ALSO INSIDE:

- A review of PPA's signature legislative priorities
- Assistive technologies for students
- Ethics in Action, a new column
- Title IX and transgender students

The Pennsylvania Psychologist

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THE BUSINESS SIDE OF MENTAL HEALTH CARE

Maneuvering the Process

Happy Holidays!

One of the real joys this holiday season is the opportunity to say "thank you" and wish you the very best now and always. Warmest thoughts and best wishes for a wonderful holiday and a very happy New Year!

Your PPA Staff
Krista, Iva, Rachael, Justin, Judy, and Erin

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Living a Little and Learning a Lot!

David A. Rogers, PhD; Hershey Psychological Services

Dr. David A. Rogers

In the past, I have had the privilege and opportunity to write articles for the *Pennsylvania Psychologist*, highlighting the fun activities to be found during our annual convention. Admittedly, most of the activities involved the restaurants, nightlife, and other venues in and around our beautiful capital city. As many of you are becoming aware, however, PPA has decided to relocate our 2017 convention to Bedford, Pennsylvania, and for the first time in over 10 years, we will be experiencing a very different venue! Granted, the event will offer the same number of high quality CE presentations that attendees are accustomed to receiving, but a noticeable difference will be the surroundings within which they occur.

As a quick Google search will reveal, the Omni Bedford Springs Resort will be the home of PPA2017. The resort, which is a National Historic Landmark, prides itself on having an unrivaled spa, cutting-edge conference center, and magnificent golf course. This historic thermal springs resort sits on 2,200 acres and is only 3.5 miles from Old Bedford Village and 19.3 miles from Buchanan State Forest. Additionally, the resort offers tennis, pools, and endless opportunities for walks on the lush grounds. A wonderful fire pit is available for late-night friendship, fun, and s'mores. It's the perfect setting to renew the spirit of family and friendship and explore the outdoors with great fun and activities.

When you are not out of doors enjoying the many features of this pastoral setting, you can relax by taking advantage of this 30,000-square-foot destination spa's natural spring water treatments! At the end of a rewarding day of learning, living, and growing, you (and your family) can retire to your elegant room, which will feature antiques, a mini fridge, and a flat-screen TV. Some have porches, marble floors, and desks. Suites add extras such as soaking tubs, rain showers, separate living areas, kitchens, or balconies.

PPA has decided to relocate our 2017 convention to Bedford, Pennsylvania, and for the first time in over 10 years, we will be experiencing a very different venue!

A steakhouse, upscale dining room, and a tavern, plus a casual café, are on-site. Amenities include a spring-fed indoor pool and an outdoor pool. A spa, a renowned golf course, and other activities are available for a fee. The resort fee also covers valet parking.

So, as 2016 is coming to a close and you are starting to plan you and your family's personal and professional commitments for the coming year, add PPA2017 to your list of "must-do's and must-see's." Join us in Bedford, Pennsylvania, in June 2017, and take advantage of a stay at the Omni Bedford Springs Resort. There you can rekindle your zest for outdoor adventure, provide an opportunity for quality time with friends and family, and "live a little and learn a lot"!

One Day at a Time

Krista Paternostro Bower, MPA, CAE


Krista Paternostro Bower

As usual, our fall season here at PPA has been filled with executing exciting events while making plans for the future. Since our last issue of the *Pennsylvania Psychologist* published in September, we have hosted two successful webinars, our Ethics Educator event, the Doctoral Summit, and our Fall Continuing Education and Ethics Conference, in addition to numerous committee events and special meetings. We have conducted routine fundraising campaigns for the Pennsylvania Psychological Foundation and the PennPsyPAC.

In addition to these very visible efforts, we also continue to do quieter work behind the scenes on your behalf. For instance, using member input obtained during our 2016 Town Hall and subsequent online survey results, our PPA Board of Directors is working on an important update to our strategic plan. We should be able to share the results of this work soon. In addition, our newly formed Interpersonal Violence Committee has established four energized subcommittees all working to support this year's presidential theme on interpersonal violence. And, we are tracking several pieces of legislation of importance to psychologists (please see the Bill Box, page 9). These examples highlight a few of PPA's recent endeavors on behalf of ***you***, our valued member. Please allow me to share a little more detail:

Suicide Prevention Mandatory CE

Pennsylvania's Act 74, signed in 2016, requires all psychologists to complete 1 CE credit on suicide prevention per biennium. This requirement will go into effect for the current biennium, meaning that psychologists must complete at least 1 hour of suicide prevention CE before November 30, 2017. As your go-to resource for professional development compliance, PPA is here to help! Dr. Sam Knapp has already developed two home studies (1 hour and 3 hours) to meet this new requirement. These home studies are currently available through our website, both online and in hard-copy format.

Change Healthcare/Highmark Response

In October, PPA and APA Practice Organization (APAPO) held a conference call with representatives from Highmark and Change Healthcare about Change Healthcare letters regarding the use of billing code 90837. Many PPA members felt this letter was meant to discourage the billing of the 90837 code. During that call, representatives from Highmark and Change Healthcare assured us that the intent of these letters was truly to be educational. Highmark does not presume that a higher use of 90837 involves inappropriate billing. We learned that there will be no routine audit of those who use 90837 at a higher rate than other psychologists, nor will Highmark initiate any unusual efforts toward seeking refunds from psychologists who use the 90837 codes more frequently than others. Providers will continue to receive these letters on a quarterly basis.

Since our last issue of the Pennsylvania Psychologist published in September, we have hosted two successful webinars, our Ethics Educator event, the Doctoral Summit, and our Fall Continuing Education and Ethics Conference, in addition to numerous committee events and special meetings.

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EXECUTIVE DIRECTOR'S REPORT

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To receive a copy of the complete PPA statement regarding the outcome of this meeting, please contact Rachael Baturin at rachael@papsy.org. In addition to PPA team members Rachael Baturin and Dr. Sam Knapp, we offer our special thanks to PPA Insurance Committee chair, **Dr. Vince Bellwoar**, and APAPO regulatory representative, **Alan Nessman**, for their leadership on this initiative. PPA members should contact our director of Legal & Regulatory Affairs, **Rachael Baturin, MPH, JD,** at rachael@papsy.org or 717-510-6340 for further guidance.

PPA & BizVision Online Learning Center

In late October, PPA signed a partnership agreement with BizVision, a Salt Lake City-based company used by APA and several state psychological associations, to offer PPA members a platform for live and on-demand, video-based online courses and event streaming. We are thrilled to be able to expand our CE delivery vehicles in this way and hope that you will take advantage of this new format. We have already cataloged our most recent webinars on this site and plan to populate the offerings as future events unfold. Please visit our site at papsy.bizvision.com to learn more!

PPA2017 Venue Decision

Have you heard the exciting news about **PPA2017**? The PPA Board of Directors and staff are thrilled to invite our membership to check out our 2017 conference location—the **Omni Bedford Springs Resort** in beautiful Bedford, Pennsylvania! This historic property is located just minutes off of the Pennsylvania Turnpike with quick access to Interstates 70 and 99. Our staff and volunteers are building a great event for you next summer! The call for presentations is open until December 9, 2016. Why not be a presenter this year? Come and make new memories with us in Bedford! Stay tuned for all of the latest PPA2017 details by visiting our convention page at papsy.org. Or, stay up-to-date on everything PPA by following us on Twitter @PAPsychGA or liking us on Facebook at PA Psychological Association.

As you can see, the PPA team is hard at work to strengthen and grow the community of psychologists working across Pennsylvania. We are grateful to each and every one of our members and volunteers who give tirelessly to support our efforts all year through. This time of year offers the perfect time to extend a special and heartfelt *"thank you."*

We are thrilled to be able to expand our CE delivery vehicles in this way and hope that you will take advantage of this new format.

On behalf of everyone at PPA, we extend our best wishes to you and yours for a happy, healthy, and jolly holiday season. By the time we publish our next issue, we will already be three months into the new year. Here's to hoping that it's grand!

A wise man whom I loved once told me not to wish my life away but to work to be present in this moment. So for today, I will continue to allow life to unfold one day at a time. (Love and miss you, Dad . . .)

Mandatory Continuing Education Training in the Assessment, Treatment, and Management of Suicide Risks

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


Dr. Allan M. Tepper


Dr. Samuel Knapp


Rachael L. Baturin

State licensing boards are public protection entities. They are administrative bodies put into existence by the state legislature. Pursuant to their statutory authority, licensing boards are granted power to promulgate rules and regulations to carry out their public protection mandate. Rule making is an arduous process that includes regulatory and public review before a new rule or regulation is finalized. In 1992, the Pennsylvania State Board of Psychology wrote and adopted the first continuing education (CE) regulation for Pennsylvania licensed psychologists. Since 1992, this regulation has been amended on a number of occasions. The most current version of the psychology board's CE regulation is contained in 49 Pa. Code Section 41.59.

Over the past few years, the Pennsylvania legislature also has become active in requiring specific types of CE credits for Pennsylvania licensed psychologists.

For example, in 2015, the Pennsylvania state legislature mandated that Pennsylvania-licensed psychologists, as well as all other licensed health-care professionals in Pennsylvania, obtain CE in the recognition and reporting of child abuse. This change in events was somewhat unique in that it was the first instance in which the state legislature dictated that a licensing board shall require all of its licensees to obtain a particular type of CE training.

Recently, the Pennsylvania state legislature acted again to require that certain Pennsylvania licensing boards require a particular type of CE training for their respective licensees. More specifically, on July 8, 2016, the Pennsylvania state legislature passed what is known as the Matt Adler Suicide Prevention Continuing Education Act (63 P.S. Chapter 26A, Section 1221–1225, also being referred to as Act 74 of 2016). This new CE statute pertains only to the Pennsylvania State Board of Psychology and the Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors.

Pursuant to 63 P.S. Section 1223, all Pennsylvania psychologists, social workers, professional counselors, and marriage and family therapists must complete at least 1 hour of CE in the assessment, treatment, and management of suicide risks as a portion of the total CE required for license renewal.

