Update on Duty to Report Child Abuse

Floyd L. Jennings, Ph.D., ABPP

Supervision Rules
Paul Andrews, Ph.D.
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Texas Psychological Association
A Note from the Editor

What will the future bring to the profession of Psychology?

Brian H. Stagner, Ph.D.
Editor

It seems absurd to pose such a question, but it is even more fatuous to show up for work tomorrow without trying to answer it. If we ask seismologists to predict earthquakes, they’ll sidestep any specific predictions while assuring us (correctly, on the basis of their best data), that deep but inexorable forces are moving things around underfoot and we ought not be surprised if the floor suddenly tilts or the ground opens up where we expected to find things familiar and unchanging.

Usually the Texas Psychologist tries to remind and prepare our members about things that are coming soon---known things that are in the pipeline and have a more or less predictable schedule. Think of the roll-out for DSM-5; It got delayed a couple of times and there was some controversy about how particular debates would be resolved in the final product, but we pretty well knew what was coming and the articles in this and other outlets served as movie trailers. This issue is somewhat different. We have a couple of articles that are included to raise awareness about things moving deeply and inexorably underfoot but neither the changes nor their timetables can be clearly seen from where we are standing.

One issue where change is unavoidable is that the Texas State Board of Examiners of Psychologists (TSBEP) will be formulating some very important changes to the rules governing supervision. The present supervision rules have been largely unchanged since the mid 1990s. At the time the prior rules were relaxed in the spirit of acknowledging that the psychologist/supervisor should be accountable for determining the nature and scope of supervision activities. Some of the dinosaurs among us, uh like your editor, felt that simply relaxed standards left psychologists without guidance about how to proceed. Be that as it may, the present rules are antiquated. First, in the past two decades the profession has moved from theoretical and metaphorical discussions about supervision to a substantial accumulation of empirically informed understanding about what supervisory activities are effective; ethical, desirable, or minimally adequate. The present rules predate this new empirical base.

The present rules also largely predate the dramatic changes in the way behavioral health services are delivered and reimbursed. Both trainers and practitioners who supervise have been bootstrapping a standard of care that has been a patchwork response to regulatory and contracting changes----recall the confusion about billing for extenders a few years ago.

The latter led to the recent passage of HB 808 which now makes it lawful for psychologists to bill for extenders. All these developments highlight the need to refine and specify the rules that govern supervision in training settings and in the practice world. We don’t know what shape these rules will take, exactly but the article by Dr. Paul Andrews will update you on the sorts of things that the TSBEP may consider.

Another area where change seems inevitable but amorphous is the upheavals that will reverberate from the current effort at healthcare. Mostly we focus on the near term, preparing to meet new regulatory deadlines or update to new procedure or diagnostic coding. The article by Dr. Lubna Somjee, Dr. Jon Marrelli, Dr. Megan Eliot, and Dr. Jennifer Doran takes a longer view, outlining a shift in thinking that informs the long term goals.

The authors represent a sister organization, the New York State Psychological Association and Drs. Marrelli and Somjee are co-chairs of APA’s Division 31 Health Care Reform Task Force. Their article explicates the public health construct of population management. This concept will be a pivot point for policymakers, insurance companies, and, ultimately, for providers in the coming years. This is a new perspective for most of us and it will require us to rethink our professional identities. However, it will evolve gradually, not precipitously, which will give psychologists and their associations time to anticipate, and one hopes, to advocate and shape the emerging roles for psychologists in this new world.
This issue differs somewhat from the usual fare for the Texas Psychologist in that we have a piece that was previously circulated and was written by a non-member. It is included here for two reasons. First, it is a cogent presentation of a theoretical perspective that will cut across most of the venues where professional psychology will be practiced in the next decade. The second reason for its inclusion here is that another article that had been slated for this spot was going to be late due to a personal emergency by the author. Our bank of articles in queue was depleted.

How do articles get selected for the Texas Psychologist? They come two ways: Many are solicited by personal appeals to authors who, it is felt, will have something useful and educational for our membership. Other articles are volunteered by members. I am grateful for all these authors for pitching in. In her President’s Letter, Dr. Marcy Laviage has some embarrassingly nice things to say about your editor. (I’m blushing, but not too shy to call attention to her remarks.) She then concludes with a call for submissions from the members. I concur, with enthusiasm.

This is the cue for me to discuss the informal policies that have guided the Texas Psychologist for the past several years. We publish quarterly and TPA has been able to sustain the costs of publication through the very capable pursuit of advertising by TPA staff. The content for every issue drops into two broad categories:

**Advocacy:**
Articles that update the members on the advocacy efforts of TPA and its representatives who promote the interests of professional psychology with judges, legislators, public policymakers, and private sector decision makers.

**Innovations:**
Articles that update the members on new developments that will be of general interest. These may include:

- Discussion of research-based innovations in assessment or intervention
- Emerging business opportunities which have proven marketability
- Explication of ethical or legal concerns for practitioners (see the thorough review about child abuse reporting by Dr. Floyd Jennings in this issue)

While there are no set-in-stone restrictions as to authorship, our intention has been to limit authors to

1. TPA members
2. Scholars from Texas institutions
3. Persons who are not campaigning for APA president or other offices

Reading between the lines you might conclude that we look for articles that are written by Texas folks who are trying to educate their colleagues to promote both good scholarship and Texas psychology. We’ve generally tried to avoid reprinting stuff you can find elsewhere, e.g. at APA or APAPO and to pass on material that is low on substance and big on self promotion. All that said, if you think you might have something appropriate, I’d love to see it, or at least a short prospectus of what you might like to contribute.

---

**TPA 2014 Annual Convention**

**Location:**
The Westin Galleria
Dallas, Texas

**When:**
November 13 - 15

Visit TPA’s website at www.texaspsych.org periodically for updates about the annual convention.

Beginning October 1st 2014, PD requirements go up to 20 hrs. instead of 12 hrs. Of the 20 hrs. of Professional Development, at least half (10 hrs.) are required to come from endorsed providers such as TPA. (See page 6 at the end of the APA Council Meeting article for more information about the rule changes or just visit http://www.tsbep.state.tx.us/.)

TPA’s Annual Convention offers a multitude of Professional Development opportunities!
A Message from the

President

What does the psychology profession mean to you?

Marcy Laviage, Ph.D.
President

Since I last wrote an article for the January edition of the Texas Psychologist, it is amazing how much has happened! It truly feels like only a couple of weeks ago when Dr. Brian Stagner reminded me that my last article was due when I received his latest reminder that it is that time again.

Having said that, I realize I cannot go any further without talking a bit more about Dr. Stagner. Most of you know that he is a Past President of TPA and currently serves as Director of Professional Affairs providing consultation on business and ethics to TPA members when called upon. In addition, it would fill up pages to describe what he has done for you on the legislative front which is why he so deservedly was the recipient of the Robert H. McPherson Legislative Action Award following the 2011 legislative session. I could go on and on about his enormous amount of other contributions to psychology in Texas (did I mention he served on the state licensing board?), but the focus of this big shout out is to show what he has done for you on the legislative front which is why he so deservedly was the recipient of the Robert H. McPherson Legislative Action Award following the 2011 legislative session. I could go on and on about his enormous amount of other contributions to psychology in Texas (did I mention he served on the state licensing board?), but the focus of this big shout out is to show my tremendous appreciation for the quiet, under-appreciated role he has as editor of the Texas Psychologist. Imagine how difficult it is to find psychologists willing to write an article about an interesting topic and/or research – wait! This should not be so difficult!

