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Essential Resources to Practice Legally and Ethically

What Do You Need to Know?

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Dr. Samuel Knapp

Psychologists who do very well in their careers have developed what Johnson and others (2012) refer to as a "competent community," or a network of colleagues who help provide resources and continual feedback. It is "a consortium of individual colleagues, consultation groups, supervisors, and professional association involvements that is deliberately constructed to ensure ongoing multisource enhancement and assessment of competence" (p. 566).

One of the goals of professional associations, such as the Pennsylvania Psychological Association (PPA), is to be a part of our member's competent community. PPA strives to keep its members up-to-date on current events in the field by providing information that psychologists need to know to practice in accordance with state and federal laws.

The purpose of this article is to identify some common resources for psychologists to use when they review and update their office policies and procedures. It identifies seven areas of practice where psychologists could do well to strive to keep up-to-date with their forms and procedures. These areas are: (1) informed consent, (2) confidentiality, (3) record keeping, (4) continuing education, (5) telehealth, (6) insurance and billing, and (7) other professional topics. Of course this article only identifies some of the more common issues individual psychologists will have. By necessity, I have had to omit some topics of interests.

This article reviews the major topics and then identifies articles or resources relevant to that topic. Many of these resources can be found on the PPA website (papsy.org) and especially under Practice Resources. To get to the Practice Resources from the PPA website, log in as a member, click on Psychologists (this link is on the navigation bar near the top of the page), then click on Practice Resources in the menu that opens, and then go to Legal and Ethical Articles (or the Business Practice or Insurance sections, as appropriate) to find the list of specific articles available.

This article reviews the major topics and then identifies articles or resources relevant to that topic. Many of these resources can be found on the PPA website (papsy.org) and especially under Practice Resources.

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[1] I would like to thank Dr. Charles Cooper and Ms. Sally Cameron of the North Carolina Psychological Association for their assistance. In addition, I would also like to thank Ms. Rachael Baturin and Dr. Allan Tepper who wrote or co-wrote many of the articles referenced herein. Drs. Jeanne Slattery and Edward Zuckerman made especially valuable comments to an earlier version of this manuscript.

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Intrusive Political Advocacy at Work

Ethics Acculturation, Naïve Realism and Partisan Bias

Claudia J. Haferkamp, PhD; Graduate and Clinical Psychology Program Coordinator, Millersville University

Dr. Claudia J. Haferkamp

It may be an understatement to say that America just ended one of the most controversial and divisive presidential campaigns in recent memory. For more than 18 months, the 24/7 news cycle revealed some of the most unsettling public remarks and behavior ever displayed in presidential campaigns or debates. It was impossible to ignore, even if one wanted to. I attempted a "news ban" in September which lasted only 72 hours when I realized that it was impossible to avoid campaign news without unplugging entirely from all media. Besides, the unfolding events were too important for me to choose to remain ignorant of them anyway. I knew that I wasn't the only one who struggled to appear somewhat neutral about these issues if they were mentioned at work, even though I did not feel neutral about what was happening.

My inbox was filled with subject lines revealing outrage about the latest disturbing candidate quotes. And the conflicts between my political values and professional role increased as the election drew near. A good friend gave me a bumper sticker for a candidate but I never displayed it because I was afraid of my car being attacked; neighbors had their campaign signs for that same candidate vandalized. I was also concerned about being stereotyped if I publicly "came out" for my candidate even though other colleagues had done so. As I considered whether and how to be open with my views, I found it confusing to justify selective self-disclosure. Whom to tell or not tell and on what grounds to make that choice? The public displays of extreme partisanship in the campaign made self-disclosure feel like it had to be an "all-or-none" phenomenon. The sense that "if you're not with us, then you're against us" was in the air. None of this was helped by the failing contract talks between our faculty union (i.e., APSCUF) and the state system which made a faculty strike imminent. I knew that once I made a public declaration of my political leanings, other assumptions about my worldview and values would get made and I was unsure whether that was a good thing. I knew that political sharing crossed professional boundaries and need not be exploitative, but I was uncertain what the consequences of my sharing versus not sharing would be, either short- or long-term. Perhaps the worst part of my struggle was the sense that I was betraying key values by staying "in the closet" as long as possible. So what if someone was offended by my bumper sticker? My freedoms of speech and association were as constitutionally protected as anyone else's.

In my graduate Cognitive Therapy class there were many opportunities to illustrate cognitive distortions heard in some candidates' remarks. But I avoided most of it unless a student raised the issue because doing so may have revealed my political views. (This seemed likely because one candidate's statements so often showed dichotomous thinking.) As an ethics educator I knew that asserting my personal rights to express what I believed in was similar to the "separated" ethics acculturation style wherein the professional elevates his/her personal values over professional considerations. I knew that my own personal rights and political values were just one aspect of the complex dilemma unfolding around me. What further intensified my dilemma was hearing a few colleagues state their political views in and out of classes weeks before the election. Some spoke about candidates during their office hours without apparent embarrassment or hesitation. I wondered how students who didn't share their political views felt when they heard their candidate being made the butt of sarcastic jokes. And I wondered if students who agreed with the professor's views (or who felt obligated to laugh at the jokes) got treated any differently than those who did not share those views. One thing was clear: this dilemma was giving me one huge ethical headache. And I knew that I was not alone.

