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HOW LONG WILL I BE ABLE TO PRACTICE TELEHEALTH?

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HOW LONG WILL I BE ABLE TO PRACTICE TELEHEALTH?

What Conditions Will Apply to Telehealth Services?

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At the time of this writing, the COVID-19 pandemic is in its seventh month. The United States declared a public health emergency (PHE) on January 31, 2020, and Pennsylvania put into place its first public health restrictions on March 13. Currently it is unclear how long the pandemic will continue to require physical distancing and other social restrictions. Even the most optimistic reports suggest that the creation and mass dissemination of a vaccine for COVID-19 will not occur until early 2021. The less optimistic reports suggest that no vaccine will be developed for decades.

As Pennsylvania begins to ease restrictions, psychologists will be faced with choices about resuming face-to-face services. Some Pennsylvania psychologists have maintained at least limited face-to-face services throughout the PHE. Some are just now beginning to see patients for face-to-face therapy sessions and other services. Others do not expect to return to face-to-face services in the foreseeable future.

Psychologists are placed in a difficult position wherein they want to plan for the long-term treatment of their patients through telehealth services. Psychologists who contract with public or commercial insurance companies face additional uncertainties. The Pennsylvania Insurance

Department, which regulates commercial insurers in Pennsylvania (except for self-funded plans), does not require insurers to provide telehealth services. The availability of insurance reimbursement for telehealth services was already expanding prior to the COVID-19 emergency. However, insurers varied tremendously in what services they covered and in their rules for coverage. As the PHE developed, the U.S. Department of Health and Human Services, as well as the Pennsylvania Insurance Department, encouraged insurance companies to make temporary policies to support and encourage telehealth services, including psychological services as a way of slowing the spread of coronavirus (Pennsylvania Insurance Department, 2020). Most

commercial insurers responded, often with sweeping temporary rules. In Pennsylvania, the state issued rules which increased access to telehealth for patients with Medical Assistance. Medicare has also greatly expanded availability of reimbursement for telehealth services during the PHE.

Insurance and Telehealth during the COVID-19 Crisis

During the COVID-19 emergency, all the insurance companies listed in Table One permitted in-network providers to bill for telehealth for psychotherapy when the encounter is conducted in real-time with video and audio link using a HIPAA-compliant platform. Some, including

1. The authors thank Valerie Domenici, Tiffany Griffiths, Sean Healey, and Gail Karafin for their assistance in gathering the information used in this article. The authors also relied on the resources published by the American Psychological Association to supplement the information that the Insurance Committee of PPA gathered directly.

Medical Assistance in Pennsylvania and Medicare, permit the use of telephone (audio-only) for some services. Prior to the PHE, some companies required providers to file a form attesting to compliance with HIPAA or other rules before providing telehealth services. All the listed companies waived that requirement during the PHE. In addition, some insurers are temporarily waiving patient deductibles and copays to further encourage the use of telehealth. (When insurers waive copays and other costs, they will reimburse the provider at the full contracted rate.)

There are exceptions to coverage rules. Most commercial insurance companies also administer benefits for employer-funded insurance plans. Employer-funded insurance plans have enough purchasing power that they can set their own conditions for insurance and are federally regulated and exempt from state insurance laws. Some self-funded plans decided not to allow telehealth. Others allowed telehealth but did not waive copays. It can be difficult to determine which patients are insured through self-funded plans. Therefore, a psychologist should not rely on our tables or even on insurance company bulletins to determine a patient's benefits. *It is prudent for psychologists to always check coverage provisions for each patient, even if other patients with the same insurer have telehealth coverage, by contacting that insurer and confirming that patient's mental health coverage.*

The procedure codes covered for telehealth services vary from one company to another. Some insurance companies cover testing, applied behavioral analysis (ABA), autism services, or health & behavior codes when the service is delivered by audio/video link or by telephone. Others cover psychotherapy when delivered by audio/video link or by telephone, but cover ABA and autism services only when delivered by audio/video link. Most require that psychological

services be delivered in a "synchronous" manner, meaning that there must be an open connection between provider and patient at the time of the service. Thus, texting and email services are not covered.

The usual billing code for place of service is 02, although there are some exceptions (see Table One). Some companies require a CPT code modifier as well. A standard policy at some insurance companies is to reimburse telehealth at a reduced "facility rate." For Medicare, these reductions in reimbursement are more than 10%. Some companies, including Medicare, are offering a temporary workaround to receive the standard reimbursement amount: bill the service with the Place of Service code used as if the session were face-to-face and use a modifier. See both Table One and accompanying notes for each company.

Table One summarizes the rules of most commercial insurance companies operating in Pennsylvania, as well as Medicare and Medical Assistance. The table has previously been made available online to PPA Members. The online version has been updated as new information has become available. It is accurate at the time of this writing, as far as the authors know. Table Two includes a link for each insurance company to a general bulletin or policy announcement. Many insurance companies have multiple announcements which may be difficult to track. Because information is continually changing, psychologists may wish to verify the information before providing services. Information is more complete for some insurances than others. Readers may wish to pay special attention to the column identified as "Provisions Expire" and to Table Three which may help psychologists to prepare for the time that the special provisions related to telehealth expire and many companies will revert back to their pre-pandemic policies.

Table One: Insurers and Telehealth²

Insurer	Platforms allowed	Telephone allowed?	Copay waived?	Place of Service	Modifier	Provisions expire
Aetna	HIPAA compliant preferred; alternatives allowed during pandemic	Yes	Yes	02	GT or 95	September 30
Capital Blue Cross		Yes	Yes	11	95	September 30
Cigna	HIPAA compliant preferred; alternatives allowed during pandemic	Yes	Yes	11	CQ	July 31, 2020, after that Cigna will require an attestation and a HIPAA compliant platform
Compsych	HIPAA compliant preferred; alternates allowed during pandemic	Yes				

2. Both Tables One and Two are based upon the work of Brett Schur, Ph.D. *To the best of our knowledge the data is accurate as of July 6, 2020.* However, insurers are continually updating their policies and some of the data herein may become obsolete. We urge all psychologists to check the benefits for each patient before initiating services.

