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From the Editor

Brian H. Stagner, Ph.D.

Professional psychology is changing faster than Texas weather in the springtime. This issue of the Texas Psychologist samples some of the changes that psychology faces across many domains. The emergence of robust, detailed neuroscience models for disorders will be a permanent factor for our discipline and our professional practice from now on; see the article by Holland, Glasier, & Stavinoha on ADHD for an excellent example. Likewise, neither our profession nor our country can afford to ignore rapid demographic changes that are already changing the social landscape; Dr. Mercado's review of last year's cultural diversity workshop provides a tantalizing reminder of how cultural sensitivity is fundamental to our efficacy.

There are many more immediate changes looming as we continue to ride the whirlwinds of change and uncertainty in the evolution of new health care models. There are corporate forces, legislative mandates, and regulatory hurdles that will force disruption and rebuilding of our present delivery systems. Anticipating and adapting to these changes is the role of APA and, at the local level, TPA. These are the two entities that will protect and promote our profession in whatever new health care delivery landscape emerges from all the current upheaval. A number of these issues were discussed at APA's State Leadership Conference and a sample of the information presented there is included in several articles in this issue, beginning with Dr. James Bray's overall description of the SLC.

There is some folk saying about living in interesting times. Is it a curse or a blessing? Get involved and shape the answer!

All article references can be found at www.texaspsyc.org.

From the President

TPA Participates in the APA State Leadership Conference

James H. Bray, Ph.D.

What happens every March when psychologists from across the U.S. and Canada come together to advocate for psychology? It's called the American Psychological Association State Leadership Conference. The APA and the APA Practice Organization (APAPO) organize the SLC. The APAPO is funded through our practice assessment dues and is the organization that advocates for the profession of psychology and psychologists. Officers, federal advocacy coordinators, and public education campaign coordinators from all state, province, and territorial associations (SPTAs) come together for leadership training and to advocate for changes in federal laws for psychology with the U.S. Congress. We spent three days in training seminars and then a day on Capitol Hill to meet with our members of Congress to advocate for psychology. This year Texas was represented by Drs. James Bray, Greg Simonsen, Jerry Grammar, Cheryl Hall, Alice Ann Holland, Rick McGraw, Alfonso Mercado, Dean Paret, Brian Stagner, and Executive Director David White.

This is an exciting and fun conference. The SLC provides an opportunity to network and learn from other SPTAs about issues and solutions to common problems. It also provides an opportunity for APA
to educate us about federal issues that are impacting the profession of psychology. This year’s theme was on “Practice Innovations,” and Dr. Katherine Nordal, APA Executive Director for Practice, discussed in her keynote address how the Affordable Care Act is impacting the practice of psychology. She articulated how the profession of psychology needs to take advantage of these national trends and to step up to participate in integrated health care systems and affordable care organizations, implement electronic health records in practice, and advocate for payment reforms. Dr. Jason Hwang gave an interesting talk about the nature of “disruptive innovation” in health care that will dramatically change the current business models of health care. Ann Compton, Former White House Correspondent for ABC News, told about the political climate in the federal government and her predictions for the 2016 elections. Andy Goodman gave an engaging and thought-provoking workshop on how to use storytelling to be more effective in advocacy efforts. “Change the Story, Change the World,” utilized the latest scientific evidence about how the brain processes information to make an impact on decision-making. (Please see Dr. Cheryl Hall’s article on page ___ for more specifics on the importance of storytelling.)

Psychologically Healthy Workplace and Organizational Excellence Awards
Each year the APAPO gives awards to businesses for creating psychologically healthy workplaces. Businesses from around the country compete to obtain this coveted designation.

I met with other SPTA presidents to discuss our concerns about membership drops, infringement on the practice of psychology by other professional groups, and how to expand our scope of practice. Several states are having Applied Behavioral Analysts submit bills to become independent licensed professionals. This is happening in Texas. There is a general consensus that ABAs provide valuable and important services for a limited population, but they are not distinct from the practice of psychology. In several states, ABAs have been brought under the psychology board for licensure. Many states are experiencing drops in their membership. Those that are not have active organizations that include more opportunities for engagement and participation. TPA will be using some of these ideas to increase our membership. What we learned from these sessions is that TPA is on the forefront of our legislative process and effectiveness. Many states plan to model their legislative work after our successful model.

“Options for Psychologists Going Big” was a workshop on how psychologists are using the Affordable Care Act to form integrated health care networks and accountable care organizations to create large state and national psychology and mental health practices. They are collaborating with insurance companies, such as Aetna, to integrate and coordinate care. Other topics included using the ICD-10 as an alternative to the DSM-V, integrating diversity into clinical practice, establishing an integrated clinical practice, and removing barriers to Medicaid practice, to name just a few.

There was a special session for states seeking prescriptive authority for appropriately trained psychologists. There was a lot of “buzz” and new energy on RxP efforts after the recent passage of the Illinois RxP bill. Besides Texas, Hawaii, Idaho, and New Jersey have active bills and many other states are moving forward with their legislative efforts.

Hearing from Members of Congress
At this year’s SLC we heard from two U.S. Senators. There was a “black-tie” fundraising dinner for Senator Mike Crapo (R-ID). Mr. Crapo is on the powerful Senate Finance Committee that oversees Medicare federal legislation. Senator Heidi Heitkamp (D-ND) gave a rousing speech at the Monday night banquet. She is extremely knowledgeable about mental health issues and knows the importance of including psychologists in federal legislation.

Onto Capitol Hill
The most exciting part of the conference was trooping around the halls of Congress to meet with our elected officials and their staff. We advocated for changes in Medicare rules to repeal the Sustainable Growth Rate (SGR) that would reduce payments for our services by over 20%. We also focused on the need to eliminate unnecessary physician supervision of our services by including psychologists in the Medicare definition of physician, and including psychologists in the High Tech Act that provides incentives for using electronic health records. At this writing the repeal of the SGR has passed the U.S. House and is awaiting passage in the Senate. Please make a phone call or write a letter if you are asked to contact your member of Congress to support the repeal of the SGR.

This is a great opportunity to stand for psychology and protect and expand our profession—Engage; get involved, this is your TPA. Contact me anytime at jbray@bcm.edu.
By the time you read this article the 84th Texas legislative session will be winding down. I have spent many years strategically advocating for the profession and the practice of psychology; propelling “Psychologist” to become a household name inevitably linked to mental health among legislators. Moreover, the goal has been for legislators to understand and appreciate the value and importance of the psychological services you, psychologists, provide.

It goes without saying that you know what your doctoral degree allows you to do. With it you are able to perform a wide variety of mental health services, and as the highest-trained mental health professional, you provide these services as long as it is an area of competency. While most, if not all, legislators are now familiar with the title “psychologist” and its connection to the field of mental health, many of them still do not know what services psychologists actually perform.

Herein lies the disconnect at the Capitol.

When searching for a solution to an issue that constituents face, a legislator’s mindset is to find an “expert” who can best protect the citizens of Texas. Typically, they define an “expert” as an individual who has received specific training and certification on the topic at hand. So while they acknowledge that psychologists are the highest-trained mental health professionals, they do not immediately deem psychologists the expert when there are numerous sub-doctoral niche groups who provide specific services or who have received specific certifications. The result: legislators will support bills that allow sub-doctoral “experts” to provide services that psychologists are trained to provide.

We have seen this play out tenfold this session: courts are seeking sub-doctoral individuals to perform child custody evaluations; occupational therapists are seeking to be considered mental health professionals; and behavioral analysts are arguing that licensed psychologists are not properly trained to work with individuals who have an autism spectrum disorder.

As TPA monitors every single piece of legislation filed in the Texas Legislature, we continue to represent psychologists’ interests on all bills that may impact the profession and the practice of psychology. We are currently monitoring almost 60 bills. The status of some bills change daily. Please look for the Summer issue of the Texas Psychologist wherein I will recap all the bills affecting the field of Psychology.

Join me for a moment to look beyond the 2015 legislative session. This summer we are hosting the 2015 Professional Education Conference: Future of Practice in the Era of Health Care Reform in Austin on June 12-13. This conference, developed by President Dr. James Bray, has been designed to teach new, practical techniques for psychologists to take back to their practices and immediately implement. Additionally, attendees can earn the TSBEP required ethics (3 hours) and cultural diversity (3 hours) professional development.

Below is a brief schedule of conference workshops. Full details and registration can be found online at www.texaspsyc.org.