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Ethics acculturation and intrusive political advocacy

Intrusive advocacy may occur when psychologists place their personal values and opinions ahead of patient welfare and other therapeutic concerns. Many

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discussions of intrusive advocacy focus on therapists pressuring clients to prosecute their abusers or to take public stands on issues of personal relevance (Knapp & VandeCreek, 2012). The "dark side of ethics" pertains to areas in which colleagues may think they are acting ethically and properly but their actions do not quite rise to a formal disciplinary level (Knapp et al, 2013). But psychologists with different ethics acculturation styles might think about and approach the issue of discussing politics at work differently. Each of the non-integrative acculturation styles (i.e., separated, assimilated, and marginalized) has its own "dark side" despite the actor's best intentions (Knapp et al, 2013). Because "separated" types allow their personal moral values to dominate their professional lives, this may elevate the risk of engaging in intrusive advocacy on political and "hot button" issues. So "separated" professionals may not think that discussing politics with a friend, an acceptable social behavior outside work, could be problematic in a professional context. The downside is that one may speak beyond one's knowledge and competence level and unwittingly foster distorted perceptions of psychologists' roles which can encourage more boundary crossings or violations (Knapp et al, 2013).

I suspect that some colleagues who crossed boundaries with their opinions during the presidential campaign might not have fully considered the impact of their words on their ability to fulfill their professorial roles competently and with objectivity. I suspect that they believed that they were right and entitled to express themselves as citizens with the same rights as everyone else. I also suspect that they believed that they were better informed than others on the issues and were providing meaningful education. I believe it possible that they saw themselves as both enlightened and helpful to those who would listen. But nagging questions troubled me such as: how easy was it for a student listening to gracefully leave when s/he had heard enough? Did s/he fear any negative consequences for doing so? Did s/he feel reluctant to express disagreement? Did s/he feel free to share contrarian political views? And even if these political talks were relevant to course content, was this the best and most objective way to address it?

One simplistic solution to this dilemma is to avoid all discussions of the "Big Three" (i.e., religion, sex, and politics) at work. But this choice may reflect an "assimilated" acculturation style in which professionals identify more strongly with professional codes and regulations than with personal moral values. So the "dark side" of the assimilated acculturation style is that one may apply rules too rigidly and fail to temper judgments with compassion and adapt one's behavior to unique situations (Knapp et al, 2014). The "assimilated" professional may be no better off ethically than the "separated"

The "dark side of ethics" pertains to areas in which colleagues may think they are acting ethically and properly but their actions do not quite rise to a formal disciplinary level.

professional because of this "all-or-none" approach to ethical reasoning. Seeing self-disclosure about politics as "all bad" causes one to reflexively dismiss the potential advantages of limited, thoughtful self-disclosures. I was unexpectedly faced with this in my Cognitive Therapy graduate class when a student accurately noted a specific cognitive distortion (i.e., dichotomous thinking) in one candidate's comments that were widely reported. Because her observation was accurate, I validated her observation as technically correct but sensing a bigger issue, I asked about how dichotomous thinking might be useful to both candidates and reporters. This seemed appropriate from an instructional standpoint, but it dodged the dilemma I felt. So I told them that I'd heard many cognitive distortions during the campaign, but I struggled with how to choose one candidate's remarks over another's because singling out one could seem biased. I added that

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this dilemma seemed acute during this campaign and it was hard to know the right thing to do without seeming too partisan. They seemed to appreciate that much self-disclosure and I did not focus further on candidates' remarks. I still question if this was sufficient at the time.

Naïve realism, attributional biases, and naïve cynicism

What else makes us overstep professional boundaries with ill-timed political talk? And what makes us so confident that we are "right" and those who disagree are "wrong?" One partial answer is the chronic tendency to assume that our views are correct and rational, whereas differing views are incorrect, flawed, and irrational. Lee Ross called this "naïve realism" which subsumes three assumptions: (1) that we see events objectively and our attitudes, beliefs, and preferences come from that rational analysis; (2) that other rational persons should share our views if given access to the same information; and (3) those who do NOT share our views: (a) had different information; (b) may be lazy, irrational, unwilling, or unable to process the information rationally; and (c) may be biased by ideology, self-interest, or other forces (Ross & Ward, 1996). Naïve realism appears connected to other social cognitive biases including the false consensus effect (discussed below), actor-observer bias (i.e., perceiving others' actions as dispositionally caused and our behavior as situationally determined), and the fundamental attribution error (i.e., tendency to give greater weight to internal/dispositional causes for others' behavior over external/situational factors). False consensus effect is the tendency to assume that one's views enjoy greater popular support than may be the case. Lee Ross' classic "Eat at Joe's" study (Ross et al, 1977) asked students how willing they'd be to wear a large sandwich board sign around campus saying "Eat at Joe's" and to estimate how willing others would be to do the same and to give opinions about others who would or would not wear the sign. As predicted, students willing to wear the sign were more likely to believe that others would also and that not wearing the sign was more revealing of others' attributes than wearing the sign, which supports the third tenet of naïve realism.