There are over a thousand of you out there who receive this publication. There are over a thousand of you who are brilliant and engaged in interesting work. My goal is that for the next edition of the Texas Psychologist, instead of Dr. Stagner hunting down authors for interesting articles, he has to have a waitlist because you want to share your hard work with others. We are psychologists. We are communicators. Let’s communicate what we are doing out there across Texas – your innovations in research, treatment, and/or training – with one another. So, please contact Dr. Stagner at stagneraap@gmail.com if you would like to volunteer to send an article.

Ok, now that is out of the way. Let’s get back to the fact that there have been some exciting things happening in such a short time. First, the newly installed 2014 TPA Board of Trustees held its first board meeting in January. If you want to know how incredibly amazing your board members are, I want you to look back at the news headline on the day of January 24th. You will see that much of Central Texas was literally shut down due to ice and snow. Houston, Austin, San Antonio and the rest of the region had closed schools and businesses. Where were your board members? Every single one of them was on the road to Austin for the early meeting the following morning. The commitment shown by each and every one of them did not go unnoticed by me nor do I want it to go unnoticed by you. During that meeting, we discussed the exciting ideas for our Membership Chair, Dr. Sydney Kroll Register, to implement; we heard from Justine Grosso, TPA’s Student Division Representative from Baylor University. She revealed innovative ideas to energize our Student Division. We reviewed committee updates including the strong state of TPA’s finances, the solidarity of our 2015 legislative agenda, the ideas for this year’s annual convention in Dallas (is it on your calendar yet?), and how to increase the presence of our Diversity Division. It was a productive meeting that left me energized and exhausted at the same time! Our next board meeting will be held in Houston in April 12th.

The second big event to occur thus far this year occurred the weekend of February 8-9th; Ten Local Area Society Presidents from around the state attended a TPA/LAS Presidents Retreat in Austin.

The following individuals participated:

Dr. Kay Allensworth
Capital Area Psychological Association

Dr. Smitha Bhat
Collin County Psychological Association

Dr. Stacey Bourland
Houston Psychological Association

Dr. Gail Brothers-Braun
Fort Worth Psychological Association
These individuals, along with the incredible team who put the event together of Dr. Sydney Kroll Register, Dr. Ron Garber, Dr. Lane Ogden and your Executive Committee of Dr. James Bray, Dr. Steven Schneider, myself, and your Executive Director, David White, all met to discuss how psychologists across the state can work together to promote one another and our profession, and more importantly, how TPA and Local Area societies can work together to make this happen. Within the first hour of the retreat it was evident that the collegiality among the group was more than anyone expected and the ease with which ideas could be exchanged and evaluated made for a successful process. It was a diverse group related to age, gender, ethnicity, religion, political viewpoints, geography, work settings, experience with TPA, and likely many other factors; however, the group unified over the common goal of protecting psychologists in Texas.

One thing I heard loud and clear is that no matter how many ways or how many times TPA tries to disseminate information about our legislative efforts, nothing beats the old-fashioned face-to-face way of delivery.

Therefore, TPA has committed to making a stop at every LAS (by invitation only of course!) during one of your meetings to keep you updated on legislative action as well as other TPA happenings that may be of interest to you and to answer any questions and/or concerns you may have. We have two meetings set up thus far. Please contact me at marcylaviage@gmail.com if you would like TPA to come to you!

Thank you again to these incredible LAS Presidents for taking a weekend to devote to furthering our careers and thank each and every one of you for continuing to support TPA. January and February were big months for TPA – I look forward to what the rest of the year brings!

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**Did you Know...**

You can purchase a small paperback copy of the *TSBEP Acts and Rules* book for just $19.95+tax from the Texas Psychological Association?

1.) Go to www.texaspsyc.org.
2.) Under the Professional Resources drop down menu, click on publications.
3.) Select the *TSBEP Acts and Rules* book and follow the payment instructions.

You will receive your book by USPS within 5 - 7 business days.
The 2014 Winter Meeting of the APA Council of Representatives in Washington D.C. was greeted with a welcome interlude of sunshine and warmth for those in attendance. I was especially appreciative of the ease of travel and of the fact it was warmer when I arrived there, than when I left San Antonio. The downside was the flu symptoms that began to surface as soon as I returned and continue to linger as I struggle to meet a graciously extended print deadline.

The Council Agenda continued to include a continuation of the, so far, over three-years-long Good Governance organizational reform process. I will discuss the recent decisions in this report, but I want to note that some decisions planned for the August Meeting will require APA by-laws changes that need to be approved by the APA membership.

Two of the other agenda items related to the definition of an Early Career Psychologist and to APAs continuing efforts to facilitate and encourage ECP involvement in APA governance. The number of years past receipt of the doctoral degree is proposed was extended to ten for ECP classification. Also, each APA Board and Committee will designate an existing seat or slate for an ECP every three years unless exempted by specific criteria for membership by Association Rule, e.g., Commission on Accreditation, Committee on Structure and Function (which is to be phased out), Finance Committee, Teachers of Psychology in Secondary School, Psychology Teachers at Community Colleges, and the Publications and Communications Board. This will insure ECP involvement, and in some cases, involvement by individuals who have never served in APA governance.

Of important note, especially to smaller state, provincial, and territorial associations, Council approved funding for APA representatives from these groups for travel and housing during the Council Meeting portion occurring during the APA Annual Convention. The goal is parity of support for all APA representatives and to promote equal inclusion of representatives from groups with limited resources. Another item with fiscal implications was the approval to extend funding for continuing implementation of Good Governance initiatives.

A highly debated petition for the establishment of a new Division, the Society for Technology and Psychology, did not receive the necessary support for approval by Council. Opposition to the new division was led by the existing Society for Media Psychology and Technology (Division 46), citing overlap of function.

Items on the Consent Agenda that were approved as a group without discussion by Council (any Council member has the prerogative of moving a consent agenda item to the regular agenda for discussion) included explicit clarification of APA as a data driven organization engaged in evidence based decision making to be included in the APA Strategic Plan, approving revisions to the process for recognizing proficiencies and specialties within psychology, received the report Assessing and Evaluating Teacher Preparation Programs; approving competencies for students in clinical, counseling, school and combined doctoral programs engaged in the preparation of professional psychologists for the provision of health care services in independent, group and institutional practices; endorsed Multidisciplinary Competences in the Care of Older Adults at the Completion of the Entry-level Health Professional Degree (facilitating APA efforts to collaborate with other professional organizations on age related issues); and receiving the Task Force Report on Trafficking of Women and Girls.

Of interest to students and to graduate training programs was the approval of funding to support the development of a centralized application program for graduate education in psychology. APA also is continuing its efforts to address the internship placement issue and in preparing psychology for adoption of the ICD-10. Additionally, Council approved a three year reauthorization of funding for the Center for the History of Psychology at the University of Akron.