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<td>- Mr. Darrel Spinks and Mr. Sam Houston</td>
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<td><em>Screening, Brief Intervention, and Referral to Treatment (SBIRT)</em></td>
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<td>- Dr. James H. Bray</td>
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<td><strong>JUNE 13</strong></td>
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<td><em>Towards Us and Us: Creating shared worlds and understandings with culturally diverse clients</em> - Dr. Martha Ramos Duffer</td>
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<td><em>Transitioning Your Psychology Practice to Primary and Specialty Health Settings: Competencies, Collaborations and Contracts</em></td>
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<td>- Dr. Helen L. Coons</td>
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Neural Substrates of ADHD: Implications for Assessment and Treatment

Alice Ann Holland, PhD, Paul Glasier, PhD, ABPP, and Peter L. Stavinoha, PhD, ABPP

Introduction
While significant advances have been made in the understanding and treatment of Attention-Deficit/Hyperactivity Disorder (ADHD), clinicians working with this population can attest to the lack of singularly reliable assessment methodology as well as universally effective intervention paradigms. Clinicians must cobble together tools to evaluate for ADHD that are sensitive and broad in scope to capture the multiple difficulties and comorbidities often associated with the disorder. Similarly, besides medication—which typically has been used as the first line intervention for ADHD (Zavekas & Vitello, 2012) and generally results in reasonably effective, though incomplete, symptom management in many individuals (Faraone, Biederman, Spencer & Aleardi, 2006)—clinicians are left piecing together behavioral, academic, psychological, and cognitive approaches to help children and adults with ADHD. Psychologists working with this population may observe difficulty with treatment follow-through and adherence to potentially effective interventions. Better understanding of the neurobiology of ADHD may inform clinical decision-making with regard to diagnosis and treatment implementation. The following review and discussion is adapted from a recent workshop given by the authors at the 2014 Texas Psychological Association Annual Convention. The purpose of this review is to summarize the current understanding of the neurobiology of ADHD, particularly as this relates to clinical assessment, and share clinical experience that may inform work with this population.

DSM-5 Changes
Psychologists should be aware that with the publication of the DSM-5, several changes were made to the diagnostic criteria for ADHD. Most prominently, criterion B now states that several symptoms of ADHD must have been “present” prior to age 12. This is in contrast to the previous criterion stating that there must have been “impairment” prior to age seven. According to the authors of the DSM-5, the age cutoff was increased because precise childhood onset is difficult to establish retrospectively. It also should be noted that evidence of “impairment” in early childhood is no longer required—symptoms must merely have been present, but not necessarily impairing.

Other significant changes in the DSM-5 include a slight reduction in the number of symptoms required for a diagnosis of individuals 17 years of age or older. Such individuals need only demonstrate five symptoms, as opposed to the six required for younger individuals. Additionally, the term “subtype” has been replaced with the term “presentation” (e.g., “Predominantly Inattentive Presentation”), although the three presentations remain the same. Finally, comorbid diagnosis of ADHD in an individual with an Autism Spectrum Disorder is now allowed, whereas this was not the case in DSM-IV-TR.

Neurobiology of ADHD: Imaging
Knowledge of the neurobiological substrates of ADHD spans research in both structural and functional imaging, as well as investigations of genetics and studies of the neurochemical mechanisms of various medications. Most knowledge of the neurobiological substrates of ADHD comes from studies of children, but a growing number of studies have replicated findings in adult populations.

Individuals with ADHD demonstrate decreased volume in the prefrontal cortex, anterior cingulate cortex, basal ganglia, cerebellum, and the cortex as a whole (Shaw et al., 2006; Sowell et al., 2003; Narr et al., 2009). Regarding the latter, some research suggests that findings of reduced overall cortical volume in ADHD populations may be related to decreased cortical folding (Wolosin et al., 2009). Other research has suggested that synaptic pruning in cortical areas may begin prematurely in children with ADHD, with such early pruning being less sophisticated and effective because complex neural circuits supporting attention have not yet been able to fully develop (Shaw et al., 2006).

Considering the recent change in DSM-5 criteria indicating that symptoms of ADHD must have been present before 12 years of age, it is particularly interesting to note that Shaw and colleagues (2006) found that cortical thickness in children with ADHD often does not resemble that of normal controls until about 12 years of age. In contrast, at least one study found that the motor cortex matured earlier in children with ADHD than in controls, which the authors proposed might result in excessive motor activity that the immature prefrontal cortex is not able to regulate effectively (Mahone & Wodka, 2008).

Beneath the cortex, numerous studies have shown that the caudate
nucleus of individuals with ADHD demonstrates the most prominently reduced volume as compared to controls (e.g., Castellanos et al., 1996, 2002; Nakao, Radua, Rubia, & Mataix-Cols, 2011). Normalization of caudate volume has been shown to be associated with increased age and stimulant treatment.

Functional imaging studies consistently show hypoactivation in the same regions that have been identified by structural imaging as demonstrating decreased volume compared to controls—especially the prefrontal cortex, anterior cingulate cortex, and basal ganglia. Perhaps even more interesting is that the default mode network—that is, brain activity at rest—is hyperactivated in individuals with ADHD (e.g., Dickstein, Bannon, Castellanos, & Milham, 2006; Castellanos et al., 2008; Castellanos, Kelly, & Milham 2009; Cortese et al., 2012; Fair et al., 2010; Sonuga-Barke & Castellanos, 2007).

A recent meta-analysis of functional imaging research in ADHD, which examined 39 pediatric studies and 16 adult studies, found largely consistent findings across ages (Cortese et al., 2012). Specifically, individuals with ADHD show hyperactivation of the default mode network, along with hyperactivation of the somatomotor and visual systems. This finding is consistent with the Fassbender and Schweitzer (2006) hypothesis that persons with ADHD compensate for impairments in prefrontal cortex and anterior cingulate cortex functioning by over-relying on brain regions associated with spatial and motoric processing, thus leading to hyperactivity and distractibility.

That same meta-analysis also found a pattern of hypoactivation in the ventral attention network, supporting another theory (Nigg & Casey, 2005) that children with ADHD have trouble detecting changes in the environment that should trigger shifts of attention to relevant objects and events. It should be noted that abnormalities in the dorsal attention network also may exist in ADHD, but functional imaging tasks tend to assess the inhibition of rapid, automatic responses associated with ventral network functioning.

**Neurobiology of ADHD: Genetics and Neurochemistry**

In the realm of genetics, studies have shown significantly higher concordance of ADHD among monozygotic twins as opposed to dizygotic twins (Hudziak & Faraone, 2010). Pooled analyses of twin studies generally estimate the heritability of ADHD at around 60-76% (Burt, 2009; Faraone & Mick, 2010; Wood & Neale, 2010). However, few genes have been identified as being associated with ADHD symptoms to date.

Commenting on the limited successes in identifying genes associated with ADHD, Durston and Konrad (2007) noted, “ADHD is a developmental disorder, and genes may be expressed differentially at different stages of development” (p. 382). Additionally, environmental factors may modulate the effects of genetics. Indeed, genetic factors aside, maternal smoking during pregnancy and low birth weight/prematurity are the two most consistently identified environmental risk factors for ADHD (Coghill & Banaschewski, 2009).

One recent study of 414 adolescents ages 13 through 15 indicated that variations in monoamine oxidase A (MAOA) genotype may be associated with ADHD symptoms in males, with one particular genotype being associated with higher levels of impulsivity and less inhibitory control (Nymberg et al., 2013). Since the MAOA gene encodes an enzyme that degrades norepinephrine, dopamine, and serotonin, this finding naturally makes one wonder about the roles of these neurochemicals in ADHD.

Research has provided some answers to such questions about the neurochemistry of ADHD, but much is still unknown. Positron emission tomography (PET) imaging has shown that adults with ADHD have fewer dopamine receptors, which is correlated with symptoms of inattention (Prince, 2008). In animal models, either too much or too little dopamine impairs prefrontal cortex functioning (Arnsten & Li, 2005). Similarly, high levels of norepinephrine in monkeys impair prefrontal cortex functioning, but moderate levels of norepinephrine promote prefrontal cortex functioning (Arnsten, Murphy, & Merchant, 2000).