False consensus effects arise in part from our inability to see that others may perceive the same stimulus differently and the effect is greatest when the stimulus is ambiguous and open to interpretation. It's no surprise that various "hot button" political issues are interpreted differently depending on one's political leanings. Note reactions of the political left and right on issues of abortion, gun control, immigration, and the Affordable Care Act. For example, Gilovich and Ross (2015) note that those on the right who support "enhanced interrogation techniques" are likely focusing more on terrorists wishing to kill innocent civilians, whereas those on the left may be focusing more on the needless torture of innocents by those with a personal vendetta. Thus our emotional reactions to those on the "other side" politically are heightened because people respond to what Solomon Asch called "different objects of judgment." One sees this in "pro-life" arguments against abortion that emphasize the immorality of ending a life, whereas the "pro-choice" arguments emphasize women's rights to control their choices and what happens to their bodies.

False consensus effects arise in part from our inability to see that others may perceive the same stimulus differently and the effect is greatest when the stimulus is ambiguous and open to interpretation.

We are not equal opportunity perceivers when it comes to detecting bias in ourselves or others. In the aftermath of the Bush v. Gore (2000) decision by the Supreme Court, Democrats saw the majority decision to decide the election for Bush as stained by ideological bias, although the five justices who wrote the opinion did not see it that way. Why did the justices not see themselves as biased? As Gilovich and Ross (2015) noted, a self-serving bias leads us to take credit for successes and deny responsibility for failures and we see "bias" as more likely to affect others' judgments than our own. To quote Gilovich and Ross (2015), "Bias...is much easier to recognize in others than in us" (p. 28). But there is more to this than a desire to think highly of oneself:

> "The deeper problem is that when we introspect, we find no phenomenological trace of self-interested bias in the way we've considered the pertinent facts and arguments....Naïve realism has the most impact when the gap between our...views and those of someone who disagrees with us is most pronounced." (Gilovich & Ross, 2015, pp. 28–29).

We have a "bias blind spot" (Pronin & Kugler, 2007). Pronin and Kugler (2007) attribute the bias blind spot to the "introspection illusion" which refers to our tendency to use overt behavior when judging bias in others but relying on introspection of our thoughts and motives when judging our own bias. Since biases may operate unconsciously, our introspection reveals little bias in us, leading us to conclude that it is more prevalent in others. And we may be more inclined to see biased others as having fewer altruistic motives, a cynical conclusion that can generate more conflict (Pronin & Kugler, 2007). Furthermore, "naïve cynicism" refers to the tendency to expect greater egocentric bias in others than is actually the case. In contrast to naïve realism, in naïve cynicism one may assume: (a) I am not biased; (b) you are biased if you disagree with me; and (c) your intentions/actions reflect your egocentric biases (Kruger & Gilovich, 1999).

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Key to most attributional biases such as the actor-observer bias and the fundamental attribution error is the "dispositional" versus "situational" distinction. "Dispositionists" are persons who see others' behavior as conditioned by internal factors (i.e., beliefs, values, traits) rather than by situations. In contrast, "situationists" believe that peoples' actions are caused by external factors outside their control. Although situationist attributions are seen as more accurate than dispositionist attributions, they are more likely to be dismissed which makes dispositionism the major schema for understanding others' behavior. And dispositionists tend to be most prone to exhibit naïve cynicism (Chiu & Hong, 1997). Thus, people will always be seen as "figure" and everything else is (back)ground.

To summarize, some of the factors that encouraged intrusive political advocacy during the last campaign likely had its roots in the tendency to see the self as less dispositionally motivated, more rational, and less biased compared to others combined with inflated and inaccurate judgments of the accuracy and consensus enjoyed by one's opinions. The foundation of these biases appears to be our insufficient awareness of the degree to which we operate with flawed data sets for judging ourselves and others accurately. Add inflamed emotions to this mix and it is a miracle that fist fights did not break out at work last semester (although they DID break out at some political rallies).

Social identity and partisan bias

Perhaps one of the strongest influences on the unrestrained political talk is the increase in partisan bias in American political life. As noted by social identity theorists, in competitive situations like politics, ingroup/outgroup polarization processes are intensified. Positive evaluations of the ingroup (i.e., the group with whom one identifies) and correspondingly negative evaluations of outgroups (i.e., the group with whom one does not identify) become stronger (Iyengar, Sood & Lelkes, 2012). However, unlike social identity based on gender and race where social norms may constrain one's words and actions, there are fewer norms to inhibit expressing disapproval – if not contempt – of the opposing political party. As Iyengar and Westwood (2015) demonstrated in a series of studies, partisan animus in the American public actually exceeds levels historically associated with racial hostility. They note that while "Americans are inclined to 'hedge' their overt expressions of animosity towards racial minorities, immigrants, gays, and other marginalized groups, they enthusiastically voice hostility towards the opposing party and its supporters" (p. 705). Thus, the 2016 presidential campaign was replete with examples of candidates and their supporters at rallies expressing aggressively virulent political rhetoric which drew enthusiastic approval from supporters present. The egalitarian norms that would otherwise limit overt expressions of racial animosity appear less influential in limiting political animosity. And studies show that outgroup animosities more consequentially affect decision-making and behavior than ingroup favoritism (Iyengar & Westwood, 2015). Hating is stronger than liking.