Pursuant to 63 P.S. Section 1223, all Pennsylvania psychologists, social workers, professional counselors, and marriage and family therapists must complete at least 1 hour of CE in the assessment, treatment, and management of suicide risks as a portion of the total CE required for license renewal. This requirement is not a "once and done" proposition. That is, similar to the child abuse CE requirement adopted in 2015, this particular type of suicide CE requirement must be fulfilled for *every* succeeding biennium license renewal period. In addition, similar to the 2015 child abuse CE requirement, there is no increase in the total number of CE credits necessary for license renewal.

Under 63 P.S. Section 1224, the two designated licensing boards shall promulgate regulations necessary to effectuate the requirement no later than 18 months from the effective date of the act. These rules would include such issues as the type of approved sponsors, live credits versus home-study credits, and other alternative means of fulfilling the requirement. To date, neither of the two designated boards have promulgated regulations associated with the act.

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LEGAL COLUMN

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A major question associated with this new requirement is whether it is necessary to obtain the 1 suicide credit during the current biennium period. The current biennium period for Pennsylvania social workers, professional counselors, and marriage counselors ends on February 28, 2017, and the current biennium period for Pennsylvania psychologists ends on November 30, 2017. On September 13, 2016, the Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors voted to require that the new suicide credit for their licensees begin with their March 1, 2017, through February 28, 2019, biennium period.

On September 26, 2016, the Pennsylvania State Board of Psychology voted to require the new suicide credit for psychologists be fulfilled during the current December 1, 2015, through November 30, 2017, biennium period. At that meeting, the State Board of Psychology also determined that it would monitor the compliance with this requirement through its random audits of licensees, using the same process that it currently uses to determine compliance with all other CE requirements (except for the Act 31 child abuse requirement, which has its own unique monitoring system).

It does not appear that the psychology board will make it unduly difficult to fulfill the new requirement.

In this regard, all Pennsylvania psychologists must accrue at least 1 CE credit in the assessment, treatment, and management of suicide risks no later than November 30, 2017. To date, the Pennsylvania State Board of Psychology has not promulgated the regulations necessary to effectuate the new suicide CE requirement. Based upon their discussions, however, it is anticipated that the substance of the regulation shall mirror the requirements currently contained in 49 Pa. Code Section 41.59.

For this reason, PPA is now offering both a 1- and a 3-credit home-study CE course in the assessment, treatment, and management of suicide risks. It is anticipated that an additional CE course on suicide with older adults will be available later this fall. These courses have been constructed to comply with all of the CE requirements currently contained in 49 Pa. Code Section 41.59. Additional information regarding these courses can be found on the PPA website. It does not appear that the psychology board will make it unduly difficult to fulfill the new requirement. Nonetheless, we encourage all psychologists to follow updates in the *Pennsylvania Psychologist* or to visit the psychology board's website in the upcoming months to stay current on all details associated with this new CE requirement.

Looking Ahead to the 2017–2018 Legislative Session

Justin Fleming, Director of Government Affairs


Justin Fleming

Another federal/state election has come and gone, which means that next month we will seat a new Pennsylvania General Assembly. The beginning of every session is filled with hope and promise, and while PPA achieved its signature legislative goal last session with the passage of Act 53 of 2016, our advocacy work is far from complete.

We have a full agenda of initiatives related to health care and insurance provisions that will benefit psychologists and the patients that you serve. Our signature legislative priorities include bills on telehealth, mental health parity, and efforts for starting secondary schools later in the morning. Bills related to all of these subjects were introduced in the previous session but did not pass.

Provision of Telemedicine Services

Sen. Elder Vogel Jr. (R-Beaver) and Rep. Marguerite Quinn (R-Bucks) introduced companion bills last session establishing the provision of telemedicine services and requiring insurance providers to pay for services rendered. PPA was consulted prior to the drafting of the bills, and Dr. John Gavazzi in particular provided valuable information to Senator Vogel's chief of staff, who was the primary point of contact on drafting.

The bill defined telemedicine as "The delivery of health care services provided through telecommunications technology to a patient by a health care practitioner who is at a different location. The term includes an encounter between the patient and provider and the acquisition, evaluation and transmission of patient information outside of a real-time interaction, including remote patient monitoring of medical data. The term does not include the use of audio-only telephone conversation, facsimile, e-mail, instant messaging, phone text, answers to an online questionnaire or any combination thereof."

Our signature legislative priorities include bills on telehealth,mental health parity, and efforts for starting secondary schools later in the morning.

In addition, the bill as written says, "An insurer, corporation or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation." The legislation also mandates that whenever it is passed, health insurance plans need to be updated to reflect the payment for telemedicine services.

Mental Health Parity

State Rep. Thomas Murt (R-Montgomery) has introduced legislation that would amend the Pennsylvania Insurance Company Law to achieve parity in insurance payments for mental health and addiction treatment. The legislation adds language requiring the Pennsylvania Insurance Department to implement and enforce the applicable provisions of the federal Mental Health Parity and Addiction Equity Act of 2008, and the federal guidelines and regulations issued under that act. The Insurance Department would also be required to issue a report and provide an educational presentation to the General Assembly.

Start Secondary School Later

State Rep. Tim Briggs (D-Montgomery) is the prime sponsor of this bill, which calls on the Pennsylvania Department of Education to conduct a study to determine the efficacy of starting secondary school later in the morning, primarily to enhance the circadian rhythms of teens. This effort began with two committed members, Dr. Gail Karafin and Dr. Julie Levitt, who advocated for the bill before their local legislators. Research, including from the American Academy of Pediatrics, reports healthier outcomes and fewer traffic accidents for teens who attend secondary schools that start later.

This is just a sampling of the legislation that PPA will monitor in the upcoming legislative session. As always, we will continue to comment on regulatory proposals and remain engaged with the State Board of Psychology as well.

Finally, it is appropriate to recognize the service of 24 legislators who are retiring or lost in the general or primary elections and will not return to the General Assembly next session. PPA wishes those members the best in the endeavors they choose to pursue next!

It remains a great honor and privilege to serve the association and you as a member! If you have questions or concerns, feel free to contact me at 717-510-6349 or justin@papsy.org or find me on Twitter @PAPsychGA!

UPDATE

Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646)

Rachael L. Baturin, JD, MPH; Director of Legal & Regulatory Affairs

On July 6, the U.S. House of Representatives voted 422–2 to approve an amended version of H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015. Introduced by Representatives Tim Murphy (R-PA) and Eddie Bernice Johnson (D-TX), this bipartisan legislation would reform federal mental health policies and programs to increase patients' access to effective and evidence-based care, particularly for those with serious mental illness (SMI). The legislation includes the following provisions, among others:

- Establishes a National Mental Health and Substance Use Policy Laboratory and an Interdepartmental Serious Mental Illness Coordinating Committee
- Allows federal reimbursement for early and periodic screening, diagnostic, and treatment services provided to children and young adults in institutions for mental diseases
- Directs U.S. Department of Health and Human Services to clarify HIPAA policy on sharing the protected health information of a patient with mental illness with caregivers and family members and to establish HIPAA training programs and materials for health-care providers and family members
- Establishes a telemental health grant program to promote behavioral health integration in pediatric primary care, develop networks of child and adolescent psychologists and psychiatrists to work with pediatric providers, and support pediatric mental health teams
- Reauthorizes the National Child Traumatic Stress Initiative and Garrett Lee Smith Memorial Act programs and authorizes the National Suicide Prevention Lifeline program
- Authorizes the Minority Fellowship Program
- Establishes a demonstration grant program supporting the education and clinical training of health service psychology students, interns, and postdoctoral residents
- Strengthens monitoring and enforcement of mental health insurance coverage protections under the Mental Health Parity and Addiction Equity Act

In March, the U.S. Senate Committee on Health, Education, Labor, and Pensions voted in favor of its own comprehensive mental health bill: the Mental Health Reform Act of 2016 (S. 2680). That legislation has stalled and is awaiting a vote on the Senate floor. To move the House version, the Senate version needs to be voted on, go to committee to be reviewed and reconciled, and then go to the president to become law. Please encourage your legislators to move this important piece of legislation forward during the lame-duck session. If you have questions about identifying and contacting your federal legislator, please contact PPA.

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of October 10, 2016

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action	Governor's Action
SB 21	Provides for Assisted Outpatient Treatment programs in the Mental Health Procedures Act. – Sen. Stewart Greenleaf (R-Montgomery)	Against	In Public Health and Welfare Committee	N/A	N/A
SB 63 **HB 92**	Authorizes licensing boards to expunge disciplinary records for certain technical violations after 4 years. – Sen. Stewart Greenleaf (R-Montgomery) – Rep. Kate Harper (R-Montgomery)	For	(HB 92) In Consumer Protection and Professional Licensure Committee	Passed House 4/21/15 (194–0)	N/A
SB 554 **HB 1178** **HB 2241**	Amends the Insurance Company Law providing for retroactive denial of reimbursement of payments to health-care providers by insurers. – Sen. Dave Argall (R-Schuylkill) – Rep. Stephen Barrar (R-Delaware) – Rep. Karen Boback (Luzerne)	For	HB 2241 Passed Senate 47–0 on 10/26/2016	HB 2241 Passed House 188–0 on 9/28/2016	Signed by Governor 11/4/16; becomes Act 146 of 2016
SB 772	Updates the psychologists licensing law, eliminates certain exemptions, and modernizes the experience requirements. – Sen. John Gordner (R-Columbia)	For	Passed Senate 10/13/15 (49–0)	Passed House 6/13/16 (187–4)	Signed by Governor 6/23/16; becomes Act 53 of 2016
HB 2267 **SB 1342**	Act providing for telemedicine and for insurance coverage. – Rep. Marguerite Quinn (R-Bucks) – Sen. Elder Vogel Jr. (R-Beaver)	For	In Banking and Insurance Committee	In Insurance Committee	N/A
HB 64	Requires licensed psychologists to take 1 hour of continuing education in the assessment, treatment, and management of suicide risks. – Rep. William Adolph (R-Delaware)	Against	Passed Senate 6/29/16 (50–0)	Passed House 6/10/15 (188–0)	Signed by Governor 7/8/16; becomes Act 74 of 2016
HB 132	Provides Commonwealth support for a Mental Health and Intellectual Disability Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program. – Rep. Thomas Murt (R-Montgomery)	For	N/A	In Human Services Committee	N/A
HB 133	Act establishing a bill of rights for individuals with intellectual and developmental disabilities; and conferring powers and duties on the Department of Human Services. - Rep. Thomas Murt (R-Montgomery)	For	N/A	Reported as Committed from House Appropriations 9/29/15	N/A
HB 214	Increases oversight and accountability in Home & Community Based Services. – Rep. Mauree Gingrich (R-Lebanon)	For	N/A	In Aging and Older Adult Services Committee	N/A
HB 706	Provides for insurance companies to reimburse practitioners for telehealth services – Rep. Mark Cohen (D-Philadelphia)	For	N/A	In House Insurance Committee	N/A
HB 2105	Amends Public School Code, in preliminary provisions, providing for study of secondary school start times. – Rep. Tim Briggs (D-Montgomery)	For	N/A	In Education Committee	N/A
HB 2173	Amends the Insurance Company Law, in casualty insurance, further providing for mental illness coverage; for outpatient alcohol or other drug services; for adoption for federal acts, for penalties and for regulations. – Rep. Tom Murt (R-Montgomery)	For	N/A	In Insurance Committee	N/A