These findings help explain why finding the right medication—and the right dose of that medication—for a child with ADHD is often such a difficult balancing act. Methylphenidate (e.g., Concerta, Daytrana, Ritalin) blocks the reuptake of dopamine and norepinephrine; amphetamine (e.g., Adderall) does the same and additionally promotes the release of those two neurotransmitters. The aforementioned animal studies illustrate how too high or too low of a dose of such medications may be ineffective or even detrimental to an individual with ADHD.

With the correct dose, methylphenidate has been shown to improve resting state functional connectivity between the thalamus, basal ganglia, motor cortex, and frontal lobe even in healthy adults (Farr et al., 2014), which perhaps enables the frontal lobe to better regulate attentional (thalamic) and motor (basal ganglia, motor cortex) functions. Unfortunately, research has yet to explain why “the correct dose” differs so greatly from one individual to the next, and why some children with ADHD benefit from one medication but not another.

Another unanswered question regarding the neurobiological substrates of ADHD is that of gender differences, as most existing studies are skewed toward or exclusively include males. Female brains mature earlier, and females with ADHD are more commonly diagnosed with the Predominantly Inattentive Presentation, so it is logical to assume that the neurobiology of ADHD in females may differ in some ways. Indeed, the few studies that have addressed this issue illustrate the need for further research on this topic. For example, one study found that basal ganglia volumes were decreased in males with ADHD but not in females with ADHD (Qui et al., 2009).

Finally, it is important to note that despite the rapidly increasing amount of knowledge regarding neurobiological substrates of ADHD, we are far from being able to apply this knowledge to clinical assessment. Imaging findings are sensitive but not specific, and imaging provides insufficient diagnostic accuracy and reliability. Additionally, the high cost of imaging makes it unrealistic for routine screenings. Although imaging and other such exams (e.g., genotyping) may someday be used as an adjunct to psychological and neuropsychological evaluation, the American Psychiatric Association has declared that at the present time, “the available evidence does not support the use of brain imaging for clinical diagnosis or treatment of psychiatric disorders in children and adolescents” (2005, p. 1).

**Assessment: Rating Forms**

Because there currently are no recommended biomarkers (e.g., brain imaging findings,
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For children and adolescents, the Vanderbilt Scale, ARS-IV, and BADDS enable direct ratings of ADHD symptoms by multiple reporters. Although the Vanderbilt Scale screens for oppositional behavior, rule-breaking behavior, anxiety, depression, and learning difficulties, the bulk of questions pertain to the DSM-IV-TR symptoms of ADHD. The Vanderbilt Scale and ARS-IV are free for clinical use, though the ARS-IV requires a one-time purchase of its manual. The BADDS is a fee-for-use measure of ADHD symptoms. Each rating scale shows strong correspondence with DSM-IV-TR ADHD criteria and demonstrates high diagnostic utility (Wolraich et al., 2003; Power et al., 1998). However, some clinicians argue that scales specific to ADHD symptoms prompt respondents to overly focus on such symptoms and can lead to over-pathologizing (Thomas, Mitchell, & Batstra, 2013; Harrison, Edwards, & Parker, 2007). The BASC-2, CBCL and Conners 3 are fee-for-use measures that provide indexes of ADHD symptoms as well as other psychiatric disorders, expanding the respondent's focus beyond ADHD symptoms and allowing clinicians to assess for comorbid issues that may complicate the presentation of ADHD. Of note, only two of the broad assessment measures—the BASC-2 and Conners 3—include validity scales to detect trends of excessively positive or negative responses and assess the consistency of responses to similar items.

For adults, the ASRS is a measure based on DSM-IV-TR criteria that is freely-available through the National Comorbidity Survey website. The CAARS, BAARS-IV, and BADDS also are direct measures of ADHD symptoms in adults. The CAARS and BADDS are pay-per-use, while the BAARS-IV is fee to copy and use for clinical purposes with the purchase of the manual. All four of these measures correlate strongly with ADHD diagnoses in clinical samples based on DSM-IV-TR criteria (Hines, King, & Curry, 2012; Barkley, 2011; Brown, 2001). However, few of these adult rating scales include validity indicators, though the CAARS includes an inconsistency index. Of note, only the CAARS includes an observer report, which may be helpful to corroborate the presence and functional impact of symptoms identified in self-ratings. Individuals with ADHD often have deficits in executive functions (EF), a term which refers to a set of higher-order cognitive skills needed for tasks such as working memory, planning, organization, and emotional regulation. Consequently, several behavioral measures assist the evaluation process by providing “objective” evidence of ADHD symptoms.

Table 6: RATING FORMS

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<thead>
<tr>
<th>ADHD-Specific Rating Forms:</th>
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<tbody>
<tr>
<td>• The National Institute for Children’s Health Quality (NICHQ) Vanderbilt Assessment Scale (Vanderbilt Scale; NICHQ, 2002)</td>
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<tr>
<td>• Brown Attention Deficit Disorder Scales (BADDS; Brown, 2001)</td>
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<tr>
<td>• Conners’ Adult ADHD Rating Scales (CAARS; Conners, Erhardt, &amp; Sparrow, 1998)</td>
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<tr>
<td>• Adult ADHD Self-Report Scale (ASRS; World Health Organization, 2003)</td>
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<tr>
<td>• Barkley Adult ADHD Rating Scale-Fourth Edition (BAARS-IV; Barkley, 2011).</td>
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<th>Broad Emotional/Behavioral Rating Forms:</th>
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<tr>
<td>• Behavior Assessment System for Children-Second Edition (BASC-2; Reynolds &amp; Kamphaus, 2004)</td>
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<tr>
<td>• Achenbach System of Empirically Based Assessment (ASEBA) Child Behavior Checklist (CBCL; Achenbach &amp; Rescorla, 2000)</td>
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<tr>
<td>• Conners Third Edition Rating Scales (Conners 3; Conners, 2008)</td>
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<th>Executive Function (EF) Rating Forms:</th>
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<tr>
<td>• Behavior Rating Inventory of Executive Function (BRIEF; Gioia, Isquith, Guy, &amp; Kenworthy, 2000)</td>
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<td>• Comprehensive Executive Function Inventory (CEFI; Naglieri &amp; Goldstein, 2013)</td>
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<tr>
<td>• Barkley Deficits in Executive Functioning Scale (BDEFS, Barkley, 2011)</td>
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program and the long form of the BDEFS include indicators of ADHD diagnosis likelihood. BRIEF and BDEFS norms encompass child, adolescent, and adult populations, while CEFI norms are limited to the range of 5 to 18 years of age. The BRIEF and CEFI both include indicators of unusually negative responding, and the CEFI also includes an indicator of excessively positive response patterns. Both the BRIEF and CEFI are pay-per-use measures, whereas the BDEFS is free to copy for clinical use with purchase of the manual.

As with the evaluation of any psychological condition, clinicians are cautioned to take care in collecting comprehensive data (e.g., multiple rating forms plus direct clinical measures) rather than hastily providing an ADHD diagnosis, as such a diagnosis may have profound implications for an individual. On a related note, the use of measures that include validity indicators is recommended, as the high rates of malingering in studies of college students undergoing assessment for ADHD (Jasinski et al., 2011) are not necessarily limited to that population. Adolescents and adults may be motivated by the potential to obtain stimulant medications or academic accommodations, but parents—who often serve as primary reporters for young children—may be similarly motivated to obtain certain advantages for their children by means of an ADHD diagnosis. This is just one of many reasons that when using behavioral rating scales, obtaining ratings from multiple sources (e.g., teachers, daycare workers) is the “gold standard” when assessing for ADHD. There is no single “gold standard” rating form, but the principle of obtaining multiple ratings is such an important concept that it has long been written into the DSM diagnostic criteria for ADHD—symptoms must be observed in multiple settings. Clinical observations of the individual in real-world settings also may enhance diagnostic accuracy and help resolve conflicting reports.

Indeed, there are many limitations associated with the use of behavioral rating forms, illustrating the importance of also including direct clinical measures in any ADHD evaluation. For example, ADHD rating forms have been criticized for demonstrating low sensitivity and specificity in preschool children (Wolraich et al., 2011). In general, behavioral rating forms for ADHD are highly subject to rater bias (Joyner, Silver, & Stavinoha, 2009; Koziol & Budding, 2012), suggesting that caution always is warranted when interpreting the results of such forms, with or without validity scale elevations.