The Council also reviewed a proposed resolution on the interrogation of criminal suspects which addresses issues related to false confessions and wrongful convictions. This item is expected to return to Council for action in August. Another resolution addressing aid in dying attempts to clarify the psychologist’s role, including assessing the patient’s decisional capacity, in health teams in states with laws that regulate physician assisted aid in dying. Important implications for general end of life care exist. The final form of this resolution is expected to return to council in August. In an important move with significant implications for both the restructuring of APA and of the APAPA, Council approved in principle sun-setting the c3 responsibilities of the Committee for the Advancement of
Professional Practice rendering it a c6 only entity which will move totally within the APAPO, the organization that focuses on the professional needs and interest of practitioners. The relevant amendments to APA Association Rules and APAPO Bylaws will return to Council for action in August as well. Action on APA restructuring included a three year trial delegation of certain areas of fiduciary responsibility to the APA Board of Directors.

These areas include:
- financial/budget matters:
- hiring, evaluation and support for the Chief Executive Office,
- assuring alignment of the APA budget with the APA strategic Plan
- internally focused policy development.

Also, Council approved requesting that relevant Bylaws and Association Rule changes which reconfigure the APA Board of Directors and establishes a new Needs Assessment, Slating and Campaigns Committee (NASCC) for identifying governance candidates. Changes to the Board of Directors will include:
- a new public member appointed by the Board
- six members at large elected by and from the general membership
- and the Chair and Chair-Elect of the new Council Leadership Team (the new executive committee of Council).

Regarding the new composition of Council, two models were offered by the Good Governance Implementation Work Group, upon which no agreement was reached and the IWG was directed to return in August with recommendations based on input from lengthy Council discussion. Basic elements of the models to be incorporated include one vote for each Division and for each state, provincial and territorial association. The apportionment process will end. Additionally, possible inclusion of voting representation of the seven Regional Psychological Associations; five ethnic minority psychological associations; designated seats for ECPs, members-at-large nominated and elected by the general membership, and designated representation from science, public interest, practice, education, health, and advocacy.

Finally, Council spent a great deal of time and energy focusing on its first “mega issue,” the Impact of the Affordable Care Act on Psychology and Psychologists. This process generated many recommendations addressing issues we face as a profession and as professionals, many of which are expected to return to Council in August as action items. Also expected are some specific solutions and potential practice models from APAPO to be presented at the upcoming APA State Leadership conference.

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**PROFESSIONAL DEVELOPMENT FOR TSBEP LICENSEES**

*Have you heard about the changes? Are you confused?*

Let’s take a moment and clear up any confusion you might have about the updated TSBEP professional development requirements. Beginning October 1, 2014, all licensees renewing their license will be required to show completion of 20 hours of professional development (formerly continuing education). Of these 20 hours, 3 hours must be in the areas of ethics, Board rules, or professional responsibility, and 3 hours must be in the area of cultural diversity. Furthermore, at least half of the required 20 hours of professional development must be obtained from or endorsed by national, regional, state, or local psychological associations, public school districts, regional service centers for public school districts, or psychology programs at regionally accredited institutions of higher education.

1) Continuing education is now termed Professional Development.
2) The changes affect licensees renewing beginning in October 2014. Therefore, if you renew in September 2014, August 2014, July 2014, etc, you are not required to adhere to the updated rule until your 2015 license renewal.
3) For those renewing October 2014 forward, you must earn at least 20 hours total of professional development.
   a. At least 3 of those 20 hours must be in the areas of ethics, the Board’s Rules of Conduct, or professional responsibility. Examples include: confidentiality, patient rights, dual relationships, sexual harassment, billing fraud, HIPAA, risk management, duty to report.
   b. At least 3 of those 20 hours must be in the area of cultural diversity. Examples include: age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and social economic status.
   c. 10 of those 20 hours MAY be earned from any of the sources from which you have earned qualifying CE before, as long as it is directly related to the practice of psychology.
   d. 10 of those 20 hours MUST be earned from or endorsed by national, regional, state, or local psychological associations, public school districts, regional service centers, for public school districts, or psychology programs at regionally accredited institutions of higher education.
4) If you are a provider who wishes to fit into 3(d) and wishes to be formally endorsed by Texas Psychological Association, please contact Sherry Reisman at tpa_sreisman@att.net. Staff can walk you through the details and the process to become an endorsed provider or provide a single endorsed workshop.

If you have any questions about these requirements, Sherry would have happy to answer them for you. Call the central office at 888-872-3435 or email tpa_sreisman@att.net.
Supervision Rules Changes Being Considered by Texas State Board of Examiners of Psychologists (TSBEP)

Paul Andrews, Ph.D.
Chair of TSBEP Committee

Editor’s note: Dr. Andrews’ article below was written to keep the members up to date on the thinking that may inform policy decisions that TSBEP will be making about standards for supervision. He has described the results of preliminary work. It is important to understand that we are very early in the rulemaking process; there will be several iterations before the full board even considers adopting a final rule. It is likely that many of these recommendations will be tweaked and modified before then.

For the past two years TPA and TSBEP have worked together very well on many projects of mutual concern. The staff at TSBEP is stretched very thin and they are working very hard on a number of other projects. Please do NOT contact the board about this issue at this time.

Under the law, the board is always required to post any proposed rule and to invite public comments both taking any action, but this is still several months away. In the interim, if you have suggestions or other thoughts about this article we, at TPA, are interested in hearing from you. Please feel free to forward your comments to TPA or to Dr. Andrews (pand75711@suddenlink.net) or to me at stagneraap@gmail.com.

Consider these scenarios...

1.) An entrepreneurial licensed psychological associate (LPA) gets a contract to provide services in a nursing home and then looks for a licensed psychologist (LP) to sign off on billing forms for his work.

2.) An independently oriented provisionally licensed psychologist (PLP) rents an office, solicits clients, and contracts with an LP to “supervise” her practice to satisfy TSBEP requirements.

3.) Another PLP, who operates in a community where people scarcely can define differences between counselors, psychiatrists, and psychologists, decides that he does not want to take the oral exam and get licensed as LP as he can continue to provide services indefinitely as PLP and is for all practical purposes known in the community as a psychologist anyway.

4.) A busy LP with a successful referral system and business acumen hires three LPA’s to provide services in nearby rural locations for the benefit of clients but establishes only cursory supervision meetings as she trusts her employed LPA’s.

5.) A psychology graduate doing post doctoral practice hires an LP to fulfill TSBEP supervision requirements but fires the supervisor after being told by the supervisor to cease delivery of services to a client he (supervisee) is not equipped to treat; the agency where the post doctoral supervisee is working is not aware of the exchange but does not really care anyway as there is a need to generate income by provision of services.

6.) A person who obtained a masters degree in experimental psychology is not accepted for further graduate work and in an attempt to salvage a future contracts with an LP who is an acquaintance to do the required 450 hours of supervised practice in her private practice so that he can meet requirements for LPA.