Advocating for Our Patients and Ourselves

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Dr. Samuel Knapp

Psychologist tend to like their careers. However, one continual source of frustration is the relatively low income compared to other professionals of similar educational levels. For the last 22 years, PPA has surveyed its members and included questions about their satisfaction with their careers as a psychologist (it is generally high), their satisfaction with their incomes (which is always lower), and their absolute income levels. The real income of psychologists (when adjusted for inflation) has declined slightly over the last 20 years. Much of the decline in actual income is due to the failure of third-party reimbursement rates to keep up with inflation.[1] In addition, psychologists report that dealing with insurance companies is the part of their jobs that they find most unrewarding and frustrating. This article will review three salient issues surrounding insurance coverage and the need for advocating: reimbursement rates, parity, and individual patient claims.

Reimbursement Rates

Psychologists are at a disadvantage when it comes to advocating for fairer reimbursement when dealing with insurance companies. Antitrust laws prohibit professional associations from advocating for better reimbursement with insurance companies. However, professional associations may advocate for better reimbursement with government programs, such as Medicare. Knapp (2013) detailed how Medicare's fees schedule has had a ripple effect across health care because, among other reasons, most commercial insurers base their fees on a percentage of what Medicare pays. In other words, changes in Medicare payments often lead to changes in payments in other reimbursement programs.

The efforts of the American Psychological Association Practice Organization (APAPO) in 2014 resulted in a modest increase in the reimbursement rates for psychologists doing psychotherapy, reversing a long trend of fee reductions for psychologists. In the next few years, APAPO will be working to ensure adequate reimbursement for psychologists who are conducting assessments. Medicare fees are set by a complex formula involving several different agencies. Making changes is time intensive at the federal level. Much of the work is behind the scenes. The best way for psychologists to advocate for better rates is to support APAPO by joining or renewing their APA membership, paying the special assessment for APAPO, and responding to legislative alerts.

Mental Health Parity

In 2008, Congress passed a mental health parity law that unfortunately was described in some accounts as "full parity." However, that phrase is misleading. It is full parity in the sense that, when it applies, mental health must be reimbursed in a manner comparable to physical health. However, it was not full parity in the sense that it did not cover all insurance policies, and it did not even require mental health benefits. A few companies, with very limited mental health benefits, decided to drop mental health coverage entirely. Furthermore, its enforcement was virtually nonexistent for several years. Finally, the expansion of mental health coverage occurred in the context of continuing increases in deductibles and copayments. Consequently, some patients suddenly got mental health coverage at parity, but with such high deductibles that it was essentially a meaningless benefit.

Nonetheless, the Affordable Care Act expanded mental health parity further, and the U.S. Department of Health and Human Services eventually developed regulations specifying how to determine parity. In addition, state governments, which have the option of enforcing parity laws, have been lax in doing so, although Governor Tom Wolf has stated that the Pennsylvania Insurance Department will develop a mechanism to enforce parity laws. I estimate that, overall since 2008, the amount of resources spent on outpatient mental health services has increased 10% even when adjusted for inflation. It has not been a "full employment for mental health professionals" act as described by some critics; but it has some modest expansion of patient access to mental health services.

The efforts of the American Psychological Association Practice Organization (APAPO) in 2014 resulted in a modest increase in the reimbursement rates for psychologists doing psychotherapy, reversing a long trend of fee reductions for psychologists.

Closing the existing gaps in coverage requires a long-term and sustained effort. I attended my first mental health parity meeting almost 30 years ago in 1987. At that time, psychologists were not covered in Medicare or Medicaid, and many insurance companies had very limited behavioral health coverage. We have made substantial progress in the last 30 years, although much more needs to be done. PPA members can support the continuing efforts to expand mental health coverage by continuing their support for PPA and PennPsyPAC and participating in grassroots advocacy efforts as needed.

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[1]The decline of incomes and the increase in student debt has resulted in a lower anticipated standard of living for recently licensed psychologists. The problem with student debt, however, is shared by other professions (Knapp, 2014).

Understanding Your Role in Health-Care Reform

Vincent J. Bellwoar, PhD; Chief Executive Officer, Springfield Psychological

Dr. Vincent J. Bellwoar

Three years ago as the president of PPA, I spoke to our members about the "perfect storm" of events before us. Not only did we face substantial changes in our PPA leadership, but health-care reform was looming. While PPA has survived and thrived in the transition to Executive Director Krista Bower and her terrific staff, health-care reform continues to challenge most psychologists. Our health-care system is struggling, perhaps even in crisis. While we may have the best health-care system in the world in terms of technological advances, each year more consumers struggle to afford it.

According to the Milliman Medical Index (Girod, Weltz, & Hart, 2016), 15 years ago health-care coverage for the average family of four—including health-care premiums and out-of-pocket costs—was $8,414. Today, those costs have tripled to $25,826. In 2001, employers covered 61% of these costs while employees paid 39%. Over the last 15 years, employees have absorbed more of the increases than employers such that, in 2016, the employee's portion of health-care costs has risen to 43%. In today's dollars, the average consumer pays $11,105 for a family of four compared to $3,281 in 2001.

Over the last 10 years, health-care costs have increased by more than twice the rate of inflation. The good news is that the annual rates of cost increases have declined dramatically from 10% per year to now less than 5%. Experts call this "bending the cost curve." Nevertheless, while annual rate increases have been bent downward, they still substantially outpace inflation. Simple math, projected over the next 5–10 years, indicates that our health-care system is not economically sustainable.

Psychologists rightly complain that while health-care costs have skyrocketed, reimbursement rates have remained stagnant. Most health-care providers and the general public share the frustration and anger at a system that seems out of control. Yes, health care is a mess, one that is not getting cleaned up anytime soon. As psychologists, our ability to weather this storm depends on a number of factors. Following are a few of these factors:

Get Out of Your Silo

Practicing in isolation, independent of other psychologists and medical professionals, is a risky long-term business decision. A central tenant of health-care reform is increased communication, ease of access, and economies of scale. Innovation and implementation of new payment models is much more easily obtained via large, integrated provider groups versus hundreds of individual providers.

Witness what has been happening on the medical side. Physicians rarely practice independently but have joined large practices or hospital groups. Hospitals have merged to form large networks. Of course, when physicians join together into large groups, they gain more leverage to bargain with the payer, not only in regard to reimbursement rates but in having a voice in health-care policy and strategy.

And so, move out of your silo mentality. At the very least, strengthen your collateral relationships. Share office space, secretarial services, backroom operations, and overhead. Investigate business models that offer varying degrees of practice independence, such as Independent Provider Associations, Clinical Integration, and Management Service Organizations (APA, 2014).

Integrate

Developing meaningful connections with the medical community is another step toward insuring your professional future. Primary care physicians (PCPs) find that 30%–50% of patients referred to an outside behavioral health provider never follow through. When those same patients are able to see the behavioral health professional in a PCP office, they are much more likely to follow through with the appointment.

PCPs are quickly realizing the benefits of working closely with psychologists. Offer your services to a PCP and try to use one of their empty offices for a few hours a week. When you are there be flexible, adaptable, and likeable. If you can't get in to a PCP office, improve the communications with them. Send them summaries of your work with their patients. Become that dependable behavioral health provider who the PCP relies upon to address patients' behavioral health needs.

In today's dollars, the average consumer pays $11,105 for a family of four compared to $3,281 in 2001.

Prove Your Worth

Even though behavioral health accounts for only 4% of the total health-care dollar, psychologists serve an important role in helping to bend the cost curve. When patients with chronic medical conditions such as heart disease, diabetes, or pulmonary disease have a serious mental health issue, health-care costs skyrocket well beyond the typical costs of caring for the medical issue. When psychologists intervene to reduce that mental health issue, patients' medical conditions improve, saving the payer a lot of money.

In addition to their role in managing chronically ill patients with comorbid behavioral health issues, psychologists help consumers achieve better health by helping them to manage stress, have more fulfilling relationships, and eat, sleep, and exercise in a healthy way. When psychologists do that, they should

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ADVOCATING FOR OUR PATIENTS AND OURSELVES

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Individual Insurance Issues

Individual psychologists will periodically report problems with insurance companies. Sometimes these include errors by the psychologist; sometimes they include errors by the insurance company. One of the most common problems occurs when patients fail to tell psychologists when their insurance changes, such as when an insurance company changes behavioral health subcontractors. However, sometimes insurance companies will make a mistake themselves and state that patients have coverage when, in fact, they do not. The psychologists may receive a notice several months (or even years) later asking for a refund because the patient was not ever really covered. PPA worked with a coalition of other health-care professionals and was successful in restricting these retroactive denials to 2 years (unless there is evidence of fraud). Members of the Pennsylvania General Assembly had previously been resistant to the idea, although this long-term effort to gradually educate legislators on this important issue finally paid off! PPA is also working with a coalition of health-care professionals to get telepsychology services reimbursed by all insurers.