Geisinger	HIPAA compliant preferred, alternates allowed during pandemic	Yes	Yes	11	95	Will waive copays and deductibles for telehealth services for in-network providers until July 31, 2020
Highmark	HIPAA compliant preferred; alternates allowed during pandemic	For some plans	See note		GT or 95	September 30
Horizon BC/BS	Alternatives allowed, no stated preference	Yes	Yes	See note	GT or 95	August 31
IBC	No information	Yes	No	02	See note	December 31 (for products not managed by Magellan)
Medicare (traditional)	HIPAA compliant preferred; alternatives allowed during pandemic	Yes	No	11	95 (see note)	Until emergency lifted by HHS Secretary, after that, unless Congress or CMS changes the rules, Medicare will only pay for telehealth at a facility rate, using HIPAA compliant platforms for substance abuse services. Medicare Advantage Plans must offer benefits not less than what traditional Medicare offers and may have telehealth options beyond what traditional Medicare offers
Magellan	HIPAA compliant preferred; alternates allowed during pandemic	Yes	Yes	02	none	Special COVID-19 waivers will continue until emergency lifted by HHS Secretary; regular telehealth rules for resume after that requiring an attestation and use of HIPAA compliant platforms
Optum/United	HIPAA compliant preferred; alternates allowed during pandemic	Yes	Yes	02	See note	October 22 See note
Quest	HIPAA compliant preferred; alternatives allowed during pandemic	Yes		02	GT	Special COVID-19 waivers will continue until the emergency is lifted by the Governor, after that Quest will require an attestation and a HIPAA compliant platform
MHC	HIPAA Compliant only	Yes	No	02	GT or 95	
Tricare/Humana	HIPAA Compliant only	Yes	Yes See note	02	GT	After HHS Secretary lifts emergency, copay waivers will end, and HIPAA compliant platforms will be required, and some plans may require an authorization
UPMC	HIPAA compliant preferred; alternatives allowed during pandemic	Yes	Yes	02	GT	UPMC will continue to authorize telehealth services and waive deductibles and copay for in network providers until Sept. 30

Table Two: Direct Links to Company Policies

Insurer	Link for more information
Aetna	https://www.aetna.com/content/dam/aetna/pdfs/health-care-professionals/bh-televideo-service-codes-covid-19.pdf https://www.aetna.com/health-care-professionals/covid-faq.html
Capital BC	https://www.capbluecross.com/wps/portal/cap/provider/covid-19-information/telehealth
Cigna	https://cignaforhcp.cigna.com/web/secure/chcp/resources/lut/p/z1/jZDBbslwEES_hUOOrdeRockxCSS4oTJtIBB-fkEINsARozIdW7dfXRvV7Arq3nXkj7Szial24Fm-qEb1qtTi4veKjzTwplzgPCbD0eQIUUR2RB2BAgwGh1BrJg6GcxwVm-QU-IA9phHZeoDAOL_yV8BvvNwYSJAIs_bFgWjPC0gCIaMAINi3ju0ydHYFQgjriRO1R5YFUvrQf1vu48MNK2J1PLm-doaYT48OMpXVYvDy49uZ8r2v-q4VbqJT1Zpae1K9ftENvR82dv3OmElHd_h8L4TjXTF-Pn2a6-5Va47Ltefi103iQaDL0zYvio/dz/d5/L2dBISEvZ0FBIS9nQSEh/
Geisinger	https://www.geisinger.org/health-plan/providers/coronavirus
Highmark	https://hbs.highmarkprc.com/COVID-19/Telemedicine-and-Virtual-Visits https://content.highmarkprc.com/Files/ClaimsPaymentReimb/ReimbPolicies/rp-046.pdf
Horizon BC/BS (NJ)	https://mail.google.com/mail/u/0/#search/horizon/WhctKJVqrsTKlwrLBDgmshSfpRHZGHwtGSzpCIZRpZpsgjHXbxGCL-JTvNwMKqcVHLDdVrVv
IBC	https://provcomm.ibx.com/ibc/news/Pages/20-2351.aspx
Magellan	https://www.magellanofpa.com/media/5507/final-covid-19-telehealth-memo-april-6-2020.pdf
Medicare	https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
MHC	https://myemail.constantcontact.com/Important-MHC-Provider-Alert--Telehealth-in-Response-to-Coronavirus--Covid-19--Pandemic.html?soid=1114798526322&aid=X9IJkqi70Y
Optum/United	Go to www.providerexpress.com , then click on the link for COVID-19.
Quest	https://www.questbh.com/providers/telemental-health/
Tricare/ Humana	Regular telehealth policy: https://tricare.mil/CoveredServices/BenefitUpdates/Archives/03_24_2020_TRICARE_covers_certain_telemedicine_services Temporary pandemic addendum to policy: https://www.tricare.mil/CoveredServices/BenefitUpdates/Archives/05_18_2020_TRICARE_Revises_Telehealth_Policy_to_Respond_to_COVID_19
UPMC	https://embed.widenet.net/pdf/plus/upmc/22cs5qhtzm/Appendix-A-Covid-Benefits-and-Cost-Sharing.pdf . https://www.upmchealthplan.com/providers/medical/resources/guidelines/clinical-practice.aspx

Company Specific Notes

This data is accurate, to the best of our knowledge, *as of July 6, 2020*. However, companies are always updating and changing their policies as conditions change. Furthermore, as has been noted elsewhere, individual insurers may issue hundreds of different policies, including policies for self-funded plans, that include unusual riders or benefits. Therefore, we urge psychologists to check the benefits for each individual patient before treatment begins.

Aetna: Aetna's commercial policies pay for case management services only by telephone. Aetna's Medicare Advantage plans, like all Medicare plans will pay for telephone services during the federal pandemic emergency.

Out of network benefits vary according to individual plans.

Capital BC: Copay waived for virtual visits only, and only for those who use their preferred BC platform. Telehealth may be provided by any provider who is in-network with

Capital BC or any BlueCard provider. At this time, the following ABA services will be considered covered services when performed telephonically: 97151, 97155, 97156 and 97157. Allied health professionals listed in this policy will be considered for reimbursement at their standard professional rate for the facility discounted rate. When reporting a telehealth service there are no billing requirements for the utilization of modifiers. Health & Behavior codes are covered. Group psychotherapy is not.

Cigna: Cigna authorized telehealth before the pandemic and will continue to authorize it after the pandemic. Psychologists need to sign attestation to bill for telehealth using HIPAA compliant platforms. Visit the Cigna for Health Care Professionals website at CignaforHCP.com > Resources > Forms Center > Behavioral Health Forms for the [Specialty Attested Form](#). Upon receipt of the completed form, "telehealth" will be added as a specialty to your Cigna profile. Use POS code as if it were a face-to-face session. Do not use POS 02 for Cigna. (This is a CIGNA-suggested

workaround for a payment discrepancy.) Telephone only may be used while HHS permits. The telehealth option is only available to in network providers.

Compsych: See referral sheet for copay information. If psychologists received a referral for a client for EAP services and the client's employment status has recently changed, they may continue to provide EAP services per the referral letter that they received. There is no need to contact ComPsych to inquire if the services are still authorized

Geisinger: Providers should bill standard E&M codes with a location code of 02 for telehealth. Providers should bill code G2012 for a brief virtual visit. Other codes covered by GHP for virtual visits that are more involved and longer in duration include the following code sets: 99421-99423 for physicians, G2061-G2063 for non-physician providers.

Highmark: Any Highmark participating mental health provider who has the necessary telecommunications technology to support a virtual outpatient mental health visit may participate. Virtual behavioral health services are not available for members with Medicare Advantage and Medicare supplemental plans. Note: This is also available for Federal Employee Program (FEP) members. I have read conflicting information about CPT modifiers. One Highmark bulletin shows no modifier, while another says to use either GT or 95. Copay waiver: we have an email from Highmark which says copays are waived for many commercial plans, but not for Federal employees.