Partisan bias differs from social identities in other ways. Race and gender offer permanent physical cues to affiliation, but bumper stickers, lawn signs, baseball caps with slogans, political arguments on social media, and political talk at work make cues to one's party affiliation quite accessible. There has been a slow encroachment of party affiliation into personal, non-political domains resulting in more politically homogenous neighborhoods, stronger preferences for same-party dates on dating websites, and greater preferences for same-party marriages (cited in Iyengar & Westwood, 2015). Finally, because one chooses rather than inherits party affiliation, one may be seen as more responsible for one's partisanship than for one's ethnic affiliation (Iyengar & Westwood, 2015). And this partisan bias can make us more vulnerable to fake news stories because of the tendency to use source credibility as a heuristic for determining whether to believe statements about an issue (Drucker, J., 2001). Ingroup reporters or news channels (i.e., Fox or MSNBC, depending on one's affiliation) may be perceived as inherently more credible and trustworthy than those representing the opposing views. The net result may be that Americans at opposite ends of the political spectrum belong not just to different political parties but different tribal nations that inhabit separate realities filled with different facts derived from different trusted sources.

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So the short list of social cognitive factors contributing to intrusive political advocacy would read like the index in a social psychology text: actor-observer effects, bias blind spots, dispositionism, false consensus effects, fundamental attribution error, ingroup/outgroup polarization, introspective illusions, naïve cynicism, naïve realism, and partisan bias – to name a few. It will perhaps require a separate article to address how to cope with this, much less to "fix" it. I accept that non-partisan discussions will be hugely challenging given this biasing backdrop of seriously flawed information processing combined with heated emotions. I can live with some of the personal/professional role conflicts for now and I'll wade my way through my own ethical decision-making process armed with knowledge of the many sources of bias that may be operating.

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Knowing what pulls us in extremist directions is helpful because it emboldens me to occasionally take a walk on the "other side" politically by watching "opposition" news channels or reading contrarian editorials while searching for common values. I may react strongly and counter-argue with the talking heads or the editor, but I'll do so with greater awareness of the processes behind those urges. And maybe asking myself some of those Socratic questions often used by good cognitive therapists would help. What is the evidence this is true? Or not true? What impact is this information having on me? What would be the impact of changing my views? And perhaps most important of all: what's another way of looking at this? That seems like one small step in the right direction.

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ESSENTIAL RESOURCES TO PRACTICE LEGALLY AND ETHICALLY

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In addition, PPA members can access recent issues of the *Pennsylvania Psychologist* or the *Pennsylvania Psychologist Update* through the PPA website in the same drop-down menu.

In addition, I rely on some resources from the Ethics and Psychology blog administered by Dr. John Gavazzi. I can get there easily by googling Ethics and Psychology Blog, or directly at ethicalpsychology.com/p/ethics-and-psychology-podcasts.html. I highlight a couple of his podcasts on specific topics below. Also, a number of books have been written which provide assistance for psychologists in independent practice. I have not done a systematic review of them, but generally I have found *The Paper Office* by Edward Zuckerman to contain many helpful documents (the latest edition has been issued with Dr. Keely Kolmes as a co-author).[2] It contains a number of forms on a CD that readers can modify for their own use as well as guidance on issues and concerns.

Finally, I recommend that psychologists can use *Pennsylvania Law and Ethics in Psychology* as a resource. This book, written by Samuel Knapp, EdD, ABPP; Rachael Baturin, JD, MPH; and Allan Tepper, PsyD, JD, reviews the relevant laws in Pennsylvania including the licensing laws, duty to warn or protect, confidentiality, mandated reporting, child and adolescent consent to treatment, and many other relevant topics. It is now in its 6th edition and is available in an electronic format through the PPA office.

As helpful as these resources are, often psychologists will need to have professionals available for consultation when specific, complex, or unusual issues arise. The PPA staff is available to help its members under such circumstances.

Informed Consent Forms

The Trust, formerly the APA Insurance Trust, offers a good informed consent agreement which is in the public domain and may be downloaded. Psychologists can go to the Trust website (trustinsurance.com/) and then to Resources, and then to Download Documents. *The Paper Office* by Zuckerman and Kolmes also contains a very detailed chapter on informed consent with a sample document and decisions to make when creating or modifying an informed consent document.

The Trust document is currently labeled as a "sample." Sometimes members will ask for a model document. But there is a big difference between a model document and a sample document. We do not provide such a model document because we cannot anticipate all of the different ways that psychologists may want to modify this document to reflect the unique ways in which they run their practices. Much of the information in the consent form will vary according to the individual procedures of each psychologist. For example, some psychologists will require the consent of both parents before they see a child who is 14 or older, even though such dual consent is not legally required. Other psychologists will see a child who is older than 14 with the consent of only one parent (even though the child him or herself could grant consent). The informed consent should be modified to reflect this and other differences in the policies and practices that each individual psychologist adopts.

Informed consent becomes especially complex when dealing with children and adolescents.