Sometimes individual patients will be denied coverage for services that they think are covered by their insurers. Those patients usually have few options other than to go through the insurer's appeal process.

Providers who fail to get paid in a timely manner can appeal the delay through Pennsylvania's Act 68. However, this state law does not apply to self-insured policies, which are the most frequent violators of the timely payment rule. For these and other payment issues, the PPA listserv has been a valuable resource for psychologists who have specific questions about billing or reimbursement procedures.

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UNDERSTANDING YOUR ROLE IN HEALTH-CARE REFORM

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share in financial savings. But we can only do this if we prove our worth.

Gather Data

The most effective way to prove your worth is with data. Most of the medical world still struggles to understand what we do and how our services can bend the cost curve. Psychologists must educate consumers by routinely using outcomes measures, patient satisfaction surveys, and other metrics that prove their worth. The ability to compile and analyze data on patient health makes you an attractive provider.

Many electronic medical record (EMR) systems provide a range of tools to manage data effectively. The better EMRs already have outcome measures embedded in their programs and provide a range of practice management reports. Payers are very interested in data and data analytics as these are the keys to managing cost-efficient health-care delivery. Providers who can supply data are more valuable to payers than providers who can't. With this in mind, PPA's Integrated Care Committee (ICC) aims to assist psychologists with data collection and sharing data with PCPs. The ICC is investigating an app that allows for easy communication between a psychologist and PCP.

Understand the Evolving "Consumer"

As health-care costs continue to soar, pressure mounts to contain costs. Each year, clients and/or their employers choose their insurance plan, and what drives their choice, more than any other factor, is cost. Insurers are under tremendous pressure to provide the best care with the widest network of providers for the least amount of money. Providers should understand these pressures and embrace their role in bending the health-care cost curve. Understand the pressures insurance companies face in creating a product that employers and consumers want to buy each year. The goal is for the insurer to need you as much as you need them so that psychologists get a seat at the decision-making table. Understand that the provider and the insurer have a role in bending the cost curve so that our health-care system does not implode.

Providers who can supply data are more valuable to payers than providers who can't.

Become Part of the Solution

Dramatic changes in health-care delivery are coming. Instead of adopting a learned helplessness stance, understand the problem. Educate yourself. Tough decisions will be made about who gets what interventions, and those decisions will be financially based. Advocate for your profession and the fact that psychological interventions can improve consumers' overall health, not just their mental health.

Psychologists understand the interplay between the mind and the body. Our treatment goals should include a healthier body, not just mind. Psychologists should pursue an active role in reducing overall medical costs, not just mental health costs. When we do this, patients, psychologists, and the health-care system benefit.

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The EPPP Step 2: Concerns and Considerations

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Dr. Julie Radico

On May 2, 2016, the Association of State and Provincial Psychology Boards (ASPPB) published a YouTube video (ASPPB, 2016) announcing the development and implementation of the Examination for Professional Practice in Psychology (EPPP) Step 2. Additionally, an announcement letter to ASPPB membership was sent several months earlier (DeMers, 2016). Included in this letter and on the companion EPPP Step 2 pages of the ASPPB website (EPPP Step 2, n.d.) is information about the newly approved examination. According to DeMers (2016), the EPPP Step 2 serves as a tool to assess the competency-based skills necessary for entry-level licensure and practice. The EPPP Step 2 is a companion to the EPPP, which assesses knowledge. If adopted by state licensing boards, new graduates will need to pass both the EPPP and EPPP Step 2 before obtaining licensure. The target date for implementation of the EPPP Step 2 is January 2019.

The announcement of the EPPP Step 2 has raised many concerns from graduate students and early career psychologists (ECPs). Several boards and committees within the American Psychological Association (e.g., Committee on Early Career Psychologists, American Psychological Association of Graduate Students, and the Board of Educational Affairs) and state ECP committees (e.g., Louisiana) have sent letters to the APA Board of Directors identifying concerns raised by this announcement. Additionally, the past chair of APAGS (Jehu, 2016) wrote a blog expressing concerns about the EPPP Step 2 and the chair of the EPPP Step 2 Implementation Task Force responded (Rodolfa, 2016). Some of the concerns expressed by ECPs and graduate students are summarized here.

Costs

To patients: Adding the EPPP Step 2 to the requirements for licensure may delay new psychologists from becoming part of the workforce and relieving the shortage of mental health professionals (Sun, 2015). This delay in licensure may result in continued lengthy wait times for patients to see a psychologist.

The announcement of the EPPP Step 2 has raised many concerns from graduate students and early career psychologists (ECPs).

Of the exam: The EPPP currently costs $687.50, an amount which can easily increase with the addition of study materials and courses (e.g., Academic Review). Recent graduates completing a postdoc are often making low salaries and, unless the exam is covered by their postdoc, may be adding to their loan or credit card debt to cover these costs. The EPPP Step 2 would add further monetary burden during this period as well as increase the length of time before individuals have completed all of the requirements for licensure.

Delaying Earning Potential

Graduate students reported an average anticipated total debt of nearly $130,000, with the median at $110,000 (Doran, Kraha, Marks, Ameen, & El-Ghoroury, 2016). A further delay in licensure can impede the expected increase in ECPs' earning ability. Loan grace periods usually end 6 months after graduation. Deferment options may be available on some loans while in postdoctoral training but interest is compounded during this time, creating an even higher repayment burden for ECPs. Doran et al. (2016) report that salaries in psychology have remained fairly stagnant while the average debt burden has grown, resulting in many graduates being unable to work in underserved communities as they need to search for the highest paying jobs. The EPPP Step 2 is clearly not to blame for these levels of debt; however, it will be imperative to consider this factor when deciding exam pricing and state adoption of the EPPP Step 2.

Test Development

There is concern regarding the speed at which the test will go from development to implementation (i.e., announced to membership in March 2016 and to be employed January 2019) and that the speed of this process may result in a test that is not validated or fully developed.

Question of Necessity

There is doubt about the necessity of the EPPP Step 2 given that the practicum, internship, and postdoctoral experiences all focus on assessing competency. Incorporating testing of competency in graduates who have already completed this training does not fix or create standardization in the supervision provided to students, interns, or fellows. Also, the rate of disciplinary actions taken against psychologists appears to be low, thereby raising the question of whether this test is fulfilling a true need.

Sequence of Examinations

ASPPB has proposed that the EPPP Step 2 should be taken after the EPPP, which, in most states, means after licensure requirements have been completed. Due to recent postdoctoral requirement changes in Pennsylvania law, licensure can occur sooner for graduates; however, adding the EPPP Step 2 to this sequence may undermine these gains. Consideration should be given to changing the sequence of these requirements by allowing applicants to sit for the EPPP after completing their graduate course work, ideally prior to internship. The EPPP is a test of knowledge and usually requires applicants to review materials

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Health Information Exchange for Integrated Care

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Dr. Dan Warner

Seismic transitions in the health-care landscape are encouraging behavioral health integration into primary care. At its most basic level, this is a simple process of getting behavioral health clinicians involved and in communication with a client's physical health-care provider. This movement is motivated by the bevvy of research demonstrating that many of the most pressing physical health problems (e.g., heart disease, diabetes, and so forth) have a significant behavioral component or are exacerbated when a patient has a comorbid mental health condition. A "team approach" is being encouraged, since it will allow the treatment of the whole person: body and mind. While this model is intriguing to many psychologists, offering interesting work and new referral streams, it is important to note that the consequences for information sharing between behavioral health clinicians and physical health clinicians do not yet have clear answers.

First, behavioral health documentation has special rules and regulations about its storage in general that gives it the status of "super-protected data," not just regularly protected, as is the status of most medical documentation. For instance, clients must actively consent to share their behavioral health information with a physical health provider (i.e., "opt in"), while physical health documentation can be shared by a clinician who deems the sharing medically necessary, just so long as the patient has not actively "opted out."

Second, these limitations become more complicated when the information sharing is done between entities, instead of within an entity. That is to say: If the psychologist works in the hospital where a client is getting physical health care, the sharing of information is much less complicated than if the psychologist works in private practice, or for a separate group, that is merely in relation with the physical health provider. In such a situation, we now face the challenge of making two separate documentation systems communicate. If both the physician and the psychologist have electronic systems, the issue is how to make them communicate and move information between them (which is no mean feat!). In cases where only one side has electronic documentation, then other daunting challenges to sharing this information exist.

If the psychologist works in the hospital where a client is getting physical health care, the sharing of information is much less complicated than if the psychologist works in private practice, or for a separate group, that is merely in relation with the physical health provider.

In light of these challenges, psychologists are starting to pay attention to the Health Information Exchanges (HIEs) that are available in the state. HIEs are large computer databases designed to facilitate the motion of health information between separate entities. They are meant to facilitate efficiency, so that any given clinician does not need to make a data bridge with all other clinicians. Instead, the HIEs warehouse clinical information by regularly pulling and holding health information from participating clinicians, which is then available for download whenever another clinician queries it. In Pennsylvania, there are approximately six official and registered HIEs, and they are distributed regionally across the state. In principle, any health-care provider can or should contract with the HIE that dominates in his or her region to help pass and receive information for proper integrated care.

This vision works in principle, but there are many barriers for its actualization in behavioral health. First, the problem of super-protected data still lingers, and many of the HIEs at this time simply do not move behavioral health information, since the rules on how to do so correctly are not clear. Many of the HIEs actually refuse to hold behavioral health information at all because of the liability it seems to hold if it is shared incorrectly, while some HIEs will pull in behavioral information but not share it. This is further complicated by the technical and cost limitations in doing this. As of yet, HIEs are primarily orienting their business models toward hospitals and large primary care groups. Thus, psychologists who want to "link up," face technical challenges, including costs that are out of the range of what traditional psychological practices can handle and interfaces that are simply not well designed to capture and share behavioral health data and information.