Horizon BC/BS of New Jersey. Out-of-network providers permitted, but member must pay usual cost sharing. "Horizon BCBSNJ will continue to accept claims for telemedicine services when modifiers 95 or GT are appended to CPT® or HCPCS codes that ordinarily describe face-to-face services." Not clear whether Horizon is asking for POS=02 or 11. Please refer to Horizon announcement. (See link above.)

Independence Blue Cross: Most IBC products are administered by Magellan (see Magellan's policies) **Medicare Advantage members:** Eligible providers performing telemedicine services must report the appropriate POS code 02 (Telehealth) to ensure payment of eligible telemedicine services.

Magellan: Applies to all Magellan products, including commercial plans and Magellan's Medical Assistance program. Use no modifier for telehealth. Use CPT modifiers according to usual practice for other purposes (e.g. diagnostic interview or psychotherapy with medical assistance patients). When pandemic ends, Magellan will require an attestation before delivering telehealth services and will require HIPAA compliant platforms.

Medicare: Most Health and Behavior codes are included. Group psychotherapy is now included. Use the Place of Service code as if the session had been held face-to-face (i.e. 11 for office, 13 for assisted living facility, etc.) Use CPT modifier for video. Telephone (audio only) was approved on April 30, retroactive for services after March 1. We are awaiting

word on the proper modifier for audio-only. New codes (98966-98968) were approved April 3 for brief assessment & intervention telephone calls initiated by the patient. Details are unclear, but it sounds like it could be used for brief crisis intervention or maybe helping a patient through a panic attack.

MHC (Mental Health Consultants): Note that telehealth is available for some plans only. Contact MHC office at 215-343-8987 for more information.

Optum Behavioral Health: (commercial plans) will reimburse telehealth services which use standard CPT codes and a GT modifier or a Place of Service of 02 for both video-enabled virtual visits and telephonic sessions to indicate the visit was conducted remotely. Instructions vary for public plans. Optum is waiving copays for telehealth services for in-network providers only, for the effective period March 31-June 18. Note that these dates differ from the effective dates of other Optum policies. See website.

Optum has a platform that is available for free for non-prescribing in network providers for Optum. The use of the platform is optional, not mandatory.

Quest: "Once the COVID-19 state of emergency has been lifted, you may only treat patients through face to face appointments, or if approved by Quest, through a HIPAA compliant platform." After the emergency is lifted, Quest will require an attestation nor will is require HIPAA compliant platforms. Quest covers psychotherapy for telehealth, but no testing codes except 96116

TRICARE for Military, administered by Humana: TRICARE covers the use of interactive audio/video technology services and are subject to the same referral and authorization requirements and include, but are not limited to clinical consultations, office visits, and telemental health. When submitting claims for telemedicine services, the provider may indicate "Signature not required – distance telemedicine site" in the required patient signature field.

During the state of emergency, copays will be waived but will resume after the emergency declaration is lifted. However, beneficiaries must pay the copay and then seek reimbursement from TRICARE.

Some TRICARE plans for out-of-network providers and others do not.

UPMC: Before the COVID-19 emergency, telehealth for UPMC was limited

No cost sharing for telemedicine (all providers) for 90 days. For more information about telehealth requirements, see <https://embed.widencdn.net/pdf/plus/upmc/4fbcjl0ork/MP.148.pdf>. Waiver of HIPAA compliant requirement confirmed in letter from UPMC to providers on March 20, 2020.

Deductibles and copays differ for in network and out of network providers.

How Can We Plan for Telehealth Services When the PHE Ends?

Eventually, the PHE will end and insurance companies will discontinue their special provisions for telehealth. In most cases, insurance companies will revert to their pre-COVID-19 rules for telehealth. It is highly likely that insurers that covered telehealth services before the pandemic will continue covering them once the pandemic ends and it is possible that some of them may continue with some expanded telehealth services after the pandemic ends.

- We do not expect copay and deductible waivers for telehealth services to continue.
- It is likely that insurance companies will require HIPAA-compliant platforms for telehealth services when the U.S. Office of Civil Rights (OCR) resumes enforcement of HIPAA privacy provisions. In addition, the Pennsylvania State Board of Psychology regulations require that telehealth services utilize a HIPAA-compliant platform. That requirement has been waived by Governor Wolf during the PHE but will likely be enforced once the emergency ends.

- It is likely that many insurance companies will stop paying for telephone (audio only) services once the PHE ends. APA and PPA have been advocating for the continuation of telephone only services for Medicare patients after the pandemic ends, although we cannot predict the outcome of our advocacy.

APA, on the federal level, and PPA on the state level have been advocating with payers to extend the telehealth provisions for one year beyond the official end of the emergency declaration in anticipation that the mental health needs and the social circumstances will continue to justify the use of widespread telehealth services beyond an official end of an emergency declaration.

Table Three lists current expiration dates for the special COVID-19 provisions of each insurance company, as well as the pre-COVID telehealth policies. Our best guess is that these rules will govern insurance coverage of telehealth after the expiration of special provisions.

Psychologists can prepare for the end of the pandemic by completing attestations for insurance companies that require them and ensuring that they have a HIPAA compliant platform that they can use.

Table Three: Post-Pandemic Insurers and Telehealth

Insurer	Current Termination Date for Special Provisions	Continue Telehealth for all in-network providers?	Attestation Required Post-Pandemic?
Aetna	September 30	yes	no
Capital Blue Cross	September 30	yes	no
Cigna	July 31, 2020	yes	yes
Geisinger	July 31, 2020	Yes, but limited codes	no
Highmark	September 30	yes	no
Horizon BC/BS NJ	August 31	yes	no
IBC	December 31 (for products not managed by Magellan)	yes	Yes, for products managed by Magellan
Medicare (traditional)	Until emergency lifted by HHS Secretary	Substance abuse, ESRD, and stroke only	no
Magellan	until emergency lifted by HHS Secretary	yes	yes
Optum/United	July 24	yes	yes
Quest	until the emergency is lifted by the Governor,	yes	yes
Tricare/Humana	After HHS Secretary lifts emergency,	yes	Some plans
UPMC	Sept. 30		no

How Will Out of Jurisdiction Practice Change?

The conservative assumption is that, except in emergencies, psychologists should be licensed or otherwise authorized to practice in the state where the patient is physically located. This interpretation has created great difficulties for psychologists who have had to expand their telehealth services as patients move across the country.

