 years of age
   b. 6–18 months of age
   c. 2–7 years of age
   d. Age range has no effect on outcome

9. The author suggests that the ideal person to assist with communication about the special education process is the:
   a. Pediatric neuropsychologist
   b. Neurologist
   c. School psychologist
   d. Parent/guardian

Piselli et al.

10. All of the following may be accessible to children and teens through their schools without out-of-pocket expenses, *except*:
    a. Contraception counseling
    b. Screenings for sexually active teens
    c. Medication/treatment for those diagnosed with STI
    d. STI prevention counseling

Zuckerman

11. *DSM-5* uses a subset of about half of the diagnoses available in the full *ICD-10-CM*.
    True
    False

12. Dr. Zuckerman believes the Z codes support comprehensive biopsychosocial assessments.
    True
    False

Continuing Education Answer Sheet

The Pennsylvania Psychologist, September 2014

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

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

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 _____

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I verify that I personally completed the above CE test.

Signature_____ Date_____

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

Now available online, too! Purchase the quiz by visiting our online store at www.papsy.org. The store can be accessed from our home page. Please remember to log in to your account in order to receive the PPA member rate!

Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between May 13 and August 7, 2014!

NEW MEMBERS

Sarah L. Allen, PhD
Southampton, NJ

Carol L. Armstrong, PhD
Malvern, PA

Brenda D. Barton, MSW
Allentown, PA

Michelle Bisno, MS
Pittsburgh, PA

James R. Bleiberg, PsyD
Wynnewood, PA

Giselle C. Booker, PsyD
Plymouth Meeting, PA

Christa L. Coleman, PsyD
Hummelstown, PA

Edward G. Crosby, PhD
Lewisburg, PA

Lesli M. Dahl, PsyD
Mill Valley, CA

Jennifer Daley, PhD
Warrington, PA

Dina del Amo, PsyD
Philadelphia, PA

Donald J. Domenici, PhD
Boiling Springs, PA

William J. Evans, PhD
Hermitage, PA

Rhea Fernandes, PsyD
Souderton, PA

Laurie J. Friedlander, PsyD
Narberth, PA

Jeffrey W. Garis, PhD
University Park, PA

Sari K. Goldman, PhD
Bala Cynwyd, PA

Sarah M. Gomez, PsyD
Philadelphia, PA

Angela J. Hartman, PsyD
Pittsburgh, PA

Amanda Hirsch, PhD
Pittsburgh, PA

Sue A. Hoffman, MA
Elysburg, PA

Robin T. Hornstein, PhD
Narberth, PA

Renny M. Hutton, PsyD
Devon, PA

Ai Ikunaga, PsyD
Philadelphia, PA

Lori Jagoda, PsyD
Reading, PA

Susan E. Jarquin, PhD
Pittsburgh, PA

Amanda Y. Katchur, PsyD
Lancaster, PA

Kimberly R. Koebler, MS
Clairton, PA

Melissa A. McCall, PsyD
Pottstown, PA

Susan E. Moses, PsyD
Hershey, PA

Shannon M. Nicoloff, PsyD
Johnstown, PA

Sarah Nokes-Malach, PhD
Pittsburgh, PA

Kevin C. O'Leary, PsyD
Philadelphia, PA

Meredith L. Petruccelli, PhD
Kennett Square, PA

Katherine A. Restuccia, PsyD
Bethlehem, PA

Janine Rinderle, PsyD
Downingtown, PA

Philip A. Rutter, PhD
Pitman, NJ

Joshua V. Saks, PsyD
Flourtown, PA

Mark D. Schenker, PhD
Blue Bell, PA

Kara Schmidt, PhD
Swarthmore, PA

Robert A. Schwarz, PsyD
Haverford, PA

Jeri A. Sebastian, PhD
New Hope, PA

Diane S. Snyder, PsyD
Venetia, PA

Lisa A. Spatafore, PsyD
Langhorne, PA

Gina Spicknall-Cook, PsyD
Schnecksville, PA

Rebecca K. Stern, PsyD
Philadelphia, PA

Rebecca S. Taylor, PsyD
Pittsburgh, PA