It is in light of this current situation that PPA's Integrated Care Committee has undertaken an innovative project to create our own cloud-based Behavioral Health Information Exchange (BHIE) application. The BHIE is only in its prototype stage but is an HIE designed to meet the needs of behavioral health clinicians who want to be able to share information with physical health clinicians in a cost-effective, legally compliant, and clinically efficient manner. The BHIE would work as a behavioral health information clearinghouse, pulling in behavioral health information from participating behavioral health clinicians, tagging it as behavioral, and then passing it on to the relevant HIEs. Once tagged as behavioral, its motion through the HIE system would be much easier. Also, the costs of connections to the HIEs would be lower, as the BHIE would have established connections with all HIEs and every psychologist would not need to re-establish

their own connections. The BHIE also has hardwired into it the appropriate system for managing the consent for documentation sharing, assuring that client control of the sharing of his or her behavioral health information is done correctly and with the client in the driver's seat, which is a fundamental premise of ethical documentation sharing.

Another important part of our BHIE project is that it is designed to put professional psychology in the forefront of what is inevitable: the electronic motion of behavioral health information. Unless we as a profession engage this transformation in health, it will be done for us by software manufacturers, nonpsychologist lawyers, and health fields that are not attentive to the science of behavior and mind the way professional psychology is by its very nature. Psychology's grand contribution to the current health field is exactly expertise on such topics, and thus we have to weigh in. PPA is certainly an active participant in many of the deliberative bodies in the state forming policies on these matters; however, the BHIE offers a more powerful way to impact the emerging field. This software would put into existence psychologists' vision of consent, clinical work flow, and documentation. If the tool gains use, its very built-in workflow would structure how behavioral health data is moved and how behavioral clinicians are actually integrated into integrated care. This is a very powerful way to impact the field—by actually controlling its tools.

It is my hope, and the hope of the integrated care committee, that our vision of proper documentation sharing in the integrated landscape is the right one and that the software can help move the whole of health care in the right direction.

Not to get too nerdy here, but the BHIE software product does not require innovative technological solutions; the technology of moving health data is already quite capable of doing this well. Instead, the innovation of the BHIE would be having the unique excellence of a psychological perspective on the task, with attention to the dignity of patient choice, scrupulousness on information security, efficiency for independent practice, and other important components of a good product that are not going to be built into an HIE unless we do it ourselves. It is my hope, and the hope of the integrated care committee, that our vision of proper documentation sharing in the integrated landscape is the right one and that the software can help move the whole of health care in the right direction.

THE EPPP STEP 2: CONCERNS AND CONSIDERATIONS

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studied during the academic portion of their doctoral program, along with areas they have never studied (e.g., industrial/organizational psychology). Allowing for earlier completion of the EPPP may also improve pass rates, since length of time between graduation and taking the exam is positively associated with a higher fail rate (Schaffer et al., 2012). The longer applicants wait to take the EPPP, the less successful they are on the exam.

Current Students

If the EPPP Step 2 were to become a required part of the licensing process in 2019, many graduate students who have already started their training will be affected by this requirement, but they would not have known of this requirement prior to entering graduate study. Additionally, graduate programs may not have sufficient time to adequately prepare these students for the test. Supervisors are not afforded the opportunity to know what competency areas the exam will assess to facilitate increasing the focus of supervision on those areas.

Grandfathering

State adoption of the EPPP Step 2 is an important issue for many reasons, one of which relates to mobility of all licensed psychologists. The differences in state licensure requirements can already create significant difficulties for psychologists who want or need to relocate to another state and obtain licensure to practice. The EPPP Step 2 could add yet another potential barrier to attaining licensure. It will be important for applicants already in the licensure process and those already licensed to be exempt from this new requirement. The EPPP Step 2 further highlights the need for reciprocity between states and consideration of these factors by licensing boards.

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Evaluating the Effects of Assistive Technology for Students Receiving Special Education

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The Individuals with Disabilities Education Act (IDEA) defines assistive technology (AT) as "any item, piece of equipment, or product system . . . that is used to increase, maintain, or improve functional capabilities of a child with a disability" (para. A, Title I, 2004). This definition includes commercial items, as well as modified or customized technological devices. Surgically implanted devices, or the replacement of such devices, are not considered AT. Assistive technology can serve as a supplementary support for a student's academic performance, social and emotional functioning, communication, mobility, and general daily functioning.

Within IDEA, assistive technology services (ATSs) are characterized as any type of direct service that assists a child with a disability in the selection, acquisition, or use of an assistive technology device (Title I, 2004). More specifically, these services include the evaluation of the individual AT needs of each child, the purchase of an appropriate AT for each identified child, and any necessary technical assistance for the child and school staff. ATSs also include the selection and customization of AT devices as well as the coordination of these devices with other therapies, interventions, or services.

A multidisciplinary team must consider whether AT and ATSs are required for a student in special education when constructing an individualized education program. If AT and ATSs are not discussed, this would be considered a violation of the student's right to a free and appropriate public education. As school teams are aware, the application of AT devices and services may require significant financial and human resources from the educational system. School psychologists are strongly encouraged to be aware of the continuum of AT that exists to improve specific student performance areas (e.g., from pencil grips to high-tech word processing devices in the presence of poor handwriting). Likewise, school psychologists should also advocate for a trial use of an AT device to establish its effectiveness before a team commits to its use in a formal service plan.


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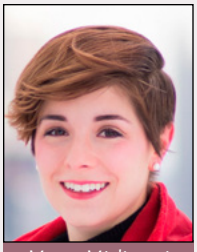
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Single-subject and brief experimental analysis (BEA) techniques allow educators to compare the effects of interventions on an individual's behavior. The results obtained from a BEA assist educators in selecting evidence-based interventions with the greatest treatment gains for students (Martens, Eckert, Bradley, & Ardoin, 1999). Two of the most straightforward BEA methods to evaluate the effects of an AT accommodation in the school setting are the AB and alternating treatments designs.

The AB treatment design involves implementation of a baseline phase (A) and an intervention phase (B). The baseline phase establishes existing levels of a target behavior without the application of the AT accommodation. In this phase, a pattern of behavior is established through collection of three or more data points. Then, three or more data points are collected regarding the target behavior when using the AT. The AB treatment design then allows for efficient evaluation of treatment effects through visual analysis of data points. Regarding the alternating treatments design, the effects of two or more interventions are simultaneously measured. This is done by alternating between data collection involving a baseline condition (no treatment control condition) and an intervention condition that applies AT. This design helps control for history effects if the BEA procedure is implemented across time. Visual analysis is the primary means of data interpretation for this method as well, which is important because nonschool psychologist team members become actively involved in the interpretation of a student's performance.

A multidisciplinary team must consider whether AT and ATSs are required for a student in special education when constructing an individualized education program.

Studies examining the effects of AT accommodations on student achievement reveal that any given AT device should not be expected to normalize a student's performance, if improvement occurs at all. To illustrate through the use of a reading AT technique, Schmitt, McCallum, Hale, Obeldobel, and Dingus (2009) found that the effectiveness of listening while reading when using continuous text-to-speech AT (i.e., entire passages were read aloud) varied by student and performance condition and that the students' reading comprehension was not normalized. In another study that investigated the effects of a reading pen AT on reading comprehension, students performed poorest when the reading pen AT provided

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An Overview of Assistive Technologies for Today's Students

Bill Keeney, PhD, CALP


Dr. Bill Keeney

Assistive technologies have exploded over the past 10 years, so much so that it is hard, if not impossible, to keep up with this ever-changing landscape. On the plus side, assistive technologies are more powerful, more readily available, and cheaper than ever before and so more accessible in school and in daily life. How accessible varies depending on the environment and resources (both technological and financial). In addition to a profusion of options, most programs are available on many different platforms, from laptops to tablets to cell phones. One might think this is an unalloyed good but sorting through these many options can be daunting.

Fortunately, several sites keep current (see "Resources" below). By far, the best of these is available from Augsburg College's Class Disability Services. Conveniently organized into categories from Reading and Literacy Support to Built-In Accessibility, this guide provides a dizzying array of "Free or Low-Cost Assistive Technology for Everyone." See the Resource section below for the link to the entire 38-page list. A slightly more manageable list is available from the International Dyslexia Association in their guide to Assistive Technology for Dyslexic Students & Adults.

It is best to choose one or at most two technologies at a time so that the user does not get overwhelmed. Also, the end user—the student—has to learn to use the technology automatically, which can only happen through daily practice over a number of weeks. Just as it takes us weeks to learn to type, for example, it will take a child weeks of daily use to learn to use dictation software or text-to-speech seamlessly and effortlessly. Therefore, it is best to pick an assistive technology in the student's greatest area of need and one that will provide the greatest utility in his or her daily and school lives. An excellent guide for parents that aids in matching a student with the appropriate technology is available from GreatSchools. While professionals have better diagnostic tools at their disposal to make these decisions, Don Johnston, Inc., has a fairly rigorous "Protocol for accommodations in reading" that also helps to match users with appropriate assistive technologies.

Therefore, it is best to pick an assistive technology in the student's greatest area of need and one that will provide the greatest utility in his or her daily and school lives.

Most students with learning disabilities, as opposed to physical disabilities, are referred for specific learning disabilities, and, for them, a technology that provides access to text is the first, best answer. For those who struggle with reading, audiobooks are key, and Learning Ally is currently the best service for K–12 students. Through Learning Ally online, books are downloadable and run on any web-accessible platform—laptops (whether PC or Mac), tablets (Androids and iOS), and smartphones—and the software syncs the recording across devices so that you can pick up in the same place even when you switch platforms. Older students particularly like the convenience (and "invisibility") that being able to listen to their audiobooks on their phones, as if they were listening to music, provides. Learning Ally's software also has variable speed playback, an important feature for older students who can often use simultaneous eye and ear reading to push their reading comprehension speeds well beyond their own silent reading speeds. With a library of tens of thousands of books, including textbooks, Learning Ally can provide most K–12 students with most of the books they need in school, as well as pleasure reading material. Some of the recordings are amateurish and some of them even switch voices midstream (sometimes even midchapter), but they are human voices, so they include the prosody so important for comprehension. Learning Ally does require a qualifying diagnosis of a print disability, and, while the company sometimes provides free subscriptions, most people pay an annual enrollment fee.