During the pandemic many, but not all, states relaxed their out-of-jurisdiction practice requirements or greatly expedited the process to get temporary practice authorizations. However, these changes represent a patchwork of policies that provide little consistency. For example, Pennsylvania has allowed out of state licensees to practice in Pennsylvania without restriction during the PHE. They must inform the Department of State of their full name, address, telephone number and email address and their license type (e.g., nurse, psychologist, audiologist), number and jurisdiction that issued it. Previously, out of state licensed psychologists were restricted to practicing for 14 days in Pennsylvania without applying for a temporary license (49 PA Code §41.52). Psychologists can use the website from ASPPB (https://cdn.ymaws.com/www.asppb.net/resource/resmgr/covid19/6.22.2020_temporary_&_teleps.pdf) which keeps up to date on changes in these out of jurisdiction practice provisions. APA also gathers similar information as well (<https://www.apaservices.org/practice/clinic/covid-19-state-telehealth-policies>)

The passage of PSYPACT legislation in Pennsylvania will alleviate some of the problems for Pennsylvania psychologists. Starting on August 1, psychologists in Pennsylvania will be able to apply for a e-passport which will allow them to practice telepsychology services in the other states which have signed on to PSYPACT. These other states are Arizona, Colorado, Delaware, Georgia, Nebraska, New Hampshire, Illinois, Missouri, Nevada, Oklahoma, Texas, Utah, Virginia (starting in 1/1/2021), and North Carolina (starting 3/1/2021). Legislation has been introduced in 14 other states for them to enter PSYPACT.

Other Considerations

In Pennsylvania, psychology trainees may receive supervision through telehealth services and may provide telehealth services while under supervision (Pennsylvania Department of State, 2020).


For psychologists, continuing education requirements may be met entirely through distance learning for the renewal period ending in November 30, 2021 (Pennsylvania Department of State, March 22, 2020; Pennsylvania Department of State, March 26, 2020). Previously no more than 15 hours of distance learning continuing education could be used per renewal period.

Additional Resources

Both PPA and APA have developed suggestions for psychologists to consider before they return to face to face services. APA, in conjunction with state and territorial licensing boards has developed an informed consent template to use with patients before returning to face to face services (see <https://www.apaservices.org/practice/clinic/covid-19-informed-consent>) which also includes a checklist for informed consent.

Advocacy Continues

Amid this changing insurance atmosphere, APA, in conjunction with state psychological associations and other health care groups has been advocating for insurance benefits that are more responsive to patient needs. They (and we at PPA) have contacted insurers directly to ensure the continuation of patient-friendly telehealth services, including a continuation of reimbursement for telephone psychotherapy in Medicare and other plans, and urging payers or Congress to get self-funded plans to cover telehealth services on the same basis as other insurance policies.

When contacted by APA or PPA to respond to a legislative alert, it is essential that psychologists respond, respond quickly, and pass the alert on to other psychologists or other members of the public. 

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COVID-19 in the Intersection of INFECTIOUS DISEASES, LIFESTYLE FACTORS, and other SOCIAL DETERMINANTS of Health

SAMUEL KNAPP, ED.D., ABPP¹: *Director of Professional Affairs*

Six months ago, when I first started working on this article, my intent was to focus on the impact of lifestyle factors on health, the increase in *deaths of despair* within the United States, and the impact of other *social determinants of health*. I was then going to discuss the impact of these on the practices of psychologists. Deaths of despair are deaths from drug overdoses, suicides, cirrhosis, and other chronic liver diseases, which are often linked to depression and demoralization (Case & Deaton, 2015). Social determinants of health are the social conditions (the conditions under which a person lives, work, and ages, including one's social environment, education, or income level) that are downstream from the actual illness, but nonetheless substantially impact the likelihood of becoming sick and the consequences of that sickness. Expressed another way, an antibiotic may effectively treat an infection, but it cannot treat the malnutrition that caused a person's immune system to become more susceptible to such infections. Nor can an antibiotic fix the leaky roof, broken furnace, or compensate for a dangerous neighborhood that stresses the immune system. Galea et al. (2011) found that low education, racial segregation,



loneliness, poverty and income inequality contributed to as many deaths as physical or lifestyle factors, although they acknowledged methodological issues in reaching their approximation and that the relevant factors may interact in complex ways.

The intent of my original article was to focus on how the increase in deaths of despair, the failure to address long term

social determinants of health, and the failure to promote healthy lifestyles adequately have resulted in a recent decline in the life expectancy among Americans. But, given the COVID-19 pandemic, I have altered the article. Although the pandemic does not alter these long-term trends, it adds more urgency and another layer to the discussion.

On the surface, COVID-19 and other

1. The author thanks Drs. Julie Radico, Sean Healey and Richard Kutz for reviewing and commenting on this article.

infectious diseases appear unrelated to lifestyle factors or social determinants of health but a closer examination of the facts suggests otherwise. Black Americans have rates of COVID-19 infections that are almost two times those found in the nation in general. The increased susceptibility is likely due to many factors including a greater likelihood of being a front line worker (such as a grocery clerk or a delivery worker), lack of access to adequate health care, a higher rate of pre-existing medical complications, and a greater likelihood of living in densely populated areas where diseases spread more easily. The recent upturn in deaths from COVID-19 is superimposed upon long-standing health care trends within the United States that link social conditions to health outcomes. Although these social conditions contributed to an increase in mortality before the COVID-19 pandemic, the pandemic has magnified their influence.

The long-term impact of COVID-19 remains to be seen. It is possible that the development of accurate tests, effective treatments, or a vaccination will greatly diminish its impact on health and longevity, although that remains to be seen. We do not know what the “new normal” will be.

Nonetheless, even if scientists find a cure or vaccination for COVID-19, it is too early to declare the end of the era of deadly infections. Public health experts had been warning of a COVID-19-like pandemic stating that it was not a matter of “if” but a matter of “when” it would happen. COVID-19 was only the most recent of several coronaviruses that have entered human populations in the last 20 years (the others include SARS, H1N1, and MERS). The human population is still vulnerable to future highly contagious viruses. Other non-coronavirus infections such as Zika, Ebola, and HIV threaten the human population as well. In addition, antibiotics are losing their effectiveness against many infectious diseases. In 2018 almost 700,000 persons worldwide died from antibiotic resistant bacterial infections (Kramer, 2020).

For decades, infectious diseases were diminishing as a major cause of illness and mortality within the United States and prevention, lifestyle factors, and social

determinants of health had emerged as contributing more to health and longevity. On the surface, the COVID-19 pandemic deviates from this century-long pattern. However, it may not be wise to distinguish too sharply between infectious diseases, social determinants of health, and lifestyle because COVID-19 stands at the intersection of the three. Although it is an infectious disease, lifestyle changes can reduce the risk of infection and social factors influence the risks and outcomes of infections.

This article looks at social determinants of health, lifestyle factors, the increase in deaths of despair, and the impact of COVID-19 on the health of Americans and the practice of psychological care.

The Downward Trend in Life Expectancy within the United States

Even before the COVID-19 pandemic of 2020, life expectancy within the United States had been decreasing in recent years. Many factors determine life expectancy including genetics, access to health care, access to healthy food, freedom from violence, and healthy lifestyles including exercise, abstinence from tobacco, and moderate use of alcohol. Given the impact of COVID-19, it is possible that researchers may consider other lifestyle factors such as wearing a mask or practicing physical distancing.

Data from the Organization for Economic Cooperation and Development (OCED) reported that Americans had a life expectancy of 81.1 years (28th among industrialized nations). Japan had the highest average life expectancy (87.3), followed by South Korea, Switzerland, Norway, Sweden, and Denmark, although the rankings for these countries often vary slightly from year to year (OCED, 2019). The United States was slightly ahead of Mexico and Estonia in life expectancy. The life expectancy decreases substantially in less developed countries. It is 60 in Yemen, 55 in Burma, and 44 in Ethiopia.