Informed consent becomes especially complex when dealing with children and adolescents. The issues become complicated because of the complex and confusing case law and statutes that Pennsylvania has dealing with this topic. Fortunately, PPA has a series of articles on informed consent issues with children and adolescents on its website. These can be found on the PPA website under Psychologists > Practice Resources > Legal and Ethical Articles > Children.[3]

[2] **I am friends with both Drs. Gavazzi and Zuckerman, but I do not think my friendship is influencing these recommendations. I believe that I can justify my recommendations based on the inherent worth of their materials.**

[3] **Access to these articles require psychologists to log in as members.**

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Record Keeping

The rules for record keeping for psychologists are established from several different sources including the Pennsylvania State Board of Psychology, the American Psychological Association, and both public and private insurers. The State Board of Psychology has regulations on record keeping (49 PA Code §41.57; pacode.com/secure/data/049/chapter41/s41.57.html), but these are the bare minimum requirements. In addition, psychologists in Pennsylvania are required to follow the standards of the American Psychological Association (see 49 PA Code §41.61, Principle 3 (e)), including those on record keeping regulations, which go into more detail than those of the State Board of Psychology. The APA record keeping guidelines can be found at apa.org/practice/guidelines/record-keeping.aspx.

Also, commercial insurers, Medicare, and Medicaid all have their own record keeping requirements that usually overlap with but go beyond what is required by the State Board of Psychology or the America Psychological Association. Most commercial insurance companies follow the record keeping requirements of the National Committee on Quality Assurance, although many insurers have their own idiosyncratic requirements. For that reason, I recommend that psychologists look at the specific requirements for each of their insurance contracts.

These different record keeping regulations overlap considerably, but they do have their unique requirements. For example, Medicare will require all records to document that the patient is likely to benefit from treatment. When considering that the Medicare program is for older adults, many of whom have some cognitive decline, this requirement makes some sense.

PPA has a series of articles from the *Pennsylvania Psychologist* dealing with record keeping including information on the usefulness of record keeping as a risk management tool (look under Psychologist > Practice Resources > Legal and Ethical Issues > Record Keeping/Retention). In addition, PPA has detailed intake forms for older adults, adults, and children that PPA members can download and modify as they wish. The sections on these forms were designed to address many of the items that insurers require in the documentation of the psychologists. PPA also has a home study on record keeping that can be accessed at its website (look under CE Events > Home Studies).

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Under some circumstances psychologists can charge for sending records to attorneys in response to a subpoena. The acceptable rates are published in the *Pennsylvania Bulletin* (the official publication of the Commonwealth of Pennsylvania) every year. The latest rates I have found can be retrieved at palegallinks.com/2016_Pennsylvania_Medical_Records_Fee_Schedule.pdf. They are also published in the *Pennsylvania Psychologist* every year as well.

Confidentiality

The rules for confidentiality have become more complicated in recent years. PPA has information on confidentiality concerning authorization forms, responding to audits, mandating reporting, subpoenas, HIPAA, and other topics.

Authorization forms

PPA has a sample authorization form (release of information form) on its website that meets HIPAA requirements (Practice Resources > Legal and Ethical Articles > Release of Information). HIPAA does allow some variation in how the specific requirements have to be framed. For example, HIPAA requires that authorization forms include an end date. Our sample authorization form includes an option for checking the end date as "at the end of treatment," although nothing in HIPAA specifically requires offering this as an option. A second article from the *Pennsylvania Psychologist* describes the requirements in these authorization forms in more detail, It is on the PPA website (Psychologists > Legal and Ethical Issues > Release of Information Form). Nonetheless, psychologists can expect that sometimes they will encounter an inpatient facility or an agency from out of state that insists upon some unique requirements that are not contained in the more generic HIPAA-compliant form. My recommendation is not to worry about such things and simply deal with such rare requirements as they occur on a case-by-case basis.

Audits

Insurance companies can audit the records of psychologists with whom they have contracts for many different reasons. One of the most common reasons in recent years is to for risk adjustment audits which were mandated for insurers involved in health exchanges. PPA has an article about risk adjustment audits and how to respond which can be found among PPA articles (Practice Resources > Legal and Ethical Issues > Confidentiality).

Mandated Reporting

Psychologists and other health-care professionals are required to break confidentiality in several circumstances. PPA has written a comprehensive review of these reporting situations that was published in the March 2017 issue of the *Pennsylvania Psychologist*, which is also on its website (log in as a member, go to Psychologists > Legal and Ethical Issues > Confidentiality).

Of course, under Pennsylvania's Act 31, psychologists must take a two-hour training in child abuse identification and protection as a requirement for

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ESSENTIAL RESOURCES TO PRACTICE LEGALLY AND ETHICALLY

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licensing renewal. Psychologists can go to the website of the State Board of Psychology and, under Announcements, find a list of approved Act 31 providers (dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Psychology/Pages/Announcements.aspx#.VHStnVZOk5t). Please note that PPA offers a very thorough home study on child abuse recognition, *Pennsylvania Child Abuse Reporting and Recognition*, both as a paper document and a podcast. PPA also offers some additional home studies on child abuse which are not intended to fulfill Act 31 requirements.

Furthermore, all new applicants for a psychology license must take a three-hour training in child abuse identification and protection and PPA also offers such a three-hour course.

Act 31 training differs from other forms of continuing education in that the provider must have its course specifically approved by the Pennsylvania Departments of Human Services and State, and that the provider must send documentation to the licensing board that the licensee has completed the approved course. More information can be found in the section on Continuing Education referenced below.