Another audio option is text-to-speech technology. Bookshare can provide text-readable copies of almost any book to K–12 students at no cost. These scanned texts are not proofread, nor are they formatted, so there are often errors in the text. However, most copiers now include OCR (optical character recognition) scanning capability, so things such as handouts and worksheets can easily be converted into text-readable formats. Most digital platforms provide cheap or free voices that are much improved over the previous generation—much less robotic in tone and often with surprisingly good phrasing and intonation. A word of warning: Mac's good voices are "buried" in the system preferences but can be easily downloaded by clicking on Customize. Voice Dream Reader is an outstanding version of text-to-speech and it has near-human quality. However, we have found that even the best readers struggle with technical language, dialogue, and text that integrates images, so we usually recommend that text-to-speech be reserved for short, nonfiction reading and for digital text such as website and email. Read&Write for Google Chrome from Texthelp offers a very nifty plug-in for Google docs, including an excellent free version of text-to-speech. The premium version, which is available free to educators and professionals, includes a pictionary, word prediction, a multicolor highlighting function that can sort the highlights into different categories, and more.

Some people swear by word-prediction software such as Co:Writer, but

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EVALUATING THE EFFECTS OF ASSISTIVE TECHNOLOGY FOR STUDENTS RECEIVING SPECIAL EDUCATION

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both decoding and vocabulary accommodations, as compared to students who received only one accommodation or neither during the control condition (Schmitt, McCallum, Rubinic, & Hawkins, 2011). Results from yet another study that evaluated the efficacy of reading pen AT with postsecondary students revealed variable improvement in reading comprehension as well (Schmitt, McCallum, Hennessey, Lovelace, & Hawkins, 2012). As is commonly found in intervention studies, students with the poorest baseline reading abilities achieved the greatest gains in comprehension compared to students with higher baseline reading abilities. Similarly, a study investigating the effectiveness of continuous text-to-speech AT with elementary school students showed that students had variable levels of improvement in reading fluency and comprehension after application of the AT (White & Robertson, 2015).

These studies demonstrate that any changes in performance are unique to the individual student after application of an AT. The studies also suggest that extent of improvement is likely related to the severity of the academic deficit and the underlying correlates of the problem. In short, educators should not attempt to predict student response to specific ATs. Rather, educators, including school psychologists, should use single-subject or BEA techniques to verify that an AT is effective for a student before committing to its purchase and use in a formal service plan and to ensure that a student's unique learning needs are being met (Schmitt et al., 2011).

Readers of this article should be aware that the Wisconsin Assistive Technology Initiative offers a comprehensive AT resource guide for school personnel (Gierach, 2009). It provides an overview of AT, legal guidelines for the consideration of AT, and a list of a wide variety of AT and AT resources by problem type. The guide also provides resources on assessing for AT need, determining goals, identifying potential AT, obtaining loaned equipment, and documenting the effectiveness of AT through trial periods.

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ASSISTIVE TECHNOLOGIES FOR TODAY'S STUDENTS

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younger students often do not have to write enough to make it worthwhile, and older students often find that they end up checking so many of the multisyllabic words that it impedes the flow in their production. Most students I work with prefer to get along with "good enough" spelling (at least one vowel letter for each syllable, etc.) and then use spell-check for correction. Grammarly has a free and very robust proofreading program that not only checks spelling but also homonyms, punctuation, and usage. Grammarly's free plug-in for Chrome works well enough for most students, although the company also offers a premium version for a price that, for some users, is well worth the cost.

Sometimes improved functionality only serves to point out the limitations of a promising technology, as is the case with voice recognition, or dictation software. While improvements have been made to the point where free and accurate versions of dictation software are widely available, from Siri to Google Voice, the difficulty students encounter is that dictation software works best for users for whom the structure of what they are writing is already well engrained, so that all they have to do is fill in the content. For students who are just learning to write an expository essay, for example, as well as struggling to synthesize new content, the composition process is just too full of halts, rewordings, on-the-spot revisions, and so forth. Most have found that, at best, they need to write the essay out first, either typing or by hand, and then dictate it. Even then, they often need to have it read back to them by text-to-speech to ensure the software accurately transcribed their dictation. This is quite a multistep process!

This article has only scratched the surface of the myriad of programs and tools available today. Sorting through them can be time consuming and sometimes even mind boggling. Fortunately, few people need more than two or three of these to make their lives much improved. A final word of caution, however: Whenever students or clients are provided with a new tool, someone needs show them how to use it, guide them through the learning process, and help them troubleshoot when they encounter the inevitable difficulties. In other words, someone who not only knows how the assistive technology works, but who can, themselves, use it proficiently so that they can guide the new user to their own proficiency.

Resources

Augsburg College's Class Disability Services: goo.gl/BA27KL The entire 38-page list is available at: http://goo.gl/Smerdb

International Dyslexia Association's *Guide to Assistive Technology for Dyslexic Students & Adults:* http://goo.gl/c3CVSP

An excellent guide for parents that aids in matching a student with the appropriate technology is available from GreatSchools: http://goo.gl/qePjaO

Don Johnston, Inc., has a fairly rigorous "Protocol for accommodations in reading" that also helps to match users with appropriate assistive technologies: http://donjohnston.com/par/

The Rights of Transgender Students in Public Schools

Shirley A. Woika, PhD; saw194@psu.edu

Dr. Shirley A. Woika

On May 13, 2016, the U.S. Department of Education's Office of Civil Rights (OCR) and the U.S. Department of Justice's Civil Rights Division (CRD) issued a "Dear Colleague" letter (Lhamon & Gupta, 2016) clarifying school districts' obligations specific to transgender students under Title IX of the Education Amendments of 1972. The letter states how the departments determine whether schools are in compliance with their legal obligations with respect to transgender students. The letter does not add to or change any existing legal requirements; however, it provides significant guidance on how the departments interpret laws with respect to transgender students. A second document from the Office of Elementary and Secondary Education (U.S. DOE, 2016) was disseminated to provide examples of policies from school districts, state educational agencies, and high school athletic associations that may be useful to schools in implementing regulations.

The letter presents the OCR's and CRD's interpretation of Title IX language. Title IX basically says that a school cannot discriminate on the basis of sex in educational programs or activities as a condition of receiving federal funds. Specifically, Lhamon and Gupta (2016) stated that a student's gender identity be treated as the student's sex for the purposes of Title IX and its implementing regulations. Further, schools are directed to begin treating a student consistent with the student's gender identity when school administration is notified by the student or the student's parent or guardian that the student will be ascribing to a gender identity that differs from previous representations or with what is indicated in the records. Requiring students to provide any type of documentation reflecting their gender identity may violate Title IX. It is clear that transgender students are to have equal access to educational programs and activities even when such access gives rise to concerns or objections from other students, parents, or members of the community.

Lhamon and Gupta (2016) also addressed schools' responsibility to provide a safe and nondiscriminatory environment. This responsibility is extended to transgender students. If harassment targeting gender identity, transgender status, or gender transition results in a hostile environment, schools must not be deliberately indifferent to such harassment. They must take steps to end the harassment and prevent future instances of harassment as well as provide a remedy for any negative effects of such harassment.

Identification documents, names, and pronoun use were also mentioned. Schools are advised to use names and pronouns that are consistent with a student's gender identity, even if these differ from information included in school records.

The letter also refers to sex-segregated activities and facilities for transgender students. With regard to restrooms and locker rooms, schools may provide separate facilities based on sex, but transgender students should have access to facilities that are consistent with their gender identity. Individual-user facilities may be made available to all students, including transgender students; however, transgender students may not be required to use them.

Regarding participation in athletics, Lhamon and Gupta (2016) noted that schools "may not, however, adopt or adhere to requirements that rely on overly broad generalizations or stereotypes about the differences between transgender students and other students of the same sex (i.e., the same gender identity) or others' discomfort with transgender students" (p. 3). If single-sex classes are offered, transgender students must be allowed to participate in a manner consistent with their gender identity.

If harassment targeting gender identity, transgender status, or gender transition results in a hostile environment, schools must not be deliberately indifferent to such harassment.

With respect to housing and overnight accommodations, Title IX does permit schools to provide separate housing on the basis of sex; however, transgender students should be permitted access to housing consistent with their gender identity. A school may choose to offer a single-occupancy accommodation for a transgender student as an option, but the school may not require a transgender student to stay in a single-occupancy room. Guidance regarding other activities such as yearbook photographs, dances, and graduation ceremonies is offered such that students may not be disciplined for behaving in accordance with their gender identity.

A final area addressed in the letter is specific to privacy and education records. Schools may disclose information to individual school personnel with a legitimate education interest in the information, but the Family Education Rights and Privacy Act (FERPA) does not allow information such as transgender status to be released to the school community at large. Directory information may not include sex or transgender status. Additionally, schools must respond to requests to correct educational records to make them consistent with the student's gender identity. FERPA requires that the request be considered, and Title IX requires that

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a response be provided to the student or parent.

In Pennsylvania, House Bill 303 (HB 303), known as the Transgender Pupil Education Rights Act, was introduced last year (Penn. GA, 2015). It addresses school uniforms, school programs and activities, guidance services, and required documentation. HB 303 requires that a student provide specific documentation in order to be considered a transgender student. For example, "a signed statement from a licensed physician, psychiatrist or psychologist, who has seen the pupil as a patient for at least six months, which recognizes the pupil as identifying as transgender" (Penn. GA, 2015, p. 3) and a "signed, sworn statement from the pupil stating that the pupil identifies as transgender and will consistently live as the gender opposite from the pupil's sex for the pupil's school career" (Penn. GA, 2015, p.3) are required in HB 303, but no such requirement exists in the Dear Colleague letter. Other inconsistencies between HB 303 and the letter exist. As of the writing of this article, HB 303 has not been passed in Pennsylvania.