Assessment: Clinical Measures
Clinical measures used in the assessment of ADHD include computerized continuous performance tests (CPT). Although numerous CPT measures are available, only the measures were selected for this discussion. Please refer to the box titled "Clinical Measures" for a listing of four selected CPT and their abbreviations. Although CPT measures are commonly used in psychological assessments to quantify sustained attention and response monitoring, existing research has raised concerns regarding the sensitivity and/or specificity of most of these measures (e.g., Gualtieri & Johnson, 2005). The publishers of all CPT measures appropriately state that these instruments should not be used in isolation to diagnose ADHD.

In addition to computerized CPT measures, several paper-and-pencil clinical measures are available to supplement the clinical assessment of attention and EF. These include, but are certainly not limited to, several of the measures listed in the box titled “Clinical Measures.” Each of these measures or their relevant subtests offers theoretical or demonstrated utility in the clinical assessment of ADHD symptoms. For example, the selective attention tasks on the TEA-Ch have been shown to be sensitive to ADHD symptoms in boys ages 6 and 16 years (Manly et al., 2001).

Clinical measures of attention and EF show some utility in psychological evaluations of ADHD. For example, some research indicates that children with ADHD who have deficits on multiple clinical measures of EF are at greater risk for academic difficulties (Biederman et al., 2004). In spite of their potential advantages, however, a few limitations of these clinical measures are worth noting. First, it can be difficult for clinicians to distinguish ADHD from commonly comorbid conditions that are associated with similar performance profiles. For example, on several measures of the D-KEFS, the performances of adults with ADHD or Specific Learning Disorder in Reading were often indistinguishable (Stern & Morris, 2013). Additionally, clinical measures of attention and EF may not capture functional outcomes in the daily environment (e.g., at work, school, etc.), which calls the external validity of these measures into question. For example, behavioral ratings of EF in adults may be more accurate than clinical measures in predicting occupational outcomes (Barkley & Murphy, 2010). More generally, given that the evaluation setting often is quite discrepant from real-world situations, clinicians should exercise caution when describing the potential relationship between performance on clinical measures and real-world levels of attention and EF.

Indeed, it is important for clinicians to keep in mind that the ecological validity of assessment methods is sometimes questionable, and differences in situational

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<td>• Conners’ Continuous Performance Test-Third Edition (CPT-3; Conners, 2014)</td>
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<tr>
<td>• Test of Variables of Attention (TOVA; Leark, Greenberg, Kindschi, Dupuy, &amp; Hughes, 2007)</td>
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<td>• Test of Everyday Attention for Children (TEA-Ch; Manly, Robertson, Anderson, &amp; Nimmo-Smith, 1998)</td>
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<td>• Trail Making Tests (TMT; Reitan, 1955)</td>
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<td>• Wisconsin Card Sorting Test (WCST; Berg, 1948)</td>
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<td>• NEPSY: A Developmental Neuropsychological Assessment for Children-Second Edition (NEPSY-II; Korkman, Kirk, &amp; Kemp, 2007) subtests</td>
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<td>• Delis-Kaplan Executive Function System (D-KEFS; Delis, Kaplan, &amp; Kramer, 2001)</td>
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variables may either inhibit or magnify the expression of ADHD symptoms. Such fluctuations are not captured by rating scales or clinical tests. For example, parents of children with ADHD are often quick to observe that their child is able to sit quietly and play video games for hours at a time, which seems inexplicable when behavioral disruption at school is the child’s norm. Considering the situational variables, this is easily explained in terms of impulse control and differences in context that may provoke or inhibit certain behaviors. There is little competition for a child’s attention that is as strong as a video game, so less stimulating stimuli—such as parent directives or homework—are ignored. In the classroom setting, provocative stimuli such as talkative peers or acts of misbehavior that draw laughs from peers may be far more stimulating and more easily capture the child’s attention than listening quietly about a subject in which the child has little inherent interest.

In summary, several limitations are important to consider with regard to both clinical and behavioral rating scales used in ADHD assessment. All behavioral rating scales are influenced by rater bias to some extent, and the face validity common among such forms makes them particularly susceptible to malingering. Furthermore, deficits detected with clinical measures of attention and EF often are not unique to ADHD, which make diagnosis particularly difficult when comorbid conditions are present. Research suggests that the utility of clinical measures in predicting environmental functioning (e.g., occupational success) may be limited. More generally, current assessment methods—both clinical and ratings-based—do not always fully capture the context- and situation-specific manifestations of ADHD symptoms, leading to questions about external and ecological validity. For example, CPT paradigms may not evoke impulsive responding in individuals with ADHD given that these tasks are often administered in distraction-limited environments in intervals shorter than the typical class period or workday. Overall, it is important for clinicians to bear these limitations in mind and to remember that the only “gold standard” for diagnosing ADHD involves careful collection of data relevant to DSM-5 diagnostic criteria, a process that does not necessarily necessitate the administration of any measures discussed in this review.

Intervention: No Magic Bullet

While pharmacological treatments are commonly relied upon as a primary method for reducing symptoms of ADHD, individuals with ADHD and their families can attest that medications do not always provide complete symptom relief or normalization of functioning. Further, parents and patients are sometimes averse to medication options for ADHD (Berger et al., 2008) and may instead wish to emphasize non-pharmacological alternatives.

In general, aside from medication, behavioral interventions have the strongest positive impact on ADHD symptoms and the clearest record of empirical support. For instance, in preschool-age children at risk for ADHD, parent training in behavior management strategies has shown strong evidence of effectiveness even relative to stimulant medication (Charach et al., 2013). A recent meta-analysis concluded that behavioral interventions have positive effects on a range of outcomes in patients with ADHD, including improving parenting effectiveness and decreasing disruptive behavior and conduct problems (Daley et al., 2014). As with medication options, normalization of functioning and complete symptom relief stemming from behavioral interventions remain elusive. Probably every psychologist who has worked with pediatric and adult patients with ADHD has witnessed treatment failures, which is frustrating for the psychologist, patient, and patient’s support system. Yet understanding the nature of the disorder and its underpinnings, along with having an appropriate mindset in terms of effort requirements and realistic treatment expectations, may help maximize treatment gains made with behavioral methods.

As reviewed above, diagnosis of ADHD is limited by imperfect assessment methods, which complicates appropriate identification of core deficits with attention, inhibitory control, and hyperactivity. Just as there is no one perfect measurement tool to conclusively identify ADHD, there is no single, perfect treatment. Owing to the existence of multiple neural contributors, the complexities of the functions purportedly underlying difficulties attributed to ADHD, and the multiple contexts in which interventions are provided, researchers have yet to provide clear and definitive guidance to clinicians with regard to best practices for non-pharmacological intervention. At the present time, science lacks the acuity to differentiate specific neural dysfunction relating to specific ADHD symptom complexes in individual patients, and this hinders intervention specific to an individual’s unique neural makeup.

A plethora of cognitive training programs claim to improve behavioral, academic, and cognitive functioning in ADHD, yet empirical support is lacking particularly in relation to generalized improvement in everyday functioning (Rapport, Orban, Koller, & Friedman, 2013). While the possibility of such training programs to improve daily performance (and not simply performance on target research measures) remains, at this time there is generally a lack of evidence to justify strong endorsement.

Intervention: Managing Symptoms & Expectations

As psychologists, both our science and our experience guide our practice, and nowhere is this on display more than when working with patients with ADHD. Central to our work is the application of evidence-based intervention paradigms, enhanced and individualized based on wisdom gained through clinical experience.

Conceptualizing symptoms of ADHD as relating to deficits in executive functions may help to individualize and refine empirically supported behavioral intervention methods as implemented with specific patients. Planning, anticipating, impulse control, adaptability to changing conditions, critical thinking with appropriate skepticism, learning from experience, and complex problem-solving are not only potential targets for intervention but also essential components of intervention. Excessively rigid adherence to a particular behavioral approach, even those that are evidence-based, may neglect important functional difficulties and comorbid conditions and symptoms experienced by an individual patient with ADHD. Critical judgment and scientific thinking are necessary to ensure that patients and/or their parents are not falling prey to the latest marketing ploys and unsupported statements of efficacy.

It is important to help patients and parents adopt an appropriate mindset with regard to treatment and treatment expectations for ADHD. We all likely have experienced the frustrated patient or parent who impatiently seeks complete normalization of functioning as a result of intervention.
Since ADHD is a developmental disorder with a clear neurobiological basis, its symptoms can require long-term management—longer than many patients or parents anticipate. Emphasizing management and accommodation of symptoms rather than "cure" is essential, especially for those patients and parents who expect a magical intervention that makes the disorder disappear with little to no effort from the patient or patient's support system. If this mindset is not corrected, such patients and parents may be less likely to consistently implement recommended behavioral management strategies and may be more likely to dismiss an otherwise appropriate intervention due to the lack of immediate benefit.