Since 1980 the average life expectancy within the United States has been growing at a slower rate than in other countries with comparable economies in the OCED.² By 1998, the average life expectancy within the

United States was lower than the average life span of OCED countries. The increased mortality within the United States occurred across the lifespan and for all the major sources of mortality, except for cancer, where the United States has a higher survival rate. Although the United States has certain demographic groups or regions with especially high mortality rates, the difference in life expectancy occurs even for upper income Americans (Woolf et al., 2013).

In addition to falling behind comparable industrialized countries in terms of life expectancy, the average life span in the United States, unlike other industrialized countries, started to decline in 2014 and has declined in four of the last five years, even though the United States spends far more on its health care than any other country (Tikkanen & Abrams, 2020).³

The downward trend in life expectancy represents a reversal of the pattern of increased longevity within the United States which especially accelerated around 1900. Around 1900 the average life expectancy was 46 in the United States, although that number was depressed because of high infant mortality. If individuals survived childhood, they often lived into their 60s or even longer. Within the United States the life-expectancy increased to 63 in 1940, to 74 in 1980, and peaked at 78.9 in 2014 (Xu et al., 2020).

The Historic Role of Infectious Diseases within the United States

The increase in life expectancy that occurred within the United States throughout the 20th century was due primarily to major improvements in both the prevention of disease and the direct delivery of health care. In 1999, the Centers for Disease Control (CDC), identified the 10 great public health advances of the 20th century: vaccinations, motor vehicle safety, safer workplaces, control of infectious diseases, declines in deaths from coronary heart disease and stroke, safer and healthier foods and drinking water, healthier mothers and babies, family planning, fluoridation of drinking water, and recognition of tobacco as a health hazard (CDC, 1999).

2. The countries within the OCED include most European countries and Canada, Mexico, Chile, Japan, Korea, Australia, New Zealand, Israel, and Turkey.

3. The US spends almost 17% of its GDP on health care. Switzerland is second highest with 12.2% of its GDP. Australia and New Zealand spend slightly more than half as much on their health care as the United States.

The control of infectious diseases was perhaps the most salient public health advance of the modern era. For example, cholera was once a major killer. In the early 19th century, physicians did not understand the relationship between cholera and drinking water. Instead, they believed that cholera was caused by “bad air,” probably reflecting the smell of garbage or sewage associated with infected water. Water systems in the early 19th century sometimes allowed sewage and drinking water to mix, resulting in plagues of cholera. It was not until 1858 that the pioneer epidemiologist John Snow proved that cholera was a water born disease. At the turn of the last century (around 1900) infectious diseases (TB, influenza, measles, smallpox, etc.) were serious health concerns of Americans and especially dangerous for babies and small children.

The rise of vaccinations and other public health measures greatly reduced the risk of death from infectious diseases. Public health efforts then shifted toward increasing life expectancy by advocating for measures to address the social determinants of health and through changes in lifestyle. The social determinants included addressing the conditions that have led to the recent increase in deaths of despair. And the lifestyle changes include improved diet, increased exercise, reductions in smoking and the consumption of alcohol and other drugs, and better adherence to disease prevention behaviors.

Deaths of Despair Were Already Precipitating Declines in Life Expectancy

Even before the COVID-19 pandemic, the life expectancy within the United States was decreasing, primarily due to an increase in *deaths of despair* among adults aged 25 to 64 and especially among White male adults. Deaths of despair have continued to increase during the COVID-19 pandemic, perhaps fueled, in part, by the economic recession accompanying the pandemic. One estimate was that the United States had 150,000 deaths of despair in 2018, although the recession caused by the pandemic may increase that number by anywhere from 8% to 19% next year (Evans et al., 2020). In any event Kramer (2020) believes that deaths of despair are underreported by at least 28% or more.

The pernicious increases in deaths of despair started in the 1990s. During much of the 1990s and early 2000s, deaths from cancer, heart attacks, motor vehicle accidents, and AIDS decreased substantially, and more than compensated for the increase in deaths from other causes (Woolf & Schoomaker, 2019). However, by 2014, the increases in the deaths from despair overtook the decreases in other causes of mortality.

The decrease in life expectancy has been concentrated in certain areas of the United States such as northern New England (Maine, Vermont and Northern New Hampshire), the Ohio Valley (Ohio, Indiana, Kentucky), the Ozarks, central Appalachia (West Virginia and southeastern Virginia), and northern California. The life expectancy in Pennsylvania essentially remained stable since 2014. It decreased in the more economically distressed rural parts of the state and increased in the more prosperous central and eastern parts of the state (Knapp et al., 2019). It remains to be seen how much COVID-19 will alter this pattern. Although most of the deaths from COVID-19 have been concentrated in urbanized areas, it has started to permeate into rural America and the extent of the damage remains to be seen.

The decreases in life expectancy have been concentrated in counties with larger proportions of older adults, and Native Americans (Woolf & Shoomaker, 2019). Also, Knapp et al. (2019) found that the 20% of the counties in the United States that experienced economic insecurity (“the likelihood of a downward trajectory of income, material resources, and socioeconomic status,” p. 1) had higher rates of deaths of despair. Decreases in life expectancy were highest among adults of working age who are most likely to be impacted by economic downturns. Nonetheless, deaths of despair are also increasing in more affluent counties as well, albeit at a smaller rate. Although mortality is increasing greatly for adults with a high school diploma or less, it is increasing slightly for adults in the higher education brackets as well (Siddiqi et al., 2019). Economic insecurity may increase chronic stress, pessimism, and indirectly encourage unhealthy ways to cope with stress such as by smoking tobacco, using alcohol to excess, or misusing legal or illegal drugs (Woolf, 2019). Given these dynamics, one could expect a sharp increase in deaths of despair in 2020 and beyond.

Although deaths of despair have increased across racial and ethnic groups, the increase is higher among Whites. Nonetheless, all-cause mortality is still higher among Black and Native Americans. For many years, the gap in health disparities between White and non-White Americans was narrowing. That trend has reversed in the last decade, especially for young children of color. Although public health efforts need to address the increase in deaths among middle aged Whites, these efforts should not detract from efforts to address the continuing disparity in all-cause mortality across racial groups (Gennuso et al., 2019).

Social Determinants of Health

The link of deaths of despair to socioeconomic status (such as lack of a high school education and lack of meaningful job skills) is an example of a social determinant of health. Considerations of the social determinants of health, such as SES and culture, can help psychologists and other practitioners to better appreciate the circumstances that lead patients to adopt less than optimal coping strategies, the circumstances that reinforce those strategies or predispose them to more illness, and the barriers that keep patients from adopting healthier life styles.

The link between lower socioeconomic status and higher rates of illness and disability, and shorter life expectancies is called the *SES gradient* (Adler, 2009). It was documented empirically and famously in the “Whitehall Study” which found that the mortality rates gradually increased as the employment level of English civil servants decreased (Marmot et al., 1984).