George S. Villarose, PsyD
Downingtown, PA

Amy Walker, PhD
Harrisburg, PA

Stephanie L. Weber, PsyD
Breinigsville, PA

Tessa T. Wolf, PsyD
Fogelsville, PA

Shoshana M. Wortman, PsyD
Horsham, PA

NEW STUDENTS

Kimberly D. Aker, MA
Wilmington, DE

Brittany Bertani, MA
Philadelphia, PA

Djouher Bessai, MA
Elkins Park, PA

Yash Bhambhani, MA
Scranton, PA

Jennifer K. Breslin, MA
Philadelphia, PA

Emily Brickell, MA
Indiana, PA

Stephanie G. Briskin, MA
Pittsburgh, PA

Caitlin Cassidy, BA
West Chester, PA

Nicole M. Centrella, MA
Glen Mills, PA

Wei Ting Chang, MA
Philadelphia, PA

Casy Chehayl, BA
Philadelphia, PA

Shirah A. Cohen, MA
Philadelphia, PA

Jacquelyn D'Amico, MS
Philadelphia, PA

Krista Dettle, MA
Lake Hiawatha, NJ

Amanda DiVita, BA
Philadelphia, PA

Jennifer Engelhardt, MA
Passaic, NJ

Isabella Ezri, MA
Philadelphia, PA

Jessica L. Fegely, BA
Reading, PA

Heather Fellmeth, BA
North Wales, PA

Allison M. Funk, BS
Levittown, PA

Kevin Gallagher, BA
Pittsburgh, PA

Rachael B. Goldberg, BA
Bala Cynwyd, PA

Alex Gould, MA
Philadelphia, PA

Tammy Gregorowicz, MS
Kingston, PA

Andrew Guzman, BA
Philadelphia, PA

Scott Herman, MFT
Philadelphia, PA

Antonia E. Hoak, MA
Mercer, PA

Jennifer S. Holzman, BA
Philadelphia, PA

Matthew Iwaniec, MA
Leechburg, PA

Christopher T. Kaczka, MA
Sewell, NJ

Sherrie A. Kahn, BA
New Castle, DE

Rachel J. Kauffman, MA
York, PA

Rachel Keegan, BS
Philadelphia, PA

Tanya L. Kindel, MS
Nanty Glo, PA

Lindsay Kurahara, BA
Philadelphia, PA

Tara S. Leitner, BA
Maple Shade, NJ

Leah Lewis, MS
Frederick, MD

Emily Markman, MA
Philadelphia, PA

Mary T. McManaman, MA
Lancaster, PA

Matthew McNally, MS
Morgantown, WV

Matthew C. Morgan, MA
Philadelphia, PA

David Nguyen, BA
Bethlehem, PA

Angela M. O'Neill, BA
Thorndale, PA

Maura Pantone, BA
Croydon, PA

Shannon Patterson, BA
Bethlehem, PA

Alessandra Pieraccini, BA
Easton, PA

Kathryn J. Pierce, MA
Wilmington, DE

Angela M. Pilewski, MA
Philadelphia, PA

Sarah Rich, BA
Pittsburgh, PA

Stephanie G. Ruggiero, MA
Merrick, NY

Michael D. Saleeby, MA
Binghamton, NY

Sommer L. Sallada, BS
Valley View, PA

Dane S. Saunders, MA
East Lansdowne, PA

Jean Schmalzried, MS
Pittsburgh, PA

Ron Schulz, BSW
Pittsburgh, PA

Shay Selden, BA
Philadelphia, PA

Heather Shaw, BS
Doylestown, PA

Lori Skucas, BA
Newtown Square, PA

Cammy L. Stevens, BS
Montoursville, PA

Kathryn Stranahan, BA
Wenonah, NJ

Matthew Taylor, MA
Blairsville, PA

Azlen Theobald, BS
Jenkintown, PA

Jillian M. Threadgill, MSW
Philadelphia, PA

Cheslea Uselding, BA
Slatington, PA

Crystal D. Witmer, MA
York, PA

Alishia A. Wrubleski, MA
Philadelphia, PA

Member News

Dr. Robert M. Gordon

Recently, the Board of Directors of the American Psychoanalytic Association unanimously elected Robert M. Gordon, PhD, ABPP, for Honorary Membership. They noted that he has "conducted research and published widely, especially on topics relevant to professional ethics, personality assessment, forensic assessment, love and intimacy, and most recently the *Psychodynamic Diagnostic Manual*. Equally important, the committee was impressed with how much of [his] work has been published in peer-reviewed journals that are not psychoanalytically oriented." Dr. Gordon will be honored at the President's Reception on January 14, 2015, at the Waldorf Astoria in New York, New York. Other recent Honorary members include Nancy McWilliams, Oliver Sacks, Jonathan Shedler, Allan Schore, and Robert Stolorow.