7.) After completing requirements for LPA, the daughter-in-law of an LP joins the LP’s private practice with her father-in-law as her supervisor.

8.) A former post doctoral supervisee becomes LP and begins her own private practice in the same community as the previous supervising LP and takes all her former client records with her.

9.) A supervising LP gets involved in a TSBEP complaint about one of his supervisees and finds that while he kept a log of supervision meetings, he has scant notation in his files about clinical cases discussed or guidance or instruction he provided the supervisee.

Do you think these scenarios (some of which are known to have happened and all of which are possible—and possibly defendable under current TSBEP Rules) should occur within our profession? Does the “high ground” of being the best trained mental health and behavioral healthcare providers call for a higher level of expectation regarding supervision practices? Does the current eleven item section on supervision in TSBEP Rules (Section 465.2) adequately address expectations and give adequate guidance for supervisors and supervisees?

Attorneys Kenda Dalrymple and Michael Flynn presented a workshop at TPA convention last year suggesting there are problems with lack of clarity in these current rules and that licensees sometimes get caught (and penalized) because interpretation of the rules can change from time to time with different TSBEP committees ruling on complaints. Questions they raised include asking what documentation of supervision
really means; why is TSBEP informed of supervisees only at time of supervisor’s license renewal; who keeps client files; can a supervisee lease an office without the supervisor’s name on the lease; can a supervisee be paid by clients?

A few years ago Texas Psychological Association designated a task force led by Dr. Roberta Nutt to develop supervision rules for post doctoral supervisees as TSBEP Rules were largely silent regarding the specifics of supervision other than for the predoctoral internship year.

The task force recommended among other things: a minimum of one hour a week face-to-face supervision; sufficient knowledge of clients for supervisor to plan effective service delivery; maximum of three full time supervisees for any supervisor; supervisee not hire the supervisor nor pay for supervision; all reports by supervisor countersigned by supervisor; written contract between supervisor and supervisee; frequent feedback to supervisee with written feedback at least every six months; written record of supervision signed by both supervisee and supervisor. More generally, there were recommendations that stated the supervisor is ethically and legally responsible for activities of the supervisee; supervisor supervises only in areas of competence; clients must be informed of supervisee’s status in writing; supervisor must hold valid license to practice; and supervisee may function only in areas where competent to function with supervision.

These proposed rule changes were presented to TSBEP and discussed but never adopted. In May, 2013, TSBEP Chair Dr. Tim Branaman directed the Rules Advisory Committee (comprised of two TSBEP members and representatives from Texas Psychological Association (TPA), Texas Association of School Psychologists (TASP), and Texas Association of Psychological Associates (TAPA)) to take a look at all current supervision rules and to make suggestions about potential changes.

Over a period of nine months, the work group developed some proposed changes which have now been sent to TSBEP Rules Committee and staff for review and refinement before they will be presented to TSBEP for consideration. The usual process for new rule adoption is discussion of proposed rule(s) at TSBEP meeting with decision to support, dismiss, modify, or table.

If supported or modified, the resulting proposed rule is sent for publication in Texas Register after which there is a period for TSBEP receive of public comments prior to TSBEP again voting to adopt, modify, or reject the published proposed rule(s). Given the far ranging implications of any rule about supervision, comments are already being sought from university and training program directors, and it is anticipated there may be a public hearing specifically to gather feedback about any proposed changes before they are adopted.

Here in summary are the current proposals for rule changes regarding supervision of LPA, PLP, or post doctoral persons by LP’s. Final proposals regarding LSSP supervision are not yet available.

Rules about Supervision (Section 465.2):

1. The timing of the Examination for Practice of Professional Psychology (EPPP) is sometimes a problem. Some university programs are beginning to use EPPP as an exit exam, but a person is granted permission by TSBEP to take the exam only when the person has an application before the board. TSBEP prerequisites for PLP application demand an applicant to have graduated with a doctoral degree. Therefore, unless a student is applying for LPA or LSSP or has previously taken and passed EPPP at the level required for PLP, the student remains in limbo.

2. A proposed rule change would allow application for PLP to be filed up to sixty days before the actual doctoral degree is conferred or completed. The applicant would be allowed to sit for exams (EPPP and Jurisprudence) but would not be licensed until the official transcript is received.

3. A person who has not taken and passed the Jurisprudence exam but meets other requirements could be given a provisional trainee status letter (good until passing the Jurisprudence exam or one year, whichever comes first) that would allow the person to begin practice under supervision of an LP to accumulate post doctoral supervised hours. This arrangement would allow a recent graduate to begin supervised practice quickly.

For LP licensure (Section 463.11):

1. Two years of supervised practice must be completed, one year of which is a pre-doctoral internship approved by American Psychological Association (APA), Canadian Psychological Association (CPA), or Association of Psychology Postdoctoral and Internship Centers (APPIC) or meet criteria spelled out in Board rules (463.11 (c ) (4)).

2. The year of postdoctoral supervised experience must be completed within two years of graduation unless a waiver is granted due to extenuating circumstances. Therefore, without a waiver, a person only has two years after graduation to meet requirements and to apply for LP status.

For LPA licensure (Section 463.8):

1. The 450 hours of supervised practice must occur within a course of study in a recognized training institution or training facility so that there is program oversight in addition to the individual supervision. If adopted, the rule change would mean a person could no longer gain the required hours of supervision through some ad hoc arrangement with a supervisor but would have to be part of a recognized program.

For PLP licensure (Section 463.10):

1. The timing of the Examination for Practice of Professional Psychology (EPPP) is sometimes a problem. Some university programs are beginning to use EPPP as an exit exam, but a person is granted permission by TSBEP to take the exam only when the person has an application before the board. TSBEP prerequisites for PLP application demand an applicant to have graduated with a doctoral degree. Therefore, unless a student is applying for LPA or LSSP or has previously taken and passed EPPP at the level required for PLP, the student remains in limbo.

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3. A person who has not taken and passed the Jurisprudence exam but meets other requirements could be given a provisional trainee status letter (good until passing the Jurisprudence exam or one year, whichever comes first) that would allow the person to begin practice under supervision of an LP to accumulate post doctoral supervised hours. This arrangement would allow a recent graduate to begin supervised practice quickly.
of work within school settings. For LP supervision, some of the questions were: Who can supervise? Is specific prerequisite or ongoing training necessary? Who pays the supervisor?

What level of oversight is expected of the supervisor? How many supervisees can one supervisor have? What about distance supervision by electronic means? What about supervisees providing services "off site" from the supervisor? Is a supervision contract necessary? What kind of documentation is expected of the supervisor? How much contact is required for supervision? Do supervision rules apply to practicum students who are in an exempt university status? When does a supervisor notify TSBEP of supervision changes?

Survey information obtained from Association of State and Provincial Psychology Boards (ASPPB) was provided by Mr. Darrell Spinks, Executive Director of TSBEP. Thirteen states and one Canadian province provided responses to his inquiry. Nine indicated no limitation on who can supervise once licensed with four requiring one to three years post licensure practice before being able to supervise; the other state was in the midst of establishing required practice time. Eleven indicated no formal training is prerequisite for supervisors, and three indicated they are establishing prerequisite training. Ten stated no continuing education requirements specific to supervision, and four have or are starting requirements. Finally, six have no limits on how many supervisees a supervisor may have, and the other eight limit it to three to five supervisees. Maryland and Pennsylvania are apparently reworking their supervision requirements as is Texas.