In addition to working ensure an appropriate mindset about management of the disorder and expectations for improvement, it is equally important for those working with children and adults with ADHD to recognize the necessity of ongoing support, collaboration, and flexibility as central components of treatment. In working with patients with ADHD, it can be helpful to consider oneself a “coach” or “mentor” and to help parents of children with ADHD develop a similar recognition of the need for and their role in providing ongoing support and oversight. An analogy to a sports coach can help parents better understand their role in supporting their child in managing her/his symptoms.

For example, the coach of any sports team teaches individual skills, oversees the practice of those skills, and provides feedback on the implementation of those skills. The coach takes an active role providing continuous supervision and oversight, at times being a cheerleader and at other times acting as disciplinarian. Following a period of extensive practice and preparation, the coach does not sit idly during the game itself (in this analogy, real life) and merely await the outcome. Instead, the coach continues to teach and provide real-time feedback during the game as new situations arise and as conditions of the game change. The coach is constantly looking to take advantage of a player's strengths relative to the opponent while minimizing the impact of areas of weakness. After each game, the coach provides constructive feedback, emotional support as necessary, and positive reinforcement as appropriate to keep players motivated. At times, negative consequences are used to gain positive results. Good coaches foster resilience, as it is rare that a player or team is consistently successful. Based on observations of each player's performance during the game, the coach modifies subsequent practices in order to achieve better results in the next game. Practice between games is essential—success is the result of hard work, and there are no shortcuts to becoming a successful player or team.

In managing symptoms of ADHD, "winning the game" may include desirable academic, social, emotional, and vocational outcomes—and winning is most easily accomplished with a good coach. All of the actions and traits of a good coach illustrated in the analogy above apply to those working with patients with ADHD. Whether it is a psychologist working directly with the patient, or a psychologist working with a patient's primary support system (e.g., parents, grandparents, teachers), adopting or teaching the role of coach or mentor can be quite valuable both to the patient and also to the individual who is adopting that role. The varied neurobiological bases of ADHD often make this disorder impossible to "cure" and quite difficult to manage except when taking the approach of a coach, which essentially means individualizing behavioral management strategies. This involves analyzing the individual's strengths and weaknesses (as facilitated by the assessment methods described above), structuring the individual's environment in a way that will enhance those strengths and minimize the effects of those weaknesses, providing constructive feedback, and gradually fostering the individual's increased independence in managing his or her own symptoms.

Conclusion
Psychologists working with patients with ADHD must recognize the considerable variability these patients present, which indeed is evident even in the diagnostic criteria for the disorder's three presentation types. The numerous, diverse neurobiological substrates implicated as contributing to the disorder can lead to highly variable expression of symptoms both across individuals and within a single individual across situations. Evaluation therefore should be based on extensive collection of data both within the clinical assessment setting as well as in-vivo clinical observations and/or reports from individuals regarding the patient's behavior in everyday settings (e.g., school, work). Due to the heterogeneity and varying degrees of severity of ADHD symptoms even within the same "presentation" category, intervention for this disorder—most effectively conceptualized and implemented as management of symptoms stemming from any number of known neurobiological mechanisms—therefore must be equally multifaceted.

Clearly, to ensure accurate diagnosis and effective treatment planning, psychologists must have a thorough understanding of the neurobiological and symptomatic complexity of ADHD and the subsequent need for flexible intervention strategies. Psychologists also must recognize that our role is a collaborative one, which often is more easily remembered in the context of a psychotherapy session with a depressed patient than in the context of attempting to "solve" the problematic behaviors of a patient with ADHD. Rather than attempting to "solve" such behaviors, the psychologist's approach should be to act as a coach in teaching the patient and his/her family how to manage such behaviors. Just as in therapy for any other disorder, the ultimate goal is to promote the patient's independence in taking on this management role. To effectively achieve this goal, the psychologist must address any misconceptions regarding the cause of and treatments for ADHD and must impart to patients and their families a more accurate understanding of this disorder, as described herein. Through such psychoeducation and coaching, psychologists can equip individuals with ADHD to become their own best coach to accomplish their goals.
Oftentimes psychotherapists ignore cultural issues in their work with clients. Only when our interventions backfire or fail to work may we then recognize the importance of surroundings, context, and culture. Cultural psychotherapy expands the traditional ethnicity/race model to a model that examines individuals and groups according to a broader set of variables. Martin La Roche (2013) describes cultural psychotherapy as an integrative framework that attempts to complement current psychotherapeutic approaches by emphasizing the need to consider individualistic, relational, and contextual elements not only during the psychotherapeutic process but also in the way we theorize and conduct psychotherapeutic research and in the world beyond psychotherapy. A wide variety of theories, disciplines, and models inform cultural psychotherapy. Examples of these include psychodynamic, dialectical behavior therapy, neuroscience, three-staged trauma recovery models, anthropology, economy, social psychology, and acceptance and commitment therapy. La Roche (2013) organizes these diverse ideas via a three-phased cultural therapeutic model that includes: (1) addressing basic needs and symptom reduction, (2) understanding client’s experiences, and (3) fostering empowerment.

The race and/or ethnicity of a person does not solely determine the existence of any psychological characteristic. Cultural psychotherapy identifies the need to measure cultural variables rather than to assume psychological characteristics according to the ethnicity and race of an individual. Such cultural variables include ethnicity and race, but also encompass factors such as sexual orientation, gender, disability status, socioeconomic status (SES), religious background, and discrimination experiences. Cultural psychotherapy argues that a more thorough consideration of cultural variables can increase the efficacy and effectiveness of our psychotherapeutic interventions. Indeed, professional guilds list cultural sensitivity as an ethical principle. The American Psychological Association lists as Ethical Principle D: Respect for people’s rights and dignity, in which psychologists are urged to recognize cultural issues and work to eliminate biases in their work (APA, 1992). The American Counseling Association and the Commission on Rehabilitation Counselor Certification use similar language in their ethical guidelines. Texas State Board of Examiners of Psychologists (TSBEP) has made clear that cultural sensitivity is an important component to competent practice.

La Roche and Maxie (2003) recommend 10 clinical considerations in addressing cultural differences and guide clinicians to intervene in a therapeutic manner when working with clients whose racial, ethnic, and/or cultural backgrounds are different from their own. These considerations should be adapted to the specific characteristics of each client, therapeutic relationship, and context. The considerations during specific treatment phases are as follows:

During Phase I
1. Cultural differences should be viewed as subjective, complex, and dynamic.
2. The most salient cultural differences should be addressed first.
3. Similarities should be addressed as a prelude to discussions of cultural differences.
4. The client’s level of distress and presenting problem often determine when and if cultural differences are discussed.
5. Cultural differences are addressed as assets.

During Phase II
6. It is necessary to consider the client’s cultural past and racial identity development.

During Phase III
7. Meanings and cultural differences are influenced by the psychotherapeutic relationship.
8. The clinician’s cultural competence has an impact on the way differences are addressed.

During Phase III
9. Cultural context affect the therapeutic relationship.
10. Dialogues about cultural differences can impact the cultural context.
    (La Roche & Maxie, 2003)

Therapist beliefs and attitudes toward culturally different clients play a critical role in psychotherapy. Thus, we should consistently and actively explore our feelings and thoughts (i.e., countertransference, prejudice, and ethnic biases) in providing treatment to clients from different cultural backgrounds or clients in general. While there are some dissimilarities within cultures, we should possess some basic knowledge of our clients’ unique cultural backgrounds (Sue & Sue, 2008). Over time, via education and clinical experience with diverse clients, therapists accrue specific skills, interventions, and strategies that are culturally sensitive and effective. There are a variety of outlets in which a clinician can further enhance their cultural competence. For example, reading about culturally diverse groups, seeking consultation or supervision from culturally diverse peers, or even attending different cultural events in your communities are great ways of increasing this knowledge. Others find traveling to other countries or even visiting ethnically diverse neighborhoods as likewise helpful.
TPA’s Diversity Division sponsored and facilitated a cultural diversity workshop during last year’s annual convention in which its goal was to discuss the multicultural perspectives and clinical considerations when working with diverse groups. This was just one of many cultural diversity workshops at the convention, which reflects the importance that psychologists place on the topic.