The *social causation* theory holds that diminished social standing causes poorer health outcomes. Several strands of evidence support this theory. For example, Morozink et al. (2010) found that those with lower education levels (a crude marker of SES) had higher levels of interleukin-6, a marker of inflammation and a predictor of poor health. Perhaps, the lower SES means fewer material resources and less access to health care (persons with higher SES are more likely to have good health insurance or the resources to pay for necessary screenings and treatments). Perhaps the stress of fewer resources itself directly harms health. In addition, *early life adversity* (such as neglect

of a child, exposure to violence or traumas, food insecurity, etc.) may be linked to poor health later in life through the development of an immune system that is less effective in fighting off infections (Elwenspoek et al., 2017).

Also, unhealthy behaviors such as the use of alcohol, cigarettes, lack of exercise, or poor diets are more common among persons with lower SES, accounting for some of the disparity in the life expectancy and overall health between socioeconomic groups (Stringhini et al., 2010). Perhaps the high stress of living in poverty increases the prevalence of unhealthy behaviors (Adler, 2009). Also, the circumstances of poverty itself may influence life-style behaviors. For example, those who live in an unsafe neighborhood would be less likely to go outside for walks or other physical recreation. Also fruits and vegetables are more expensive than low-cost processed foods, so that persons with lower incomes end up paying a substantially higher percentage of their income for fruits and vegetables than persons with higher incomes.

Education levels predict better health outcomes, although education level is a gross metric and it is not clear which elements of education cause the better health outcomes. Perhaps it is simply the fact that persons with more education are able to get better jobs and have a higher income and therefore have better access to health care or live in safer communities. Perhaps the higher education simply increases their knowledge of healthy behaviors or increases their social capital by putting them in touch with those who are better able to facilitate their careers or that they are more likely to have a social network that endorses healthy lifestyles.

Likely many factors combine to explain the SES gradient and they may interact in complex ways. Furthermore, within the United States, the SES gradient is influenced by racial and ethnic factors.

Racism has a negative effect on both mental and physical health independent of birthplace or education (Paradies et al., 2015). Also, many Black Americans receive unequal health care treatment even if they have the same health care access as White Americans. In part this may be due to implicit biases which affect health care professionals at about the same rate as the population in general (FitzGerald & Hurst, 2019). In addition, Black Americans are less

likely to trust their health care professionals, a cultural legacy of an era when Black Americans were intentionally given second rate care or used as testing subjects for treatments before they were used with White patients.

Furthermore, according to the *Hispanic paradox*, Latinx in the United States have lower mortality and better health than their non-Hispanic counterparts even though their average incomes and education levels are lower. A common explanation is that healthier persons would be more willing to make the difficult transition from Mexico or other Latin-American countries to the United States while their less healthy counterparts would be less able to attempt the transition. It is also possible that the strong social relationships (*familismo*) within the Latinx community help to buffer the ill effects of diminished SES, or that lower income persons learn to survive and thrive in their circumstances by adopting a shift and persist orientation (shifting means accepting uncontrollable circumstances and persisting means taking advantage of opportunities when they do arise). Perhaps all of these factors contribute something to the Hispanic paradox.

In summary, the relationship between SES and health is complex. Efforts to improve the health among those living in the lower rungs of the SES ladder will likely require a multifaceted approach addressing educational opportunities, interventions targeting racial disparities, changes in health-related behaviors, access to health care, and other interventions.

Lifestyle Factors Influencing Life Expectancy

In addition, the decrease in life expectancy is influenced by lifestyle behaviors such as smoking, failing to exercise sufficiently, not eating enough fruits or vegetables, having a body mass index outside of healthy ranges, abusing alcohol or other drugs, being over exposed to ultraviolet sun rays, and the failure to get preventive care (including preventive dental care). For example, skin cancer is a rapidly growing form of cancer in the United States, which is linked to over exposure to ultraviolet rays from sunbathing at the beach or at tanning salons, and the failure to use sunscreen. Tobacco is still the most preventable cause of lung cancer in the United States. Also, excess weight

is associated with an increased risk of hypertension and heart attacks, diabetes, and cancer. Death from cirrhosis of the liver is linked to drinking in excess, and so on. It is too soon to tell how much physical distancing and wearing masks will become closely linked to mortality.

However, healthy lifestyles are not distributed equally across the population but vary according to SES and education levels. As described above in the section on the SES gradient, part of the healthier lifestyles may be due to higher levels of education (Li et al., 2018).

While looking at just five low risk factors (not smoking, moderate alcohol use, healthy weight, healthy diet, and adequate exercise) in longitudinal studies, Li et al. (2018) found that women at the age of 50 who had all 5 low risk factors lived an average of 43 more years (37 years for men). However, women at the age of 50 who had none of the low risk factors lived an average of only 29 more years (26 years for men). In other words, women who had all 5 low risk factors lived an average of 14 years longer than women who had none of the low risk factors. Men who had all 5 low risk factors lived an average of 12 years longer than men who had none of the low risk factors.

In a follow-up study, Li et al. (2020) looked at the number of years that an individual was free from chronic diseases. Women at the age of 50 who had all 5 low risk factors lived free from diabetes, cardiovascular diseases, and cancer an average of 34 years more (31 more years for men). However, women at the age of 50 who had none of the low risk factors only lived free from diabetes, cardiovascular disease, and cancer an average of 23 more years (24 more years for men). In other words, women who had all 5 low risk factors lived free from these chronic diseases an average of 11 years longer than women who had none of the low risk factors. Men who had all 5 low risk factors lived free from these chronic diseases an average of 7 years longer than men who had none of the low risk factors. Depending on the course of the COVID-19 pandemic, future researchers may also be looking at physical distancing and mask wearing as another lifestyle factor that influences life expectancy.

In summary, health behaviors, physical and social environment, and socioeconomic status, as well as the quality of health care

received all influence life expectancy (Woolf, 2019). It is hard to separate the impact of these interactive factors. Good health care cannot address alone the upstream causes of poor health. "Health is more than health care" (Woolf, 2019, p. 1). Health care professionals can only do so much with patients who have experienced a lifetime of malnutrition, lack of exercise, smoking, and so on. Nonetheless, awareness of these social determinants can help psychotherapists tailor treatments to be more effective (see accompanying article).

Treatment Implications

Considerations of the social determinants of health, such as SES and culture, can help psychologists and other practitioners to better appreciate the circumstances that led patients to adopt less than optimal coping strategies, the circumstances that reinforce those strategies or predispose them to more illness, and the barriers that keep patients from adopting healthier life styles.