Below are the committee's suggestions about supervision by LP's. Supervision is defined as responsibility for clinical training and/or oversight of delivery of clinical services and does not apply to purely administrative or employment matters.

1. Supervision rules will apply to practicum students being supervised in psychology programs when services are delivered off campus or when supervision is provided by non-faculty.

Rationale:

Although university programs are exempt from TSBEP rules, members of the public (including graduate students) are best served when adopted supervision rules are applied. Many practicum experiences are off campus with graduate students providing services in settings where there is no reasonable expectation that such services are being provided by university staff. Many practicum experiences are in private practice settings. Some states are looking at allowing practicum experiences to count as one year of the required two years of supervised practice.

2. Telesupervision may take place when geographic distances prevent consistent face-to-face supervision sessions. However, no more than 50% of required supervision hours for any supervisee may be obtained using this method of supervision. Any session that is conducted electronically must be noted as such in supervision notes. Adequate protection of confidential information is the responsibility of the supervisor when using such a method of supervision.

Rationale:

Supervision is an intensive process that demands time from the supervisor not only for training interactions but also demands time to adequately review chart notes, treatment plans, and other clinical material as the supervisor retains final responsibility for all services delivered by the supervisee. This supervision limit is meant to apply to primary supervisors and their supervisees, not for ad hoc supervision of particular cases or minor rotations or otherwise limited supervision arrangements.

3. Supervisors will notify TSBEP in writing within 30 days of entering or terminating any supervision arrangement. Notification will be updated annually a time of license renewal and at other times as changes occur.

Rationale:

Currently supervisors send a list of supervisees only at time of license renewal. Consequently, TSBEP often lacks current and accurate information about supervision arrangements. If information about supervision arrangements is needed at all, it seems it would need to be current and accurate.

4. Supervisors may supervise no more than three (or three full time equivalent) supervisees at any one time.

Rationale:

5. Licensed psychologists must have a minimum of two years post licensure practice before providing supervision. Graduate students, interns, licensed psychological associates, and provisionally licensed psychologists may supervise under the direct supervision of a licensed psychologist who meets requirements to supervise. Licensed psychologists with fewer than two years post licensure practice or otherwise not meeting requirements necessary in order to supervise may with TSBEP approval
supervise if his/her work is monitored and regularly discussed (minimum of two hours per month) with a licensee who is qualified to supervise. The supervision consultant does not take on supervision responsibilities for the supervisor or for the supervisees in such an arrangement.

Rationale:

There are likely locations where newly licensed psychologists or psychologists not otherwise meeting requirements are needed to supervise. Without additional availability and flexibility, some programs might have to close or be seriously curtailed. A consultation arrangement prevents the consultant from actually bearing responsibility for all services being delivered by the supervisees and also fosters learning and professional development regarding supervision skills.

6. Supervisors are expected to participate in continuing professional development regarding supervision theory, skills, and practice. Evidence of such ongoing development must be shown annually by completion of at least three hours of professional development in supervision or participating in a supervision consultation group for a minimum of one hour a month during any period of time in which supervision is provided. Licensees will maintain documentation of how this requirement is met and will provide such documentation if requested. Hours may be counted toward annual professional development requirements of TSBEP for licensees.

Rationale:

Psychologists are expected to remain current in areas in which services are provided, and supervision is one of those areas. Ongoing professional development through a variety of methods (workshops, classes, online CE, teaching, writing) fosters enrichment of knowledge. Consultation groups are an alternative that may be expected to enrich skills and understanding of supervisory processes.

7. Supervisees provide services only in locations and situations where there is immediate or timely access to the supervisor. The nature of this access may be influenced by the experience of the supervisee, the nature of the services being delivered, and the direct availability of other clinical staff resources. Regardless of location, the supervisor retains total responsibility for the care of the patient/client.

Rationale:

Supervisees may actually work in a different building or physical location or even a different geographic location from where the supervisor is at a particular moment. Depending on the nature of services being delivered, skill level of the supervisor, and presence of other clinical staff, direct presence of the supervisor may not be necessary although the supervisor needs to be available in a timely manner.

These suggestions are offered as a way to continue discussions about what constitutes adequate supervision, a complex service to define. Part of supervision, especially in the early phases, involves instruction, demonstration, and guidance to correct errors and to impart specific skills. But another part of supervision involves socializing the supervisee into the profession, mentoring and motivating the personal and professional development of the supervisee. Supervision involves skills and concepts complementary to but also distinct from other clinical skills. How to write minimally adequate standards and expectations for supervision that covers a broad array of services, levels of training, and clinical situations is a challenge that will necessitate broad input and prolonged discussions with interested persons and groups. However, the rigor of the task should not keep psychologists from leading the way in developing sound expectations and workable rules. I think we owe it to our trainees and to our profession to develop an example of quality in this area.

Dr. Andrews is a forensic psychologist who practices in Tyler, Texas. He has made the six hour trek from Tyler to Austin to represent TPA at the quarterly meetings of the TSBEP for the past couple of years. He also serves on several TPA committees as well as being a board member of the Lone Star Psychology Internship Consortium.
UPDATE ON DUTY TO REPORT CHILD ABUSE

Floyd L. Jennings, J.D., Ph.D., ABPP

Overview

Psychologists, as well as other professionals licensed or certified by the state, have long been aware of the necessity to report suspicion of child abuse. What has been less clear is whether that duty extends to reports of abuse by now-adult patients which occurred in the patients’ childhood.

The Texas Legislature has acted to firmly establish a duty to report child abuse when the professional “has cause to believe has cause that an adult was a victim of abuse or neglect as a child and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of: (1) another child; or (2) an elderly or disabled person as defined by Section 48.002, Human Resources Code.” This note will address child abuse reporting in general and the specific duty now a matter of law.

Discussion

Generally speaking, it is well known that all professionals, including persons whose communications might otherwise be privileged, such as attorneys, clergy, mental health providers, etc., have long had a duty to report suspicions of child abuse. The matter, however, has several components or issues:

- What is the standard of suspicion required?
- When must the report be made?
- How?
- Who makes the report, is it delegable?
- To whom?
- What is the content?

The first issue is the standard of suspicion required before a duty to report exists, e.g. “cause to believe the child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person” (Texas), “reasonable cause to suspect” (N. Carolina), “reasonable cause to believe” (New Jersey, Oregon) “reasonable cause to suspect.” (Wis., Penn.), knowledge or suspicion that “indicates reasonable indication” (Ohio, Tenn.), “reason to believe” (S. Car. Oklahoma), “reasonable suspicion” (N. M.). From the provider’s point of view it is important to appreciate that this standard is low indeed. If the provider has any reasonable basis for suspicion, a report of child abuse should be made because of the gravity of non-reporting (a criminal act) and that immunity is granted to good faith reportees (in all jurisdictions).