The workshop focused on clinical considerations when working with African-American, Asian, Latino, Native-American, and sexual minority clients, and featured a panel comprised of those who focus on their respective populations in research and practice. Dr. Gregory Simonsen, speaking of work with the LGBTQ population, stated that psychologists are already well versed in the skill set needed to treat this community. In many respects, people are people and similar issues of self-esteem, relationships, and dealing with life’s ups and downs will be what the LGBTQ patient is seeking. But, while these similarities exist, they are marked by sexual expression and identity differences that escalate a sense of separateness from the culture at large. When working with sexual minorities, Simonsen cautioned that while significant strides of inclusion are being made, there is still a large part of the broader culture that will actively discriminate and judge these patients. LGBTQ individuals often judge themselves as a result of upbringings marked by isolation and disconnection from friends and family. There are often religious and moral questions that impact the LGBTQ clients’ ability to engage in broader culture. A few key points to remember:

1. Get to know your patients’ view of themselves as a sexual minority and of the LGBTQ culture.
2. Know your own views of sexual minorities and the struggles they experience.
3. Don’t make assumptions about lifestyle. Ask questions.
4. Be aware of local community issues that impact your LGBTQ clients. They are aware of them.
5. Remember, this population is hoping for what we all hope for: respect, acceptance, and the freedom to build productive lives and pursue happiness. Offer this to them in session.

Dr. Lillie Haynes spoke of the clinical considerations in the treatment of African Americans. Dr. Haynes remarked about how the mere conversation of race is often cloaked in politeness and superficiality, as individuals are uncomfortable with the topic and thus actively seek to avoid stereotypes and offensiveness. What this serves, however, is only to avoid any meaningful discussion of issues relevant to cultural minorities. African Americans make up approximately 12.6% of the U.S. population, and biraciality is the fastest growing population, making cultural competency for African Americans an increasingly important area. Dr. Haynes further cautioned that simply being a member of this or any minority group does not automatically translate to cultural competency or therapeutic skills to work with other members of the minority population.

Kim Nguyen-Finn, a licensed professional counselor supervisor, spoke of culturally sensitive interventions for Asian Americans, and highlighted the commonalities and differences between various Asian groups. Differences, according to Ms. Nguyen-Finn, are also based on level of acculturation, years in the United States, and generational level. When working with Asian clients, it is important to remember that the client may have exhausted all other sources of help prior to entering counseling. Thus, the client may initially have a feeling of shame and feel “loss of face” at needing to talk to a stranger about their problems and feel unable to handle their own issues. Sensitivity to possible feelings of shame is key in building a therapeutic alliance with Asian clients. Asian clients also may stay briefly in counseling, value structure and view the therapist as in authority. Traditional counseling values of autonomy and active participation may not work as well with the Asian client. Psychotherapists working with this population should thus practice flexibility and consider solution-focused therapy.

The term Latino is preferred rather than Hispanic, according to Dr. Alfonso Mercado, who spoke of diversity among the Latino subgroups. Mexican population is by far the largest of the Latino groups, with an estimated 20 million residing in the United States. The Puerto Rican population is considered to be the second-largest Latino group, with an estimated 3 million living in the United States. Cubans are the third-largest Latino group, totaling about 1.3 million. Dominicans are considered the newer Latino immigrant groups. Central Americans are people whose countries of origin are Belize, Guatemala, El Salvador, Honduras, Nicaragua, Panama, and Costa Rica. The Spanish-speaking countries of South America consist of Argentina, Bolivia, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay, and Venezuela. Latino-specific competencies, including counselor awareness of his/her own values and biases, are key to working with this population and include an understanding of the concepts and terms of personalismo, familismo, respeto, dignidad, and orgullo. A close family connection is especially important for Latinos, as evidenced in personalismo, a cultural trait valuing and building interpersonal relationships and characteristic of a collectivist worldview. Special considerations for the practitioner include:

1. Recognize the role of spirituality and formalized religion for individual Latino clients.
2. Consider acculturation levels and migration issues.
3. Assume the “humble expert” role, especially when working with families.
4. Incorporate spirituality and traditional folk beliefs and healers when necessary.
5. Consider language proficiency and preference. Latinos may prefer to speak, and be more expressive, in Spanish.

The multigenerational, historical trauma experienced by Native Americans and its implications for counseling was addressed by Dr. Susan Gelberg. As she stated, the pursuit of cultural competency is a lifelong learning process that is never completed. What is of paramount importance for practitioners is a genuine desire to learn with people of other cultural backgrounds, as well as an understanding of the differences between Cultural Best Practices and Evidence-based Best Practices. Some of the considerations for culturally sensitive practice with Native American clients proposed by Dr. Gelberg are:

1. Assume that clients will question your cultural competence. Consider your comfort level with self-disclosure. This includes subtle forms of self-disclosure such as how the psychotherapist is dressed and the décor of the office.
2. Understand that Native Americans are generally reluctant to self-disclose; be patient in therapy.
Thank you to our 2015 Platinum Advocates for showing your commitment to being defenders of the profession of psychology.

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The Power of Storytelling

Cheryl L. Hall, Ph.D., MS PsyPharm

During the recent State Leadership Conference the power of storytelling was emphasized as a way to be more effective when delivering messages to legislators and in communicating psychological information to the public. In two separate workshops, Andy Goodman, Director of the Goodman Center and the author of Storytelling as Best Practice and Brad Fitch, CEO of the Congressional Management Foundation, educated us on how stories can capture attention, engage people, and motivate action. Research on how our brains work has demonstrated how stories are integral to decision-making and shape our views of the world. In fact, stories help us remember things better. In a study by Nisbett at the University of Michigan, 5 year-olds remembered 16 out of 21 word pairs when they were inserted into a story, but remembered many fewer when simply asked to memorize them. Studies show that stories are remembered more than data, and the introduction of a story can help assist in letting new facts in. Stories are the “engines of empathy.” As psychologists we already recognize the power of narratives with our patients in a therapeutic context. During these workshops, the essential elements of a good story and how they can help us advance our profession and our work with patients were explored. So what are the important aspects of a story?

1. Define what you want to achieve with the story (example: begin with the end in mind). For instance, I want my legislator to cosponsor or vote for this bill. I want this audience to understand more about depression and how psychologists can help. I want the public to know about barriers to mental health treatment and how they can help. I want my patient to recognize her own self-efficacy. In other words, what is your goal? How do you want the person to feel? Then start with an opening statement that hooks the listener and sets the stage. What are the stakes? An example would be, “if we don’t address this problem now, there will be prolonged and needless suffering for patients and their families.”

2. Paint the picture without holding anything back. What did you see, hear, touch, taste and smell? Make it specific, practical and graphic.

3. Describe the struggle or conflict, including aspects that are mental, philosophical, emotional and physical. “We didn’t know it would be this hard. We were up against…”

4. Discovery; surprise your listener with what you learned through the struggle and how it can impact the present and the future. Complete the sentence, “we learned that….” Detail a straightforward solution that illustrates success and joy.

5. Finish with an ending sentence that is impassioned. Have it memorized and know when to use it for the best effect. It should be the kind of “button” that makes you and your story memorable, so much so that they repeat it to others.

I started thinking about how to craft and collect stories that would help our causes. At the national level a number of issues come to mind: adding psychologists to the physician definition and halting Medicare reimbursement cuts so that seniors have access and continuity of mental health care; providing the same electronic records incentives for psychologists that are offered to other health providers to ensure integration of mental health as a crucial part of health records; and finding a permanent fix for the Sustainable Growth Rate cuts that have been delayed repeatedly, but were scheduled to take effect as a mind-boggling 37% slashing of fees to psychologists. I have used my own stories and borrowed those from colleagues to motivate legislators to take action to ensure that Medicare recipients and their families, a group that will only grow in numbers, have access to care in a timely fashion. On the state level we have filed a bill that would solidify psychologists’ role in the supervision of psychology interns. This will improve access to care and ultimately may help generate more internship sites. Stories about patients who are unable to access a prescriber with...
Innovative Practices: Integrated Care

Gregory Simonsen, Ph.D., TPA President-Elect

I recently attended the APA State leadership Conference in Washington, D.C. It was truly a fantastic experience. I had attended two years ago as the diversity delegate, and this year attended as President-Elect for TPA. Many topics are covered at this conference, from inspiring stories from psychologists around the country (such as the Healthy Workplace awards) to very practical discussions about technical hurdles that affect service delivery (e.g. Health and Behavior Codes, or the move to ICD). Perhaps the most important discussions concerned future directions of psychology as a profession and how we can educate our legislators on Capitol Hill about what we as psychologists do and how important we can be to improving the rapidly evolving health care system.