School psychologists might review district policies regarding harassment and bullying to determine whether gender identity or transgender status is included.

School psychologists might review district policies regarding harassment and bullying to determine whether gender identity or transgender status is included. If not, the district's policies need to be updated, and school psychologists can view some sample policies in the document that accompanied the Dear Colleague letter. School psychologists might also get involved in staff development activities. The role of the school psychologist with respect to transgender student rights is further outlined in a position statement (NASP, 2014). School psychologists are encouraged to play an active role through activities such as advocating for transgender student rights, modeling acceptance and respect, preventing and responding to bullying, being a source of information, and providing counseling services.

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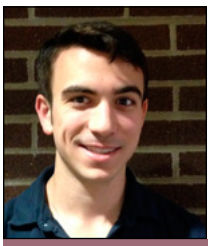
As Far as You Can, While You Can

Christopher Catalfamo, MA; ccatalfamo@m.marywood.edu


Christopher Catalfamo

Five minutes after the appointment starts and your client is not there. The possibilities abound: *Perhaps there is traffic, maybe work let out late today . . . it is a far commute*. Five more minutes pass and the thoughts change: *Maybe he forgot about the appointment, or Did we schedule for a different time this week?* Again, five minutes pass and the thoughts are different still: *He's not coming again. What am I doing wrong? Maybe I'm not helping.* Fast forward two weeks and as you begin to write the termination report, reflections on months of work turn dark. Suddenly, all of your efforts come into question. You begin to wonder whether you are an effective therapist or whether you have chosen the right line of work.

As early career clinicians, bright-eyed and optimistic, it is easy to assume that clients are as ready to work as we are. It is easy to become attached to our work as we want to make a difference—after all, that desire is what, at least partially, brings most of us to this profession. While this altruistic nature does not characterize all the reasons therapists enter the helping profession, it is nonetheless a strong component of those in our field of work (Hill et al., 2013). When clients stop coming to sessions, do not answer phone calls, and finally discontinue therapy, a student's professional self-esteem is often damaged. Whether this occurs after the first session or after the 15th, the impact can be equally detrimental. As therapy progresses, the therapeutic relationship deepens, and we become more connected with our clients. In these cases, sudden termination may have an even stronger impact on one's professional identity. As therapists in training, some of us will be experiencing this level of professional disappointment for the first time, making it an important time to reflect.

Being scientifically minded humans, we seek answers for those questions that linger to help us understand our experiences. As graduate students, some of us experience what is known as the imposter syndrome, in which we secretly determine that, despite our academic and life successes, we are failures (Clance & Imes, 1978). For beginning therapists, professional self-esteem is developing and fragile. While clients do not intentionally challenge our confidence by leaving, their doing so can stir a number of questions in an early therapist's mind.

However, guarding against these feelings may not be the answer. After all, these feelings of empathy and hope for our clients keep us connected to the work. Instead, consider the complicated nature of those we serve. Alone, there are a number of reasons an early clinician may reflect on to explain why therapy ended prematurely, but as the old adage indicates, two heads are better than one. While it may be difficult to speak openly about these thoughts, supervision is a crucial place to seek guidance. In individual and especially in group supervision, these feelings of inadequacy can be explored. It is a natural reaction to feel responsible for clients' well-being, though that thinking perhaps places more power in our hands than what may be reality. Although therapy is a collaborative effort, as ready as the therapist is for the client to change, this progress is determined by the client's attendance in therapy. Fortunately, the burden to realize this does not rest on a student's shoulders alone. Colleagues and supervisors can offer insights about their past experience with the difficulties of sudden termination and support students in this process.

Reasons for discontinuation of therapy are innumerable, and if clients never return, their reason for stopping therapy remains unknown. Yet, despite this, expectations to see other clients and fulfill academic requirements remain. Learning from one's mistakes is part of the student experience, but so is learning the limitations of therapy.

Increasingly, I find metaphors and quotes to provide the best explanations for these graduate school experiences. One that remains ever present in my conscious mind is that *we take them as far as we can, while we can*. While our clients continue to attend therapy, it is our promise to them to take them as far along in their progress as possible. Perhaps this was simply the first in many attempts by the client to challenge whatever difficulties he or she may face, and certainly the first steps are often the most demanding. The act of coming to therapy is itself often a challenge. Clients take with them the lessons learned in therapy, even if they never come back. Admittedly, this lack of closure can be frustrating and disappointing to a new therapist, particularly if it occurs more than once. If this is the case, the importance of supportive supervision and reflection on the student's work is increasingly warranted.

As therapy progresses, the therapeutic relationship deepens, and we become more connected with our clients. In these cases, sudden termination may have an even stronger impact on one's professional identity.

To reframe the experience of these early therapy terminations, each client and every session is an opportunity. Clients will not always continue therapy. Take them, while they continue to attend therapy, as far along as you can.

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An Issue of Competency

Jeanne Slattery, PhD, and Linda Knauss, PhD

Dr. Jeanne Slattery

Dr. Linda Knauss

This is the first vignette in what we hope will become a regular series appearing in the Pennsylvania Psychologist. Members of various committees of PPA—in this case the Ethics, Colleague Assistance, and Multicultural Committees—will be considering vignettes from their unique perspectives in an effort to bring greater light to the case and our work. Here is our first vignette:

> *Dr. Libby Rawl picked up a new client who had requested treatment for a history of trauma. Joe came into their appointment speaking loudly, frequently swearing, and clearly announcing his belief that he needed to protect himself from minority groups (he referred to them using racial and homophobic epithets). He then showed his handgun, for which he had a concealed carry permit. When asked, he refused to put it in another room or in his car.*
>
> *Dr. Rawl found Joe's political rants disconcerting. She had a difficult time listening to him or feeling therapeutic during their session. To complicate matters further, she and her wife had just adopted a biracial toddler. They live in a rural part of the state, however, where there aren't many other providers in his insurance network nearby.*

What Should She Do?

In addition to the two of us, the respondents to this vignette are Allison Bashe, PhD, Laura Campbell, PhD, and Jeff Pincus, PhD. Each respondent approached the vignette from a different perspective, although everyone was worried about safety. The context in which the client was being seen was an important consideration. Dr. Pincus asked whether the context created a physically and emotionally safe environment for therapy—for the client but also the therapist and other people at the agency. Dr. Campbell observed that psychologists working in agencies or institutions may have safety policies that they need to follow. Dr. Pincus further noted:

> We are trained to think about ethics from the perspective of the client's best welfare and this, of course, makes sense. But in doing so we sometimes de-emphasize that the therapist is a party to the relationship as well and also has legitimate interests that need to be implicitly and explicitly recognized and that it is not inherently unethical for a therapist to take his or her self-interest into account. Thus, we have seen questions on the listserv such as, "Is it okay to discharge a patient who refuses to pay a bill?"—as though thinking about our own interests is a bad thing. At some point, if we feel threatened or abused, or if the patient is not meeting the expectations we hopefully have laid out in the first session such as missing sessions, then I see no ethical problem in therapists taking care of their self-interest (in an ethical manner, of course).

Dr. Campbell concurred with Dr. Pincus, wondering whether it were possible to remain competent to work with this client in this context and focused on how feelings of being unsafe could compromise Dr. Rawl's objectivity. Dr. Knauss added that in addition to concerns about safety, differences in values between therapists and clients can also compromise a therapist's objectivity. Dr. Pincus wondered about the client's goals and, perhaps, the difficulties in ignoring the "flamboyance of [his] presentation" to identify both the client's goals and whether he would be able to recognize that he had the competence to meet these goals.Dr. Bashe observed the following:

> I had an eerily similar client minus the gun (at least as far as I ever knew). He was back from deployment and having a difficult time. He was so angry and frankly scary that I talked to a colleague after the first session because I didn't think I felt safe to see him again. The colleague suggested I schedule a second session before making a decision (continuing the initial evaluation so it wasn't an official first therapy session), and I'm glad I did. Once his trauma symptoms were reduced, he was like a different guy. Of course that happened over time, but my point is that my first impression of him was so different from who he truly was.

Dr. Bashe also noted that she had paid extra attention to safety at their second meeting (e.g., daytime appointment when other staff were around).

This case raised issues of technical and emotional competence for respondents, but it also raised questions about multicultural competence. Dr. Bashe asked how Dr. Rawl would feel about working with a client making strong homophobic and racist statements. Would making disclosures about her family (i.e., her wife and child) be appropriate and feel comfortable, given the size of her community? Dr. Slattery wondered about multicultural identities of both the client and therapist. Were they able to get to a place, as perhaps Dr. Bashe's client did, where they could engage each other and see past stereotypes?

Dr. Pincus observed, "In trying to be 'culturally sensitive,' I acknowledge that I grew up in an urban environment where encountering someone with a handgun

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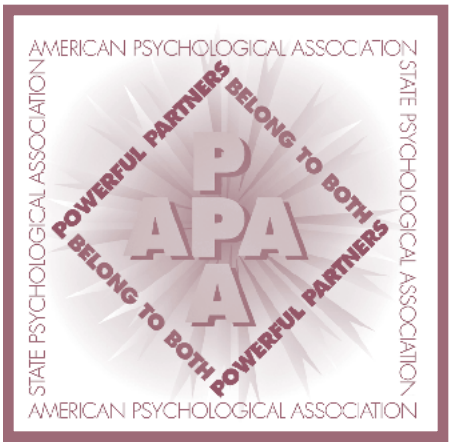
Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between August 15 and November 10, 2016!