The second issue illustrative of differences between jurisdictions is the time frame in which suspicion must be reported, i.e. “immediately” (N.J., N.Y., Ohio, New Mexico, Penn., Tenn., Wis.) “promptly” (Oklahoma), silent on time (N. Car., S.Car.), within “48 hours” (in Texas for professionals, “immediately” for all jurisdictions).

The third issue is the means of reporting and essentially whether a written report is required after having made an oral report, ("no" in N. Car., N.J., N.M., Okla., Penn, S. Car, Tenn., Texas, Wis., "yes" in Michigan (within 72 hours), Ohio (no time limit).

Note that herein are listed but a few jurisdictions, it is therefore incumbent on the provider to be knowledgeable of the rules appertaining in his/her state of residence. New Mexico is one of the few states that permit reports to be made not only to social services/child protective services, but to “tribal law enforcement or social services agencies for any Indian child residing in Indian country.” NMSA 32-4-3 (2002).

The fourth and extremely significant issue has to do with the context in which the information is made known to the provider.

That is, several jurisdictions use a phrase referencing a child “who comes before them in their professional or official capacity...,” e.g. Penn., Wisconsin’s phrase is “a child seen in the course of professional duties.” Tennessee would apply this rule to abuse other than sexual, where any source of information would create a duty to report. Most jurisdictions, however, would mandate a duty to report irrespective of the whether the source of information is the child or a third party. Only a few jurisdictions would restrict the duty to those cases in which the child, himself or herself, is the source of the concern about abuse.

The issue relative to the source of information is that a minority of states would restrict the duty to report only to those circumstances wherein the provider gained the information from having seen the child, whereas a larger number of states would require reporting regardless of the source of information, e.g. the perpetrator, or a third party.

In the vast majority of jurisdictions, the duty of reporting is non-delegable -- specifically so in Texas. This means that the duty to report may not be delegated to a third party who, himself or herself, did not have the suspicion or knowledge. Many mental health providers who trained in medical school settings recall rounds on a child and adolescent service wherein a medical school faculty person would preside and a child fellow would present a case.
Present in the room were one or more child fellows, the child psychologist, one or more psychology interns, the social worker and one or more social work interns, and perhaps a psychiatric nurse or two.

The child fellow would opine that the child appeared to be the victim of abuse where upon the faculty member presiding would sagely suggest that the social worker report the matter. In most settings this practice would now be improper both because of the time mandates for reporting, e.g., immediately to 48 hours, and because the duty to report is not delegable to some party who was not privy to the outcry of the child or disclosure of information by an adult.

What is to be reported is important. That is, while the language varies from jurisdiction to jurisdiction, most of the statutes are similar to Texas, which states that the reportee should report: (1) the name and address of the child; (2) the name and address of the person responsible for the care, custody, or welfare of the child; and (3) any other pertinent information concerning the alleged or suspected abuse or neglect. 13

The issue is that the provider must stay in his/her role and not engage in role diffusion by assuming the role of an investigator. Further, and more specifically, the provider should avoid speculating as to the identity of the perpetrator, though may report, “The child says...” (Or with reference to adults, “the patient says...”)

In Bird v. W.C.W. a then psychological associate executed an affidavit naming father as the probable perpetrator of abuse against a child, but all charges were subsequently dropped. Mother had filed criminal charges, and had also instituted a suit to terminate parental rights. But the entire case was not substantiated and father was exonerated. Father then sued the psychological associate and her psychiatrist employer. Bird v. W.C.W., 868 S.W.2d 767 (Tex. 1994) see also Vineyard v. Kraft, 828 S.W.2d 248 (Tex. App.–Houston [14st Dist.] 1992).

The practitioners were ultimately found free of liability to alleged perpetrators of abuse even though the charges against the alleged perpetrators were later found to be spurious.

The appellate courts reasoned that mental health providers' primary duty is to those with whom they have a special treatment relationship and not to individuals outside that setting. The providers were found to owe no duty to a third party not to negligently misdiagnose a condition of a patient. Moreover, the problem of child abuse is so pernicious that as a matter of public policy we would wish to encourage mental health practitioners to report suspicions.

However, the wisest course is to report what the child says without conclusive or speculative opinion. There is immunity for good faith reporting.

For the purpose of any civil or criminal proceeding, the good faith of the provider shall be presumed. The Board will uphold the same good faith presumption in any disciplinary proceeding that might result by reason of a licensee's actions in participating in good faith in the making of a report, cooperating with an investigation, testifying in a proceeding arising out of an instance of suspected child abuse.

Failure to report can result in penalties, see White v. N.C. Board of Examiners of Practicing Psychologists, 338 S.E.2d 148 (N.C. Ct. App. 1990) where a psychologist had seen children referred because of suspicions of abuse. However, the psychologist said that he thought the matter was already in the judicial system and the parents and attorneys knew of the alleged sexual abuse. The court held that the N.C. Gen. Stat. § 7A-543 “makes no exceptions for extenuating circumstances in reporting suspected child abuse.” In Texas, the penalty for non-reporting has been raised to a Class A misdemeanor, where the penalty may be a fine not to exceed $4000 and/or confinement not to exceed one year.

Reporting abuse of now-adult patients which occurred in childhood

Some years ago, the Texas Attorney General issued an opinion that professionals providing treatment to sex offenders must report suspicions of child abuse – other than the crime for which the offender was convicted and regardless of when it may have occurred. 14

In late 2011, the Texas State Board of Examiners of Psychologists requested an opinion of the Attorney General as to whether reports from adult patients of childhood abuse required reporting. That request noted that psychologists have concerns that disclosure of the limits of confidentiality to patients would “discourage some patients from discussing important aspects of their developmental histories that may be relevant to their current symptoms and functioning.” 15

The response of the Attorney General was quite clear; namely, that reporting of abuse relates to abuse of “a child” and if the victim is no longer “a child” then no necessity would exist for reporting. 16

That position remained the law until the 83rd Legislature acted to amend Tex. Fam. Code. §261.101 as follows:

(B-1) In addition to the duty to make a report under Subsection (a) or (b), a person or professional shall make a report in the manner required by Subsection (a) or (b), as applicable, if the person or professional has cause to believe that an adult was a victim of abuse or neglect as a child and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of:

(1) another child; or
(2) An elderly or disabled person as defined by Section 48.002, Human Resources Code.

The current law changes the parameters substantially and can be reasonably interpreted to place a duty upon the person...
or professional to determine whether "disclosure of the information is necessary to protect the health and safety of: (1) another child; or (2) an elderly or disabled person as defined by Section 48.002, Human Resources Code."

In practice, this means that the wiser course is to report, as psychologists are not investigators. As the 2011 TSBEF request for opinion noted, the 48 hour reporting requirement provides little time for therapeutic discussion with the patient as regards needs to protect the health and safety of "another child" – moreover, reporting the name of the "other child" may be quite problematic.