This year’s conference focused on innovation. One of the central themes is the emerging integrated health care model. APA has created a Center for Psychology and Health to help guide psychology’s participation in new health care delivery models. W. Douglas Tynan, PhD, ABPP, is associate director of this center, and the director of the integrated care initiatives being developed in the Center. He detailed some of these developments in a presentation titled “The On-ramp for Integrated Care: How to Get Started.” One of the most far-reaching changes coming as a result of the Affordable Care Act (ACA) is integrated care. It’s predicated on integrating all aspects of a patient’s mind/body care into the hands of a group of practitioners of different modalities, who then direct a patient’s care towards the goal of full health and lowered costs as a result. Traditional fee-for-service care will start to disappear in this system.

Dr. Tynan urged us to think differently about health. We must consider the similarities that we have with a physician’s office. We are attempting behavior modification and change, as are physicians. This being the case, we can work together for the benefit of the patient. Dr. Tynan discussed the triple aim of integrative care.

1. Improve the health care experience for patients.
2. Improve the health of the population as a whole.
3. Reduce health care costs.

So, you might ask, how does an integrative practice do these three things? First, by having our practices co-located, a patient has a one-stop shop. Patients see their physician, their psychologist, their nurse practitioner, and other specialists all under one roof. This improves their experience and makes things easier. Second, by working together and collaborating on a patient’s care, we are more likely to get patients to take medical advice in areas like diet, nutrition, exercise, stress reduction, diabetes, and so on. Physical and mental health disorders are often co-morbid. When we treat the whole patient at the same time, patients are healthier overall. Finally, lower costs are the result when the psychological components of health are dealt with and patients are more compliant with their health care regimens. Hospitalizations are less frequent, number of physician visits are decreased, and emergency room visits are lessened.

There is also another way that the ACA is going to use integrative practices to save costs. The ACA’s payment systems are changing to look at total patient cost; new bundled payments for integrated practices are that new form of payment. For example, in the old fee-for-service system, each physician, psychologist, hospital, lab, ER, and others all billed separately for services provided. In bundled payments, an integrated
care practice will receive a lump sum for the diagnosis a patient receives, not the services rendered. So a patient with diabetes with co-morbid depression will be allotted a lump sum of money that the integrated practice uses for this patient’s care, and divides that sum among the patient’s practitioners.

There is a new world on the horizon, and solo and small group-practice psychologists need to be positioned for it. We have a lot of opportunities ahead! While the system is in transition from fee-for-service to bundled and other forms of payment, Dr. Tynan suggests we learn and use the health and behavior CPT codes, instead of just our simple CPT codes for assessment and therapy. He also suggests that we begin relationships with the primary care practices in our area and offer our services. The ACA provides money anywhere from $5 to $17 per patient for physicians and integrated practices to manage patients, which includes screens for things like depression, other mental health disorders, obesity, tobacco use, etc. We are well suited to provide these assessments, and many physicians are not. We can sell our services to large practices and get a portion of the management fees that the ACA offers.

Another impetus for switching to bundled payments comes from insurance companies, who are quickly moving away from relationships with individual providers and increasingly demanding integrated payment modalities. Imagine an insurance company’s costs to process payments to every individual practitioner billing insurance. By contracting with larger, integrated care systems and by reimbursing for outcomes rather than services, a great deal of business costs are eliminated. If independent practitioners and small group practitioners are to stay relevant they must connect with large health practices; negotiating our services, co-locating offices for patient convenience, and proving our relevance and efficacy in helping reduce overall expenditures for keeping people healthy.

These changes are scary things for most of us, but the future is coming and we want a seat at the table. Rest assured, these changes will not happen overnight. Instead of feeling anxious about them, I encourage you to begin some dialogues with your colleagues, at your local areas associations, and with physicians who you know in your area. There is room for us all at this table, so plan to take a seat!

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The Audits are Coming (but don’t tremble)

Brian H. Stagner, Ph.D.

During the State Leadership Conference in Washington there was a day-long meeting involving Directors of Professional Affairs from several of the larger state psychological associations (SPTAs). The meeting served two purposes. First, it was a terrific opportunity to exchange information and strategies about how different groups are responding to some of the problems and challenges that commonly arise across the country. The second purpose was to update and educate the SPTAs (represented by DPAs) about APA’s efforts on our behalf in the legislature, the courtroom, and the boardroom.

There was a fair amount of discussion about audits. The most problematic audits have not penetrated markets in Texas as much as they have in other states, but we’ll be hearing more about them in the future.

What is an audit? When a psychologist contracts to provide services the contracting entity has an interest in assuring that professional standards are being met. Thus any agency or third party payor may request that you provide information to verify that you are fulfilling your contract. Psychologists face several kinds of audits.

Medical necessity audits. This encompasses the documentation one might provide when requesting authorization for additional services. Most efforts to reform and improve health care will employ these procedures. Does the provider have good evidence to support the case formulation that is being claimed? What has been tried, and what have been the results? Is it time to move to a different evidence-based treatment plan? It is legitimate to ask these questions to prevent good money chasing after bad. If these audits are deployed effectively (and not punitively) we should see better, more efficient overall outcomes.

Procedural compliance audits. These audits are most associated with Medicare and Medicaid, although in theory they could arise from any third party payor. In these situations the provider is asked to open one or more patient charts for review. Charts are judged for completeness. Was the mandated screening for mood disorders completed according to CMS standards? Is there documentation that the primary care physician has been contacted? Is there a (recent, signed) treatment plan in the chart? Is it being followed? What about those start and stop times? Does your intake predate the pre-certification? Egad.

A police officer once told me that he had a standing bet that nobody could drive two blocks without breaking the law. He had never lost – indeed half the infractions occurred before the ignition was turned because that vehicle itself was out of compliance – bad tire, fuzzy dice, etc. Now why did I think of that just then, doctor?

His point, of course, was that it is impossible to be perfect. Rather than be hung up
on operationally precise, but pickayune details, we should focus on those variables that are demonstrably mission-critical to overall outcomes. Thus these compliance audit details can be exquisitely infuriating. However, they have serious consequences. Failure of a compliance audit has led to recoupments. This is the insurance company's genteel lawyerspeak for vicious, greedy "clawbacks" in which the practitioner is forced to forfeit payments already received because notes were signed in the wrong colored ink, irrespective of the clinical outcome.

Usually recoupments occur piecemeal, but they can be disastrous for a small practice. There have been a few instances in which psychologists were faced with demands to return tens of thousands of dollars or face criminal charges.

Risk Adjustment audits? This is a new creature. It is being imposed ON the insurance companies, and it is a good thing for all of us. Furthermore, it doesn't appear to offer a major burden. Here's the context. Sometime in the next five to ten years the expectation is that a lot of health care will be reimbursed for outcomes rather than fee-for-service. Large entities (HMOs, PPOs, etc.) will be contract to provide coverage for a large population. There will be incentives to keep the subscribers healthy, and there is a dilemma for the policymakers (largely CMS). Some insurance companies have the good fortune to serve healthy people (white collar folks) while other companies may be attracting subscribers who are older or sicker. The two shouldn't be paid at the same rate if they aren't shouldering the same risk, right? So how to level the playing field?

First CMS asks insurers to self-report; to make their own representation as to how sick or healthy their subscribers are, according to some fairly detailed metrics. Policymakers want verification of these claims, so they do risk adjustment audits. In this case, the auditor pulls random names from the list of insureds and tracks ALL the health care records for those individuals. It would find, for example, that Juan Doe has received seventeen lab tests, two exploratory surgeries, a nutrition consult, several oncologist visits, two rounds of chemo, several pharmaceuticals, and eight months of CBT. Juan's HMO certainly seems to treat high risk persons. On the other hand, Gladys Jones sees her ob-gyn once per year and has a single prescription for birth control medication – a low risk person.

In these examples, the risk adjustment audit is using providers' records to audit the insurance companies. They are simply asking each provider to verify a few simple facts about the individual's overall health status. Initially the auditors will pull only a few hundred cases, so the odds of being involved in these audits will be low. It is expected that the numbers may climb in later years, however.