Classifieds

AVAILABLE PSYCHOTHERAPY OFFICE: BALA CYNWYD, PA – Very nice psychotherapy office space available for full or parttime sublet in newly renovated light-filled suite with other psychotherapists. Internet access, attractive building with good security, many amenities, free parking, location convenient to public transportation. Contact Linda Guerra PhD at 215-545-7009 or email: guerra@netmcs.com.

PHILADELPHIA CENTER CITY, Fitler Square area. MUST SEE!! Townhouse with four beautiful designer decorated offices, three waiting rooms. fireplaces, decks, garden, a/c, cathedral ceiling, skylight, one-way mirror, kitchen, wifi, fax, separate buzzer for each office. Accessible public transportation [or walking] for Center City and University of Pennsylvania. Psychiatrists and learning disabilities specialist on premises. Parking option. Flexible arrangements: Full time, day, hour. Reasonable rent. 215-546-2379, marlabisaacs@gmail.com.

CENTER CITY PHILADELPHIA, PARKWAY AREA: Office available to sublet part time. Comfortable, modern and sunny office, in a suite shared with 3 other psychologists. Includes waiting room, bathroom and kitchenette. High-rise building with lobby and concierge, very convenient to public transportation and parking. Please call me on my cell phone at 617-320-1865 or email eprice8225@gmail.com.

RETIRING PSYCHOLOGIST – USED TESTS FOR SALE – WAIS-IV Complete Kit with 8 response booklets 1 & 2 @ $700, Bender-Gestalt II Complete Kit (2003 Edition) @ $100, Reading Free Vocational Interest Inventory 2 (2000 Edition) with 14 answer booklets @ $75, Wide Range Achievement Test 4 (2006 Edition) Complete Kit with blue record forms and blue and green cards @ $100, Strong Interest Inventory (2004 Edition) with manual and 34 response sheets @ $75, Rorschach (Exner) 38 Structural Summary Blanks and Workbook (Second Edition) @ $60, Vocational Preference Inventory with manual and 48 test booklets (1985 Edition) @ $80, Beck Depression BDI-II Manual with 49 response sheets @ $40, and EAI Mechanical (non-digital) Stop Watch @ $50.*DSM*Contact Wayne Wermuth, 610-841-0553 or wermuth2@ren.com.

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Vol. 74, No. 8

The Pennsylvania Psychologist

September 2014 • QUARTERLY

The Pennsylvania Psychologist
416 Forster Street
Harrisburg, PA 17102-1748

Pennsylvania Psychological Association

2015 Award Nominations Sought

Deadline: October 20, 2014

- **Award for Distinguished Contributions to the the Science and/or Profession of Psychology**
- **Distinguished Service Award**
- **Public Service Award**

All award details, including nomination requirements, are available on our website at www.papsy.org by visiting the **PPA Awards** link under **CE/Events** from the homepage. All award nominees who are eligible to be a PPA member must be a current member unless this requirement is waived by the Board of Directors. Thank you!

Krista L. Paternostro, CAE
Executive Director
PPA
416 Forster Street
Harrisburg, PA 17102
(717) 232-3817
www.papsy.org

CE Calendar

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

October 31, 2014
Fall Continuing Education and Ethics Conference
Best Wester Premier Eden Resort & Suites
Lancaster, PA

March 19 –20, 2015
Spring Continuing Education and Ethics Conference
DoubleTree Hotel Monroeville
Monroeville, PA

June 17-20, 2015
Annual Convention
Hilton Harrisburg
Harrisburg, PA

Contact: ppa@papsy.org

Podcasts
New podcasts for CE credit by Dr. John Gavazzi are now available on www.papsy.org.

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit www.papsy.org.

Registration materials and further conference information are available at www.papsy.org.

If you have additional questions, please contact ppa@papsy.org.

also available at www.papsy.org – HOME STUDY CE COURSES

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*Introduction to Ethical Decision Making**
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*Ethics and Boundaries**
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*Pennsylvania's Psychology Licensing Law, Regulations, and Ethics**
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**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.