On the other hand, there are cases when, clearly, no report should be made; e.g. when the alleged perpetrator is deceased or incapacitated (as in a nursing home). More equivocal is the circumstance wherein the patient refuses to name the perpetrator; or when there is no known victim. For other than the therapeutic task of enabling the patient to self-report, the psychologist would have little to say save that "I must report there has been sexual abuse in this city. However, I cannot tell you the name of the perpetrator or name any potential victim; I can only assure you that there has been a crime committed here." The psychologist may have no information relating to the "name and address of the child" – which would also limit reporting.

All this having been said, the problems of this piece of legislation are multifold – not the least of which is the chilling effect on a psychotherapeutic relationship in view of required disclosures on limits to confidentiality. But on the investigative side, and practically speaking, the Texas Department of Family and Protective Services (TDFPS) is not blessed with either an unlimited budget or unlimited staff and every effort is made to deal with current issues, not to say ancient ones, or unknown future cases. Moreover, the Legislature giveth and the Legislature taketh away for simultaneous to placing more demands on psychologists, the Legislature passed an additional piece of legislation which allows TDFPS to close cases with little or no investigation "if the report does not allege sexual abuse….abuse or neglect that caused death….or serious physical injury." 17

The bottom line is that reports may well be made, in good faith, because the reportee is in no position to ascertain likely danger to a child or elderly person, and resources will be devoted to carefully entering that information, but the matter will be dropped – hopefully without opportunity for later discovery of the electronic entry in any number of circumstances. For were the report to become accessible, then the alleged perpetrator would have been painted with a brush for which there is not only no ready cleansing, but none whatsoever – as no recourse would exist to clear his/her name, was the person, in fact, innocent.

Nonetheless, as stated earlier, the penalty for non-reporting has been raised to a Class A misdemeanor, where the penalty may be a fine not to exceed $4000 and/or confinement not to exceed one year. In short, this is not the best piece of legislation; but ours is not to create law or to disregard that which is present, but to attempt to comply in good faith.

1 Tex. Fam. Code §261.101
4 N.C. Gen. Stat. § 7B-301
7 Wis. Stat. § 49.981, 23 Pa. C.S. 6311
10 NMSA 32-4-3.
15 Tex. Att'y Gen. RQ No. GA-1030 (2011)
Moving Towards Population Health Management

What You Need to Know

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Those working in the field of public health are more accustomed than psychologists to hearing the term ‘Population Management.’ In that context, the term refers to treatment and prevention strategies for groups of individuals defined by geographic location, demographic variable, or diagnosis. The U.S. Agency for Healthcare Research and Quality (AHRQ) recently coined the term “practice-based population-health” (PBPH), in which the term ‘population’ refers to any group of people under the care of a single physician, group practice, PCMH or ACO (Cusack et al, 2004). Primary healthcare is increasingly moving in the direction of a PBPH model, which assumes that medical providers are responsible for increasing the overall health of the population they manage, and not just for treating individual patients who present in their office for care. This shift is driven primarily by financial changes in healthcare reform, explained further below. However, the adoption of a PBPH model is also determined by, and further encourages, structural and cultural changes in primary care.

**FINANCIAL:**

Healthcare reform now encourages public and private insurance companies to give up a traditional volume-based reimbursement (pay per visit) system in favor of outcome-based reimbursement (pay based on health improvement).

The former system pays doctors for each service provided and is thought to lead to an increased volume of services, without necessarily improving health. The latter system is thought to encourage providers to focus more heavily on prevention efforts - with the hope that this will reduce the overall consumption and cost of healthcare services and improve health outcomes at the same time. Prepayment, bundled payment, and capitation models are all examples of outcome-based reimbursement that we will be hearing more about, in which ‘profit’ is measured by cost-savings rather than by revenue.

**STRUCTURAL/CULTURAL:**

Emphasizing overall health improvement among populations will require primary care organizations to reach out to patients that do not typically present to their doctor for care. For example, patients who are at-risk for, but have not yet developed chronic illnesses such as diabetes or heart disease. Or, patients who are not adherent to recommended treatment for existing conditions, such as high blood pressure or HIV. Reaching out to these populations will involve increasing access to care through structural changes in primary practice, such as providing more flexible hours, walk-in services, and electronic contact.

It will also require a cultural shift among physicians towards a care-team model that incorporates multiplespecialties as well as a role for non-licensed professionals like health education workers and patient navigators, who provide support with engagement and follow-up care. In the next few paragraphs, we will elaborate on the financial and cultural consequences of PBPH and how they will affect psychologists.

Population Health Management (PHM) requires a conceptual shift for many...
healthcare providers, including psychologists, who are used to thinking about client care at a personal and individualized level. Across healthcare disciplines, the standard model of care has previously involved regular one-on-one and face-to-face provider visits, typically occurring in a hospital setting or private clinical practice. As new models of care continue to emerge with an increasing emphasis on cost-effective and cost-sharing practices, PHM is gaining traction.

The Institute for Health Technology Transformation (IHTT, 2012) outlines the core components of PHM, which include: defining a subgroup or population, identifying gaps in clinical care, identifying and predicting population-specific risk factors, increasing patient engagement in care, managing care across providers and disciplines, and measuring population-wide clinical outcomes (See Figure 1).

PHM may require psychologists reconceptualizing their service delivery models. Under this model of care, psychologists may provide more brief assessments and risk analysis, psychoeduction and consultation (e.g., the “15-minute” session), and group-based monitoring and intervention. Psychological practice may likely become increasingly focused on mental and behavioral problems. Clinical work may routinely include workshops and seminars for communities, targeted interventions to groups with similar health issues (e.g., obesity, smoking, poor medication adherence), and more group-based practice to address common mental health issues such as depression or anxiety.

Focus will increasingly be on preventative care and managing chronic health conditions and outcomes will be measured. Psychologists can be instrumental in designing and implementing wellness and prevention programs, providing group-based screenings and risk assessments, participating in programs to aid in chronic disease management, and addressing mental health issues that are impacting the overall health of their communities. PHM may look somewhat different for psychologists in a hospital or private practice setting. An example of PHM for a hospital-based provider could be a psychologist running a therapy group in a primary care unit for individuals with diabetes who are non-compliant with their medication.

The psychologist would help individuals cope with their illness, provide psychoeducation about medication compliance, and address ambivalence or resistance to treatment. In private practice, a psychologist may be recruited to provide a group-based screening for depression or anxiety in a school or community. This psychologist may then be asked to give a workshop in the community on managing these symptoms and seeking treatment where appropriate.

PHM, Research, & Technology: Beyond HSPs

PHM has broad implications across the profession of psychology, and will impact research-oriented psychologists as well as HSPs. As seen in the model for PHM (Figure 1), collecting data and measuring outcomes are a critical component to the successful implementation of PM. Ongoing data integration, analysis, reporting, and communication are seen as central to the process.

In order to define populations and move towards community-based treatment, data is needed across the following domains: demographics and parameters of “populations,” rates of mortality and morbidity, rates of service utilization and barriers to care, cost of clinical...
duration of hospital stays and readmission rates, rates of prescription and drug use/abuse, treatment adherence and medication compliance, social and behavioral determinants of health, and health and quality of life outcomes. It will also be important to be able to track health status over time, preemptively identify at-risk individuals, assess disease prevalence and incidence, and monitor patient experience of care.