Subpoenas

Psychologists are often ill-prepared when they receive a subpoena or a court order for their records. Of course, PPA members can always call the PPA staff for guidance. However, it is also helpful for them to understand the basic rules which can be found in articles on the PPA website (Psychologists > Practice Resources > Legal and Ethical Articles > Subpoenas and Court Orders > Release of Confidential Information).

The Health Insurance Portability and Accountability Act (HIPAA)

Confidentiality rules are heavily influenced by HIPAA. As psychologists know, HIPAA produced major changes in how the medical professions handled confidential health-care information, although its impact on mental health was far less because state laws tended to already protect health-care information very carefully. PPA has a number of background articles about HIPAA on its website, including *HIPAA: Frequently Asked Questions, Common Misconceptions About HIPAA,* and others.

Psychologists are required to ensure that their support staff and other employees understand and comply with the rules concerning confidentiality. PPA members should feel free to use the article *What Your Employees Need to Know About Confidentiality* in their training program. This article also includes multiple choice questions and an answer guide (Psychologists > Practice Resources > Legal and Ethical Articles > HIPAA).

Psychologists who need to exchange some protected health-care information to a person other than a member of the psychologist's workforce or a health-care professional need to get a business associate agreement signed (e.g., when a psychologist hires a professional to work on his or her computer). It may require that computer professional to look at some protected health-care information. A template for such an agreement provided by the U.S. Department of Health and Human Services can be found on the web (hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html). Or a psychologist could simple enter a search for Business Associate Agreements and allow many different options to arise.

Psychologists are required to ensure that their support staff and other employees understand and comply with the rules concerning confidentiality.

In addition to the Privacy Rule, HIPAA also has a Security Rule which requires that health-care professionals take reasonable precautions to protect the security of their transmissions, including HIPAA's standards for when breaches of security require notification

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of patients or the Office of Civil Rights. Articles on security can be found on the PPA website (log in as a member, go to Psychologists > Practice Resources > Legal and Ethical Articles > Confidentiality).

Continuing Education

The continuing education requirements have been described in numerous PPA publications. In addition, psychologists who want information about Act 31 (child abuse) trainings can go to the website of the Bureau of Professional and Occupational Affairs to find information on those who are approved to provide such trainings (see discussion of this on page 9, Mandated Reporting).

I have known conscientious psychologists who believed that they had gotten all of their credits and completed all of the required courses, only to realize at the last minute that they were a course or two short.

Psychologists are also required to have continuing education in ethics and suicide prevention. In addition to programs offered through its annual convention and conferences, PPA also has 12 home studies that can be used to fulfill ethics continuing education requirements and five home studies that can be used to fulfill the mandated continuing education in suicide, including a one-hour podcast of a conversation between Drs. Samuel Knapp and John Gavazzi, and a one-hour webinar. These can be accessed through the PPA website under CE Events > Home Studies.

Every fall of the licensing renewal year, PPA publishes a front page reminder article about licensing renewals and continuing education in the *Pennsylvania Psychologist*. In addition, reminder emails are sent to every PPA member. It is very easy to get caught up in daily work and forget about the requirements. I have known conscientious psychologists who believed that they had gotten all of their credits and completed all of the required courses, only to realize at the last minute that they were a course or two short.

Telepsychology

Telehealth is a growing area of practice for psychologists, but it has several uncertainties and controversies surrounding it. Specifically, questions arise as to when to provide it and how to provide it competently and legally.

Every source I have conferred with agrees that psychologists can provide emergency services to a patient out of their jurisdiction through telehealth means. In addition, psychologists can freely consult with each other across state lines. However, controversies arise concerning the delivery of routine health services across state lines. That is, may psychologists in one state offer routine, non-emergency services to a patient who is physically located in another state where the psychologist is not licensed? It is a common assumption that the health-care service occurs in the state in which the patient is physically located, although I have been unable to find any case against a psychologist based on that fact alone. In addition, Harris and Younggren (2011) believe that this interpretation is too rigid and that the case law about interjurisdictional practice "reflects a lack of consistency" (p. 417).

Nonetheless, psychologists who take a conservative approach may want to check to see if the state where the patient is located has a temporary practice provision in its licensing law. Some, such as Pennsylvania, simply allow psychologists licensed in other states to practice in Pennsylvania up to a certain number of days per year. Other states allow temporary practice but require the psychologists to register with that state's Board. The American Psychological Association has a 50 state review of these rules (apapracticecentral.org/advocacy/state/telehealth-slides.pdf), but it is dated 2013, so psychologists may want to contact the jurisdiction directly to be certain that their rules have not changed in the meantime.

Dr. John Gavazzi's Ethics and Psychology blog has a good two-part podcast on delivering telehealth services involving an interview between him and Marlene Maheu (see the ethics and psychology blog). Also, PPA has a three-part home study webinar on telepsychology by Dr. Gavazzi which can be found at the PPA home study page (see PPA web page). The Trust contains a sample informed consent document for delivering telehealth services (see Trust website referenced above). Finally, PPA has some good articles on clinical issues when considering telehealth services under Practice Resources > Legal and Ethical Articles > telepsychology.

Some insurers in Pennsylvania will reimburse for telehealth services under specific situations. I am not going to review those policies because they keep changing and I would not want any article in this issue to become out-of-date so quickly.