Although the root causes may be far upstream from the treatment room, psychologists can consider several factors when addressing patients downstream. First, they can appreciate the role of stress in the lives of their patients. Poverty is bad for one's health and it takes a lot of energy just to secure the necessities of living. The impact of poverty, especially if it is combined with stressful experiences, can be especially problematic for young children. Chronic high levels of stress and traumas may depress children's intellectual functioning, ability to regulate their emotions, and contribute to a weakened immune system (Sleek, 2015). Consider a patient who is spending money on cigarettes instead of needed medications. Instead of viewing this as an example of personal weakness, it may be more productive to consider that this patient may have been exposed to greater stress in early life and is using one of the few available ways to reduce that stress, or that this patient has grown up in a culture where smoking is normative or expected. According to Dr. Richard Kutz, "We see our own cultural attitudes and assume them to be normal and fail to recognize that poverty has its own culture which may include behaviors contrary to adaptive health. Effective psychologists understand how hard it is to behave contrary to one's own culture"

(personal communication, June 23, 2020).

Psychologists can consider the impact of unemployment in demoralizing and depressing patients, especially men who have grown up with the notion that full employment is an essential part of "manhood." Economic downturns often result in demoralization and pessimism or internalized shame and self-stigma. It may be clinically indicated to these address issues in treatment and addressing the lack of self-efficacy may reduce a sense of entrapment (Rehder et al., 2019). Although psychologists should always be vigilant for suicidal thoughts and behaviors among their patients, this vigilance should increase. Suicide rates follow economic downturns. COVID-19 shelter in place restrictions combined with job loss may lead to increases in the loneliness, hopelessness, and sense of entrapment that are commonly found among suicidal patients.

Furthermore, if possible, psychologists can strengthen the patient's access to resources by promoting family unity and social connectedness when delivering health care. Across the SES ladder, those with strong social networks tend to have better health. This may be due to the availability of greater resources during a time of need or of the access to emotional support. At times it may be indicated to involve or strengthen the patient's relationships with important social networks such as one's family or church group.

Also, psychologists can take special efforts to be sensitive to racial issues and implicit bias in delivering health care. None of us are immune from implicit biases, but we can monitor ourselves and become closer to living out our values in our professional interactions. Implicit bias may also include class bias. Social class is often underappreciated as a variable in psychotherapy, although it does influence the patient's experiences, including the likelihood of adverse childhood experiences, levels of stress, access to resources, and expectations from others (Thompson et al., 2019). According to a review by Oh et al. (2018), childhood adversity is related to asthma, delays in cognitive development, infections, somatic complaints, and sleep disruption as well as alterations in an individual's immune system, inflammatory responses, and acceleration of telomere erosion.

In addition, psychologists can advocate

for social policies that help mitigate the stress of persons with diminished financial resources. Even modest improvements in access to resources, such as easier access to food stamps or increases in minimum wage can substantially improve the quality of the lives and health of persons at the lower ends of the SES gradient.

Psychologists can also advocate for a more integrated and holistic biopsychosocial model of health care delivery. The movement toward integrated care has facilitated a greater appreciation of psychological factors in health care, although the funding of health care still rests on a medical model (Wade & Halligan, 2017). Consider for example, how psychologists can sometimes spend hours coordinating mental health services with medical providers for patients and receive not a penny of reimbursement for doing so, although insurance companies could allow psychologists to bill evaluation and management codes and encourage such urgently needed coordination of patient care.

Finally, psychologists should consider offering life-style interventions to their patients when appropriate. Typically, lifestyle interventions focused on factors that had a major impact only on an individual's personal life and the consequences for others were more downstream. Those patients who failed to control their diabetes because of the lack of exercise or the failure to eat enough vegetables were primarily hurting themselves, although family members may be impacted years in the future. In those situations, psychologists may respectfully ask permission to discuss the health issues even if they were not directly linked to the patient's presenting problem. Of course, patients can always decline the invitation and ordinarily psychologists would respect the decision of the patients.

However, other problem behaviors, such as drinking to excess, smoking tobacco products, or failing to observe physical distancing can create more immediate problems for others. In these situations, I think that psychologists should, if they perceive a chance of success, offer to address these health care issue with their patients. This is a complex issue that requires balancing ethical principles carefully. Nonetheless, if clinically indicated, psychologists could assess their

patients' willingness to change according to the Prochaska's and DiClemente's transtheoretical stages of change model (see review by Tucker & Grimley, 2011). For example, a patient who refuses to use physical distancing may be more than just a "conspiracy nut," and may have low health literacy skills or live in a social environment where unusual theories on health care are circulated and believed. Psychoeducation, motivational interviewing, or Socratic questioning may help some of these patients, if they are amenable, to reconsider their positions and adopt habits that protect themselves and others. 📌

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SCHOOL PSYCHOLOGY THROUGH TECHNOLOGY:

Reimagining the Role of School Psychologists After COVID-19*

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The COVID-19 pandemic rapidly transformed the K-12 education system overnight as schools at best quickly adapted to online learning platforms, and at worst did not have the necessary resources and technology for an immediate transition, leaving students in limbo before classes and services resumed. The return to school in the fall, whether online or in-person, holds uncertainty, coupled with the mental health implications of the pandemic on students. School psychologists with their unique roles in schools as supports to students' social, emotional, behavioral, and academic needs, are well-suited to contribute to multiple aspects of the transition back to school in the fall. During this process, by reimagining K-12 schools with technology, school psychologists have an opportunity to improve services and supports for students.

Schooling at Home

One of the potential ways that children may be "attending" school this fall is from home, either because their parents/guardians have officially registered them for homeschooling out of pandemic-related concerns (e.g., health concerns of attending schools in person; concerns over academic learning over virtual platforms) or because the schools they are enrolled in will continue to provide classes and services via online instruction.

In either scenario, a main concern for school psychologists navigating the provision of services for students at home is outreach with students and families, but this also provides a unique opportunity to spread a wider net for connection, such as partnering with online parenting groups to share tips or creating brief videos addressing social-emotional concerns for students to access on platforms such as YouTube. School psychologists can also host online groups that foster social connections among students, as students who are home may be missing out on this aspect of their typical school environment and could benefit from intentional spaces for building and maintaining these relationships.

Counseling and behavior support will also be an area where school psychologists can play a major role. Consultation with parents or guardians will be critical in this effort, especially for younger children and some youth with disabilities who may need assistance. When working with some children with disabilities, telehealth platforms may provide added benefits, such as the ability for closed captioning for Deaf or hard of hearing students or the option of using chat features for children with speech impairments.

Return to In-Person Schooling

The other option for students is a return to in-person school. Although there

One of the potential ways that children may be "attending" school this fall is from home, either because their parents/guardians have officially registered them for homeschooling out of pandemic-related concerns (e.g., health concerns of attending schools in person; concerns over academic learning over virtual platforms or because the schools they are enrolled in will continue to provide classes and services via online instruction

is not a clear consensus for how in-person schooling will look in the fall, what is apparent is that the roles and responsibilities of school psychologists to students and their families are more important than ever. As they press on with assessments and consultations, it is important to look for opportunities to continue to support students, no matter how unconventional they are. This could mean meeting virtually/remotely or meeting in-person, while following social distance protocols. Whatever the medium, the priority should be the well-being of



students and their families, making sure their most basic needs are met.