A large part of implementing PM involves electronic health records (EHR) and health information technology. EHRs will be instrumental in sharing medical records and clinical data, increasing ease of access, and facilitating communication across treatment settings and providers. Technology is also increasingly being used to facilitate bidirectional communication between patients and providers.

Patient engagement is seen as something that occurs on an ongoing basis, outside of routine office visits or phone calls. Outreach and education campaigns can be implemented across various technologies, including email, text messages, wireless biometric devices, and smartphone applications. Examples include mobile health risk assessments, blood pressure tracking devices, medication reminders, and electronic behavioral coaching (IHTT, 2012). Given their training in data collection and management, statistical analyses, and outcome measurement, psychologists are particularly well-suited to spearheading or assisting with these endeavors.

Show Me the Money: Financial Implications

Coordinated care and initiatives like PM are gaining momentum in the context of healthcare reforms aimed at reducing overall costs. Similar to the shift from individual to population-based care, payment models are beginning to focus more on performance-based pay and cost-sharing than the traditional fee-for-service model. Private insurance companies are supposed to be adopting these new payment models, although we are unclear what they may look like, which may cause more challenges for private practice.

What it Means for You...

This new focus on population health management represents a significant shift in how healthcare will be delivered. The driving forces behind these changes seem to be that payors are looking to spread out access and services to more people across the nation, given that resources are finite; that all health care providers will be folded into more of a public health model - even those healthcare providers who have never used this approach-, and research showing that the public would benefit from such an approach which would give more people, more access, to (in theory) more effective services. While this approach is spreading across healthcare, there is not much information about how it will impact practicing psychologists - yet. This is in large part due to the fact that there continues to be a limited focus on behavioral health in the changing healthcare system, relative to other healthcare services. But one can at least begin to extrapolate based on the impact on healthcare professionals in general.

As part of population health management, it is expected that practice approaches will be redesigned. Most of the changes associated with PHM would require psychologists to be integrated into larger settings and working with teams of other healthcare professionals. While this will be seen as a new opportunity and new role for some, the use of technology to manage populations and the tracking of data (including metrics for purposes of insurance payment and capitated payments), requires new workflows and a change in practice that may become burdensome for some, particularly the private practitioner. It remains unclear how this will impact those in private practice if PHM does roll out completely.

Our Task Force is unaware of efforts to try and integrate private practices into the existing models that are rolling out, or any efforts to develop new of new models of private practice within HCR beyond IPAs (if this is inaccurate please let us know). This is worrisome as there are many psychologists in private practice, particularly in the NYS area. It remains unclear what may happen to those in private practice if PHM turns out to be less viable to the independent practitioner.

We are used to treating people individually. Yet the focus here will increasingly be on keeping populations healthy. Instead of a few people getting intensive services, larger populations will obtain fewer services in the hopes of keeping the population/more people healthier overall. Note that the focus is on using finite resources to manage a large group (population), rather than dedicating intensive resources to a few in an effort to ‘cure’. This is quite different than what many psychologists are used to, signaling a shift in how skills will be applied.

Certainly some psychologists will be eager to work within this approach, and are already being trained in PHM approaches, while others will not. To remain competitive in the marketplace, at least a segment of psychologists will likely learn how to work within this new approach to care and adopt new skill sets, such as more frequent use of screening tools, the provision of briefer treatments and treating a cohort of patients and measuring the cohort’s progress over time rather than intensive one-on-one treatments. Psychologists may need to obtain additional training if they have limited training in such treatments, and there already many certification programs and online classes available now which are designed for psychologists to learn such skill sets.

While health psychology is the specialty area of the profession most likely familiar with these concepts and skill sets, it will be increasingly useful for those psychologists who are not health psychologists to learn about the
psychosocial components of medical well-being, as well as skills like motivational interviewing, to understand and impact the interplay between mental health and physical health.

Not everyone will need to obtain specialty training in health psychology, but can obtain basic training regarding bio-psychosocial approaches to treatment of populations. Our recommendation is to avail yourself to these trainings if this is something you are interested in or want to work in more integrated/medical settings, as these skills will be more in demand as the trend of integrated care grows.

It is feasible that some psychologists will continue with the type of practice they have historically provided while adding aspects of PMH into their practice. For example, psychologists may find themselves continuing to work with individual patients but also engaging in more screenings and/or outreach within communities, as this PMH model of care spreads.

Psychologists, with appropriate training, may develop an affiliation with a medical practice or hospital (or newly forming ACOs and PCMHs) to treat a defined population (group) of individuals who have a medical problem that is exacerbated by mental or behavioral problems, by which physicians would need the assistance of a trained psychologist. Treatment might be provided at the affiliated facility or at the psychologists practice (assuming the psychologist's services are reimbursable, and that they are able to contract with the medical setting and insurance companies). For those that pursue this, it might mean that psychologists would manage a group of patients with poorly controlled diabetes, tobacco addiction, or obesity, treating a defined cohort of patients who were identified to have problems requiring behavioral intervention.

Or the psychologist may work with the medical team to help alleviate mental health symptoms such as moderate depression or anxiety, in a group setting, for those with co-occurring medical problems, particularly when the psychological symptoms are impacting the ability of that cohort of patients to manage their physical health problems. Services might also include psychoeducational groups or brief group psychotherapy approaches depending on the needs of the medical setting.

As the population management approach spreads, psychologists may be called upon to develop and implement strategies to improve the health of defined populations/subgroups, such as designing systems and programs that integrate both psychological and medical care. Given our expertise in research design and program development, this represents a potential niche area that is ripe for psychologists, and psychologist leaders, to explore.

There is room for opportunity and innovation including, but not limited to, developing ways private practitioners can plug into PCMH’s and ACO’s in order to keep private practice viable in this new arena. We continue to hope that some entrepreneurial psychologists pursue a legislative and business agenda to create a model whereby psychologists in private practice would be integrated into these emerging systems of care for those in need of longer term treatment. Given there is nothing formally being done in that area, to our knowledge, state psychological associations may want to pool their ideas and resources to develop various models. Or perhaps models that would allow private practices to somehow stand-alone while still incorporating innovative ideas such as PMH.

Additionally, there is room still to develop alternative models beyond PCMH’s and ACO’s which focus more centrally on behavioral health. PMH represents a huge paradigm shift in how one practices and treats patients, and the only way to have a voice at all is if all psychologists work together, regardless of specialty or setting, and help carve a path for psychologists and the profession in general. While in theory there is an opportunity, politics and policy may limit what we can do on behalf of our patients and our hope is that the profession advocates vigorously for varied and stratified treatments depending on the needs of our patients. As always, the only way to have a strong voice long-term is to remain united as a cohesive field, versus advocating on behalf of only some specialties or practice areas. Patients have varied needs and all needs may not be addressed by brief psychotherapies (10 sessions), or curbside consultations. Alternatively, longer, open-ended treatments may not always be the best use of resources when tackling societal health from a public health standpoint. Connecting with state psychological associations will allow us to pool ideas and person power to work together more effectively, and we hope other SPTA’s continue to make efforts to band together, share information, and strategize.

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