Business Aspects of Practice

PPA has many articles about fees and billing, business structures, business relationships, and issues dealing with employees and restrictive covenants on its website. All psychologists delivering health care should purchase professional liability insurance. An article on the PPA website explains basic information about the different forms of malpractice insurance available (Practice Resources > Business Structure). In addition, PPA offers a one-hour home study on "Ethical and Legal Issues in Fees and Billing" (see the PPA website under CE Events > Home Studies).

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Insurance Issues

Many psychologists receive reimbursement from Medicare, although the number of psychologists participating in Medicare has declined in recent years because of declining reimbursement rates. Psychologists with doctoral degrees have to accept Medicare's payments for treating Medicare beneficiaries unless they complete and send in an "opt out" agreement.

The form can be retrieved from novitas-solutions.com/webcenter/portal/MedicareJL/page/pagebyid?contentId=00004846&_adf.ctrl-state=707sxhc8r_84&_afrLoop=94305282218528#!%40%40%3F_afrLoop%3D94305282218528%26contentId%3D00004846%26_adf.ctrl-state%3Dpckimgi0r_33 (or by an internet search looking for Novitas, Medicare, Pennsylvania, opt-out). In addition, PPA's Practice Resources page has an article on how to opt out of Medicare properly (Practice Resources > Insurance > Medicare).

Compliance Plans

Some insurance companies will require compliance plans that ensure that the psychologist or agency is billing appropriately. If none of your contracted companies requires compliance plans, then you can skip this section. If your company does require a compliance plan, you can find templates for such a plan on the PPA website (Practice Resources > Business Practices). In addition, many agencies and some individuals have their own compliance plans, which largely include boiler plate language that you can borrow with their permission.

Physician Quality Reporting Service

For the last several years, psychologists have had their reimbursements under Medicare influenced by their participation in the Physician Quality Reporting Service (PQRS), although these incentives will not apply in 2017. Recently Congress passed a comprehensive Medicare reform bill, called MACRA, which uses a complex set of incentives and disincentives for healthcare professionals. The Department of Health and Human Services has the option of applying these standards to psychologists in 2018, although it is not altogether clear that they will do so at that time. Nonetheless, PPA does have a review of the PQRS program on its website, including the option of taking it as a home study (CE Events > Home Studies).

Other Topics

Over the years, PPA has tried to address important issues that come up in the practice of psychology such as the development of professional wills, reputation management, social media, and forensic work.

Professional Wills

PPA has a very good article on professional wills written by Dr. Mary Wiley and Dr. Cathy Spayd, which can be found under Practice Resources > Business Practice > Professional Will) on the PPA website. In addition, PPA has a webinar home study, "How to Prepare a Professional Will," which can be accessed through its Home Study continuing education site. Finally, Dr. Gavazzi has a podcast interview with Drs. Mary Wiley and Cathy Spayd entitled "Existential Angst and Making Your Professional Will."

Reputation Management

Unfortunately, psychologists will, over the course of their careers, encounter a highly dissatisfied patient who may file a complaint or try to harm a psychologist through harsh and unfair online comments. PPA offers a helpful home study on this topic, "Online Reputation Management: Ethical Considerations and Strategies" by Dr. Pauline Wallin.

Social Media

John Gavazzi's Ethics and Psychology blog has an informative podcast on psychologists and social media with Dr. David Palmiter as the featured guest.

Forensic Work

Although only a minority of psychologists have specialties in forensic work, all psychologist need to be "forensically informed," meaning that they have some awareness of how to respond when they inevitably encounter clinical situations with forensic implications. Articles on forensic practice can be found on the PPA website under Practice Resources > Ethical and Legal Articles > Forensics.

Self-Care

I think of self-care as an underappreciated aspect of professional competence. PPA has an extensive library of articles on self-care under Practice Resources > Self-Care Articles. I find the articles by Dr. Jeff Sternlieb to be especially helpful and insightful.

The multitude of PPA resources mentioned are accessible by members only. If you have colleagues who would benefit from this information, talk to them about joining PPA today!

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Harris, E., & Younggren J. N. (2011). Risk management in the digital world. *Professional Psychology: Research and Practice, 42,* 412–418.

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Knapp, S., Baturin, R., & Tepper, A. (2016). *Pennsylvania Law and Psychology*, 6th ed. Harrisburg, PA: The Pennsylvania Psychological Association.

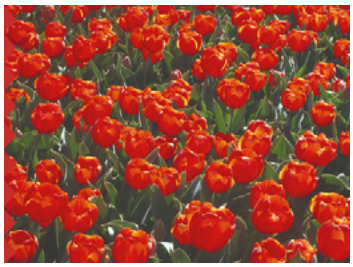
Zuckerman, E., & Kolmes, K. (2017). *The Paper Office*, 5th ed. New York, NY: Guilford Press.

Check out PPA's Exciting Upcoming Events

PPA has some great events for our members on the horizon. Hopefully you can join us for one or more of these exciting CE programs!

Thursday, April 13, 12 p.m. –1 p.m. • • • PPA Webinar Series: Psychology and Advocacy
This webinar will cover the basics of how a bill becomes a law and identify the major decision makers in Harrisburg. We will also guide you through PPA's legislative advocacy efforts, including the decision making about which bills to support or oppose. Finally, we will challenge you to become an advocate for the psychology profession and provide you with the tools to successfully advocate for you and the patients you serve.