Similar to homeschooling, school psychologists can rely on technology as a means of safely connecting with students and sharing important information and resources with their parents/guardians. This could be utilizing Zoom or Google Classroom to observe and communicate with students and their families. Zoom, and other similar platforms, can be used for counseling sessions with students and feedback sessions with families. Google Hangouts can be used to connect with teachers and other school staff. Additionally, school psychologists can use educational YouTube and/or resource videos to model to parents/guardians how interventions are meant to be implemented.

In connecting with students and their families through alternative means, school psychologists can continue to be present with them, while serving as an extension of the school and a resource to parents and guardians. Moreover, these alternative means of connecting allow for more openness and flexibility to the needs of students and their families.

Social & Emotional Behavior

School psychologists can continue to support students and their families by being available to talk and listen and creating a safe space where they can discuss and contextualize what is being portrayed in the media. It is recommended to be present and be in the moment, while

also remaining calm and reassuring the student and/or parent/guardian. These safe spaces can be done virtually/remotely over Zoom or Google Hangouts. Additionally, these ongoing conversations can further be supported by recommending educational and supplemental resources that are available online and can be easily accessible across various devices.


Adapting

The normal we once knew, no longer exists. As we all move towards a reimagined education system, school psychologists, along with educators and other school mental health professionals, will need to adapt to a new order. This means embracing new ways of conducting assessments and accepting technology as an extension of oneself and one's role.

The Educare Psychologist: Reimagining Education and Psychology's Role

Along with adapting, there is an enormous need to reimagine education and psychology's contributions and this pandemic may be the catalyst for that. 120 years ago, children were in classrooms much like classrooms today, i.e., desks, 'blackboards', material posted on walls, teacher up front talking, etc. In the intervening 120 years we have invented flight, phones, computers, digitized knowledge for instant access, extended human life, been to the moon, more. But classrooms/schools have changed little.

The little red schoolhouse became the big brown school building. Perhaps the reliance during this pandemic on teleteaching, learning wherever you are, will flourish and bring education into the digital century. Artificial intelligence (AI), virtual reality (VR), etc. will aid this evolution. School psychologists will need to create new roles in this world of portable pedagogy. They will work within the digitized domains of children's lives needing to find new ways of assessing and helping children's social-emotional/cognitive needs. School buildings may slowly slide into history as online education begins to achieve ascendancy. School psychologists' role will increasingly be that of bringing sound psychology to bear upon kids' psychological lives in this expanding digital educational environment and that role may slowly be separated from the physical school building as it recedes.

In light of the foregoing, the third author has proposed a new designation for school psychologists that divorces them from a close identity with school buildings but gives them significant responsibility in the psychological care of children for EVERY educational environment—"Educare Psychologist"! 

*This is an abbreviated and revised version of a talk presented at the Fielding Graduate University Media Psychology Symposium, July 16-17, 2020, Santa Barbara, CA, United States.





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 2019-2021 biennium regulations for the Pennsylvania State Board of Psychology permit psychologists to earn all of their 30 credits for renewal through home study or distant learning continuing education due to the COVID-19 pandemic. 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.

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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 August 31, 2022.

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.

COVID-19 in the Intersection of Infectious Diseases, Lifestyle Factors, and Other Social Determinants of Health

1. All the following are examples of deaths of despair EXCEPT

- a. Drug overdoses
- b. Suicide
- c. Accidents at work
- d. Cirrhosis of the liver

2. Social determinants of health could include

- a. Racial segregation
- b. Poverty
- c. Loneliness
- d. All the above

3. Black Americans are more likely to get infected with or die from COVID-19 because they

- a. Have a genetic mutation that makes them more susceptible to infection
- b. Are more likely to be front line workers, such as delivery persons or grocery store clerks who have greater exposure to the virus
- c. Are more likely to seek out medical attention for illnesses
- d. All the above

4. In 2019, almost 700,000 persons world-wide died from antibiotic resistant bacterial infections

TRUE
FALSE

5. Since 1980, the longevity of Americans has been increasing at a rate that is _____ than the increase in longevity found in most countries in the OCED

- a. Faster
- b. Slower
- c. The same as

6. Deaths of despair are more likely to occur in cities in the United States that have

- a. A high percentage of young adults
- b. A high percentage of Latinx Americans
- c. Experienced recent economic downturns
- d. All the above

7. The reason(s) given that more education is linked to better health outcomes is (are) that education

- a. Increases information about the benefits of healthy behavior
- b. Leads to better jobs and more disposable income to spend on health care, food, or other commodities that improve health
- c. Increases social capital, or puts people in contact with others who facilitate their careers
- d. All the above

8. The gap in health between White and Non-White Americans was narrowing until recently, but now it is increasing.

TRUE
FALSE

9. Displaying resignation when faced with obstacles that cannot be changed, yet taking advantage of opportunities when they arise is a description of the _____ strategy.

- a. Broad and Build
- b. Shift and persist
- c. SES gradient
- d. Social determinant

10. The link between socioeconomic status and health has been called the

- a. SES gradient
- b. Hispanic paradox
- c. Shift and persist model
- d. Early adversity syndrome

11. The social class of patients may influence their

- a. Life experiences
- b. Expectations from others
- c. Access to resources
- d. All the above

12. Li et al. (2019) found that women at the age of 50 who displayed all five healthy lifestyle behaviors lived for an average of _____ more years, but women at the age of 50 who displayed none of these lifestyle behaviors lived for an average of _____ more years.

- a. 43, 29
- b. 29, 43
- c. 19, 19
- d. 19, 23



CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, July/August 2020

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

1. a b c d

2. a b c d

3. a b c d

4. T F

5. a b c

6. a b c d

7. a b c d

8. T F

9. a b c d

10. a b c d

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 _____

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Calendar

MONDAY, AUGUST 3, 2020

Meaning-Making in Clinical Practice: Moral Injury, Burnout, and Self-Care: Part 1
12:00 – 1:00 PM
PPA Webinar

TUESDAY, AUGUST 4, 2020

PPF Virtual Student Education Awards Ceremony
7:00 – 8:30 PM
PPF Webinar

MONDAY, AUGUST 10, 2020

Meaning-Making in Clinical Practice: Moral Injury, Burnout, and Self-Care: Part 2
12:00 – 1:00 PM
PPA Webinar

WEDNESDAY, AUGUST 19, 2020

Religion (Spirituality), Ethics, and Psychotherapy
12:00 – 1:00 PM
PPA Webinar

Still have questions about telpsyhology? Check out PPA's available webinars:

Introduction to Telepsychology: Part 1

Introduction to Telepsychology: Part 2

Introduction to Telepsychology: Part 3

Telepsychology Q&A

Home Study CE Courses

Act 74 CE Programs

The Essentials of Screening and Assessing for Suicide among Older Adults—1 CE

Assessment, Management, and Treatment of Suicidal Patients (Extended)—3 CEs

The Essentials of Treating Suicidal Patients: 2020—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Telepsychology Q&A (Webinar)—1 CE

Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each

*Introduction to Ethical Decision Making**—3 CEs

*Ethics and Self-Reflection**—3 CEs

*The New Confidentiality 2018**—3 CEs

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

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

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