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Mariaisabel Zweig, BA
Philadelphia, PA

ETHICS IN ACTION

Continued from page 22

tended to not be as benignly viewed as it might have been in more rural cultures." He noted, however, that what was unusual in this case was that the client did not respond to, or perhaps recognize, his therapist's discomfort. All of the discussants talked about the role of good consultants and supervisors in maintaining objectivity and making good decisions under such difficult conditions.

As they talked about this case, discussants referred to the APA *Ethical Principles of Psychologists and Code of Conduct*. Dr. Campbell, for example, referred to Standard 3.06, as she considered whether it was ethical to work with someone when one's objectivity was compromised. Dr. Bashe considered the aspirational principle of respecting the client's autonomy when she suggested, "If there's no one to refer him to, maybe disclosure of her concerns could be helpful here." Dr. Pincus explicitly referred to competency, while others referred to the Ethics Code more indirectly.

In situations such as this one, there isn't just one "right answer." Thus, it is especially important to have colleagues with a variety of perspectives, people who will help us maintain objectivity, identify issues that we might otherwise overlook and, above all, help us maintain our competencies under trying conditions. We are grateful to all our consultants on this case.

Would you like to be involved in future discussions of vignettes? Let us know by emailing Dr. Slattery (jslattery@clarion.edu).

Classifieds

PHILADELPHIA CENTER CITY, FITLER SQUARE – Four beautiful designer decorated offices, three waiting rooms, fireplaces, decks, garden, a/c, cathedral ceiling, skylight, kitchen, Wi-Fi, fax, buzzer for each office. Over bridge from U/Penn. Psychiatrists and learning disabilities specialist on premises. Parking option. Flexible arrangements: Full time, day, hour. Reasonable rent. 215-546-2379, marlabisaacs@gmail.com

PSYCHOLOGISTS – Contact us regarding part-time opportunities to provide services in nursing and rehab centers. We offer training and ongoing support as you deliver a unique and valuable perspective to the interdisciplinary team. www.goldenwoodservices.com

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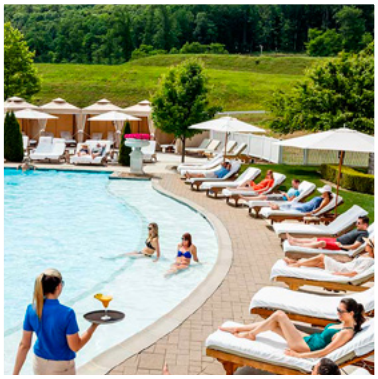

CE Questions for This Issue

The articles selected for 1 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:

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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 December 31, 2018.

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.

Bellwoar

1. Psychologists can do the following to prepare for health-care delivery changes:
   a. Gather data via outcome measures and satisfaction surveys
   b. Continue to fight insurers whenever the opportunity presents
   c. Move away from a solo practice mentality
   d. a and c
   e. All of the above

2. Bending the cost curve means:
   a. Keeping your practice overhead costs down
   b. Lowering your private pay rate to meet market demand
   c. Reducing overall health-care cost increases to be more in line with inflation
   d. Donating more money to PPA to help offset expenses

Radico

3. The EPPP assesses knowledge while the EPPP Step 2 aspires to assess _____.
   a. Skills
   b. Personality
   c. Competency
   d. Communication

4. The further from graduation the EPPP is taken, after more practical experience, the higher the pass rate.
   True
   False

Warner

5. PPA's BHIE is:
   a. A program for psychologists interested in integrated care and the various policies that have to be sorted to accomplish psychological integration.
   b. A proposed amendment to the ACA for the benefit of psychologists.
   c. A computer application being designed by the Integrated Care Committee that would facilitate psychologist integration with the larger health-care field.
   d. The unique name for Meaningful Use regulations relevant to psychology.

Schutte et al.

6. Federal law (IDEA) mandates that the need for AT be considered at every individualized education program meeting?
   True
   False

7. This article argues for which two methods to efficiently evaluate the effects of assistive technology for individual students?
   a. AB and multiple baseline designs
   b. AB and alternating treatments designs
   c. Alternating treatments and multiple baseline designs
   d. None of the above

Keeney

8. How have assistive technologies changed in recent years?
   a. They are cheap, easy to use, and readily available.
   b. They are expensive.
   c. They are hard to learn and use.
   d. They are limited to one platform or format.

Woika

9. The Dear Colleague letter provides guidance for transgender students in schools regarding:
   a. Restrooms and locker rooms
   b. Pronoun use
   c. Participation in athletics
   d. Educational records
   e. All of the above

10. According to the guidance offered by the Office for Civil Rights and the Civil Rights Division, school districts must:
    a. Establish that a student is a transgender student through a verification process
    b. Treat students in a manner consistent with their gender identity
    c. Eliminate separate restroom and locker room facilities in public schools
    d. Provide individual-use facilities for transgender students and require that they use such facilities
    e. Amend school records to reflect the gender identity of students screening and training of staff.

Slattery & Knauss

11. Which of the following kinds of competency did the discussants consider?
    a. Multicultural
    b. Technical
    c. Emotional
    d. All of the above

12. The discussants had which of the following responses to the client's threats to the therapist's safety?
    a. There is only one ethical way to approach safety issues: by installing metal detectors.
    b. Agencies should only consider what they are doing to keep clients safe when they are on site.
    c. Therapists should only consider self-care, including what they are doing to stay physically and emotionally safe during their work.
    d. Therapists and agencies should develop a plan that considers both therapist and client safety and regularly monitor safety and needed changes.

Continuing Education Answer Sheet

The Pennsylvania Psychologist, December 2016

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

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

Satisfaction Rating

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

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

Comments or suggestions for future issues _____

_____

Please print clearly.

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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, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112

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The Community Guidance Center (CGC) is a non-profit mental health organization, with five business locations in Pennsylvania. Our mission is to provide high quality comprehensive Mental Health, Drug and Alcohol, Intellectual Disability, and Early Intervention services, empowering individuals and families residing in the community to improve the quality of their lives and provide an atmosphere of hope to our consumers and each other. Open communication among all providers with the involvement of the consumer and family members is at the core of our clinical philosophy. We are always looking for motivated individuals to join our team make a positive difference in our consumers' lives! Our full-time positions all offer full medical, dental, and vision benefits at no cost to the employee for individual coverage. We also have a competitive 403B in which you can start contributing to right away!

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DESCRIPTION

- Provide direct clinical therapy service and assessment/psychological evaluations to both adult and child consumers. Provide crisis intervention, conduct Psychological Evaluations, and create/initiate new therapy groups. Conduct intake evaluations on new consumers.
- Complete appropriate documentation relevant to indirect case management services. Maintain case notes, case files, treatment plans, case reviews, case revisions, authorization and relevant paperwork requirements to ensure complete, ethical, uninterrupted clinical care for consumers and their families.
- Provide outreach/educational service in the form of presentations on site, to the community, and local agencies as needed.
- Attend appropriate meetings (Psychiatric Rounds, Departmental Meeting, Staffing when needed, etc.), interagency meetings, and supervision. In serving as part of the treatment team, facilitate communication between departments and provide support as needed to clinical staff. Serve on internal Quality Assurance Committees.
- Maintain awareness of all Federal, State and Managed Care laws, policies, regulations and procedures regarding clinical care, Best Practice Guidelines, and appropriate fiscal requirements related to Clinical services.
- Provide clinical supervision to unlicensed clinical staff as instructed by the Chief Clinical Officer. Such supervision includes students, interns, Master's level and Bachelor level staff.
- Maintain necessary educational standards through readings and attending conferences. Provide outreach/educational service in the form of presentations on site, to the community, and local agencies as needed. Comply with Pennsylvania State Law regarding the responsibilities of a psychologist. Maintain awareness of and adherence to the APA Ethical Standards and Code of Conduct.

POSITION REQUIREMENTS

- A doctoral degree in psychology from an American Psychological Association accredited university
- Completion of a clinical predoctoral internship
- Active license to practice Psychology in Pennsylvania
- Act 33/34 Clearances/FBI Clearance
- Act 31 Training Certificate
- Training has been oriented toward providing psychological services in a community based setting
- Must maintain automotive insurance coverage limits as per Center policy.

We are an equal employment opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, gender, national origin, disability status, protected veteran status or any other characteristic protected by law. Apply online at www.thecgc.com. If desired, can call Dr. Ralph May at 724-46-55576 x253.

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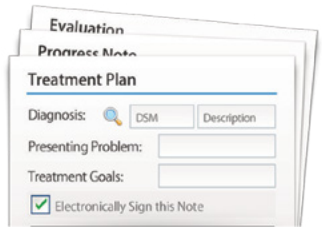

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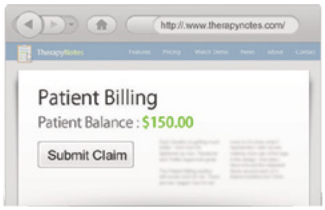

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2016–2017 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. Now and moving into 2017, we are looking to expand these options—we hope you'll join us for one or more of these programs!

Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

2017 Leadership Academy & Advocacy Day
TBD April/May 2017
Harrisburg, PA

2017 Spring Continuing Education & Ethics Conference
April 27–28, 2017
Sheraton Erie Bayfront
Erie, PA

PPA2017–PPA's Annual Convention
June 14–17, 2017
Omni Bedford Springs Resort
Bedford, PA

2017 Fall Continuing Education & Ethics Conference
October 26–27, 2017
Eden Resort & Conference Center
Lancaster, PA

Webinars and Home Studies
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Podcasts
Podcasts for CE credit by Dr. John Gavazzi are available on papsy.org.

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

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

Home Study CE Courses

Pennsylvania Child Abuse Recognition and Reporting: 2017 (Act 31 Approved)
2 CE Credits

Medicare's 2016 Physician Quality Reporting System (PQRS)
1 CE Credit

Excess Weight and Weight Loss
3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

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

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

*Ethics and Professional Growth**
3 CE Credits

*Foundations of Ethical Practice**
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*Ethics and Boundaries**
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6 CE Credits

***This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.**

For all Home Study CE courses above, contact: Judy Smith, 717-232-3817, judy@papsy.org.