Saturday, April 22, 9 a.m. – 12 p.m. • • • Victimization of Older Adults and Adults With Disabilities: Recognize, Respond, Report
While child abuse, for good reason, gets significant attention, the victimization of older adults and adults with disabilities often is overlooked. This workshop will provide participants knowledge about the types of victimization that occur; professional and ethical responses to victims; and reporting options and requirements. Participants will walk away prepared and empowered to address adult victims of abuse.



Thursday, April 27 – Friday, April 28 • • • PPA Spring Continuing Education Conference
Join PPA for the 2017 Spring CE & Ethics Conference at the beautiful Sheraton Erie Bayfront in Erie, PA. Come network with colleagues and gain valuable CE credit in a pristine seaside locale. A full schedule is available online: papsy.org/page/SpringFall.

Sunday, May 7 • • • Leadership Academy
This invitation-only event educates members about the Pennsylvania Psychological Association and offers great information about becoming a leader within PPA and the field of psychology. It will take place at the PPA office, 5925 Stevenson Avenue, Harrisburg, PA 17112.

Monday, May 8 • • • PPA Advocacy Day
Come to Harrisburg, visit the Capitol Building and help shape mental health policy! At advocacy day, you will receive 1.5 CE credits as we inform attendees about the legislative process and initiatives we are pursuing. This day, with opportunity to meet with your local state representative or senator, can't be missed.

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CHECK OUT PPA'S EXCITING UPCOMING EVENTS

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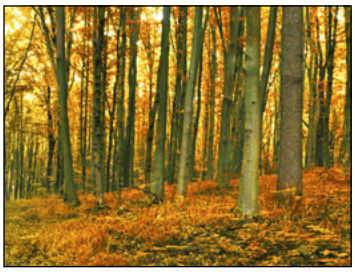
Wednesday, May 17, 12:00 p.m. – 1:30 p.m. • • • PPA Webinar Series: Depression and Cardiovascular Risk in Post-Menopausal Patients

Depressed patients with cardiovascular disease have displayed lower self-care ability in comparison with non-depressed ones. This workshop will address how depression impacts lifestyle choices and health promotion behaviors in the older adult female patient. A conceptual framework for developing collaborative interventions will be examined. This webinar is eligible for 1.5 hours of CE credit.

Wednesday, June 14 – Saturday, June 17 • • • PPA2017 Annual Convention

Visit the gorgeous Bedford Springs Resort for the PPA2017 Annual Convention, where we make it our goal to help you Live a Little and Learn a Lot! At this year's convention we will have many workshops and sessions promoting the theme *Striving to Overcoming Interpersonal Violence*. We hope you join us for PPA's premiere event!



Thursday, October 26 – Friday, October 27 • • • PPA Fall Continuing Education Conference

The deadline for licensure renewal is November 30, 2017. Join us at the Eden Resort in Lancaster, PA, for this two-day opportunity to earn CE credit as you head into the home-stretch for renewing your license!

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

THERAPY OFFICE TO RENT – MAIN LINE – HAVERFORD – Sunny first floor furnished office available. Monday, Wednesday, Thursday, Friday. Shared attractive office suite/waiting room in building with other psychologists. Psychiatrists, LCSW offices. Hi Speed Wi-Fi. Well-lighted parking lot. $50 per day/evening. carole@mstherapist.com or 610-649-9964.

Seeking a locum CLINICAL PSYCHOLOGIST to perform pre-surgical evaluations and possibly other behavioral medicine clinical services on a part-time basis at Geisinger clinics in Wilkes-Barre and Scranton (2–4 days per month, scheduled clinic hours only). Must have completed APA-accredited doctoral program and internship and hold a current PA license. Clinical experience with pre-surgical evaluations (e.g., bariatric, spinal cord stimulators), disordered eating, weight management, and pain management preferred but not required. Training will be provided. If you are interested, please contact: Laura Keys Campbell, Ph.D., Director of Training, Adult Psychology and Behavioral Medicine, Division of Psychiatry and Behavioral Medicine, Geisinger Health System, lkcampbell@geisinger.edu, (570) 271-6516.

Join PPA's Listserv!

The listserv provides an online forum for immediate consultation with hundreds of your peers. Sign up for FREE by contacting:

iva@papsy.org

2017 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 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.

April 13, 2017
12:00 p.m. – 1:00 p.m.
PPA Webinar Series: Psychology and Advocacy
Online – Register: papsy.org/page/PPAWebinars

April 22, 2017
Victimization of Older Adults and Adults With Disabilities: Recognize, Respond, Report
Philadelphia College of Osteopathic Medicine, Philadelphia, PA

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

May 7, 2017
Leadership Academy
Harrisburg, PA

May 8, 2017
Advocacy Day
Harrisburg, PA

May 17, 2017
12:00 p.m. – 1:30 p.m.
PPA Webinar Series: Depression and Cardiovascular Risk in Post-Menopausal Patients
Online – Register: papsy.org/page/PPAWebinars

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

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

Webinars and Home Studies

Check out our new Online Learning Portal at papsy.bizvision.com!

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

The Assessment, Management, and Treatment of Suicidal Patients (approved for Act 74)
1 CE Credit / 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**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

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

***This program qualifies for 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) 510-6343, judy@papsy.org.