What should be in an audit response? The simple answer is that it depends on what's being requested. Not every request is legitimate, however. In other jurisdictions in the Midwest, psychologists have reported audit practices that seem excessive, if not persecutory. Attorney Alan Nessman, an attorney at APAs Practice Directorate (APAPO), reported on several successes negotiating with the insurance companies. One company had outsourced traditional (necessity and compliance) audits to a firm called Sante. The outsourced work was reimbursed based on successful recoupments, and Sante was evidently wielding a heavy club, resulting in numerous complaints to APAPO. After educating policymakers at several companies it appears that the most draconian of these practices will be curtailed.

While we may hope that audits will be less punitive, they are here to stay. Some audits will request the full chart, but it is more likely that the audit will be more circumscribed. In general, a summary of the chart will not be acceptable as a substitute for primary documents: the auditor wants to see records that are contemporaneous records, for obvious reasons. There is likely to be a major push to increase diagnostic precision as a first step to improve health outcomes.

In light of the shifting audit landscape, opinions vary about the record keeping that will prepare us for the eventuality of an audit. Because psychologists practice in so many different contexts, it is not feasible to develop a one-size-fits-all template for doing this. Here are several viewpoints, each with pros and cons:

1. Keep very lean audits, including only information that is likely to be specified in the audit requests to which you may be subjected. This would expedite response to the risk adjustment audits. However, lean records offer scant documentation for medical necessity audits and very little protection in the event the provider comes under legal or regulatory scrutiny.

2. Keep very rich audits. “If it's not written down it didn't happen,” is going to offer a great deal of rich documentation, provides good protections against legal problems, but is extremely time consuming. In the event of a risk adjustment audit or certain other circumscribed requests it will require a lot of effort to extract only what is requested and protect the remainder of the record.

3. Keep dual records. In theory there is nothing to prohibit keeping a separate section in the chart with only the information that might be requested in partial audits. Some have suggested that HIPPA's provision for psychotherapy notes might serve this function; keep the “audit trail” in the HIPPA notes and use the psychotherapy notes for the details of the clinical record. However, this, or other dual-record systems offer no protection whatsoever from subpoena. Thus the dual-record strategy represents greater burden with little incremental advantage for most providers.

4. Prepare for traditional audits with care, but don't worry about the risk adjustment audits for now. The latter will require that the record be searched for contemporaneous documentation of health status which will take some time. However if each insurer is going to pull only a few hundred individuals whose records are audited, the odds are very good that most of us won’t face even a single such audit in the next couple of years.

Bottom line, be ready for audits. Audits are important for the overall system to function. Develop a well-defined record system that meets the requirements of HIPPA, HITECH, the rules of the TSBEP, as well as being responsive to the concerns of the entities with whom you contract. If you are audited, make sure that the information requested is within the bounds of appropriate inquiry as established in the contracts you have signed. If you're unsure it is a good idea to consult before you comply.

Dr. Brian H. Stagner is TPAs Director of Professional Affairs (stagneraap@gmail.com).
HIPAA Compliance: Avoiding Willful Neglect (Without Trichotillomania)

Patrick Randolph, Ph.D.

Though HIPAA laws have been in place since 1996, there seems to be more bark than bite when enforcing them, especially for small behavioral health providers who fly under the radar. Where are the HIPAA Police? Are there any real vulnerabilities to mental health providers for non-compliance? Recent laws, especially those brought about by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), have not only increased penalties and tightened enforcement, but changed the fundamental methods for identifying non-compliance. With these new enforcement standards, you could be subject to a mandatory minimum fine of $10,000-$50,000. This can be instigated by an online complaint or telephone call from any number of individuals in your practice environment. HIPAA violations may affect your professional status, liability insurability and rates, zap your time and energy and hurt your professional standing. Another important implication is the psychological toll it can have on you and your clients. It’s not difficult, however, to avoid harsh mandatory penalties by simply understanding “Willful Neglect” and taking basic actions to avoid it.

The Health Insurance Portability and Accountability Act (HIPAA) sets the standards for the privacy protection of all health information and requires us to: maintain reasonable and appropriate administrative, technical and physical safeguards to insure the integrity, confidentiality and availability of health care information; protect against reasonably foreseeable threats or hazards to the security of information; and protect against unauthorized uses or disclosures of the information. These mandates are outlined in Security and Privacy Standards, which apply to certain health care providers, known as “covered entities.” Texas HB 300, which took effect in 2012, is even more restrictive than HIPAA, defining a covered entity as any who: “for commercial, financial, or professional gain, monetary fees or dues, or on a cooperative, non-profit, or pro bono basis, engages, in whole or part, and with real or constructive knowledge, in the practice of assembling, collecting, analyzing, using, evaluating, storing or transmitting protected health information.” According to Pamela D. Tyner of the Epstein Becker Green attorney group, “This revision impacts any entity that conducts business in Texas and collects, uses or stores PHI.” In other words, the times of a mental health specialist dodging HIPAA standards by claiming to be a non-covered entity in Texas are days gone by. Our compliance standards, however, are generally less stringent than those for larger covered entities. Compliance criteria is scalable and may vary based upon a specific practice. For example, a solo practitioner has much less administrative burden than that imposed on a hospital. It is essential, however, to explain in writing why an administrative standard does not apply to you and how it has been modified to fit your practice.

Fortified Enforcement and Audits

The long awaited Final Omnibus Rule has implemented the HITECH Act modifications to the Privacy Rule and other rules of HIPAA. The Final Rule, requiring compliance by September 2013, has increased coverage of HIPAA’s criminal and civil penalties. It has also granted the DHHS Office of Civil Rights (OCR) more authority and further performance requirements when conducting audits. These changes are due in part to the DHHS Inspector General’s scathing criticism for the lack of adequate HIPAA enforcement. While DHHS had the authority to conduct compliance audits, HITECH now requires audits of covered entities and business associates to insure compliance. Furthermore, state attorney generals are now authorized to bring civil actions against violators in state or federal district court, meaning disgruntled clients have an avenue for civil retribution. For example, in the case of Fuqua vs Horizon/CMS Healthcare Corp, a Texas woman was awarded 310 million for punitive damages, partially because the company involved in the case was caught hiding records. This ruling is in appeal. In most cases, breaches and other HIPAA violations are not criminal and do no serious harm to the client. DHHS attempts to resolve non-compliance issues by informal means whenever possible so that covered entities may avoid penalties altogether. Now, however, there are minimum mandatory penalties for Willful Neglect.

Willful Neglect

Willful Neglect means the “Conscious, intentional failure or reckless indifference to the obligation to comply with (HIPAA).” Violations due to willful
neglect carry a mandatory minimum penalty ranging from $10,000-$50,000, escalating to $1,500,000, depending on whether the problem was corrected within 30 days following discovery. On February 4, 2011, DHHS fined Cignet Health Center $4.3 million for HIPAA violations. The penalty was not imposed for any breach of privacy; instead, Cignet was fined $1.3 million for failing to timely respond to 41 patients’ requests to access their health information, and $3 million for refusing to cooperate with the OCR’s investigation. These penalties confirm that DHHS is intent on enforcing all aspects of HIPAA, not solely the privacy provisions. It also sends a clear warning to those inclined to be uncooperative or ignore the law.9

In a presentation to the American Society of Interventional Pain Physicians, entitled Compliance for Success: OIG and HIPAA, attorney David Vaughn stated that of all the government reported cases so far, fines ranged from $50,000 to $2.3 million.11 About half of the penalty amounts were not related to breaches, but rather to the organizations’ lack of written HIPAA policies and procedures, written risk assessments and/or HIPAA training certificates for employees. According to the American Psychological Association, “While DHHS has focused its enforcement on large entities, we are aware of some small and solo practices that have been subject to substantial penalties and/or serious enforcement actions.” Now the government seems to have less tolerance for any entity, regardless of size, lacking the fundamental elements of an effective compliance program.

Who Are the Watchdogs Now, and How Does This Affect Reported Complaints? You may think that with increased government scrutiny, most HIPAA violations are uncovered in government audits, but this is not the case. Complaints come primarily from disgruntled clients or employees.13 Joe Borich, a Kansas attorney specializing in HIPAA compliance issues, reported that DHHS is required to establish a process whereby individuals affected by a HIPAA violation may receive a percentage of any penalty or settlement collected with respect to that violation.

HIPAA Compliance (Without Trichotillomania)

Avoid Willful Neglect and Medicare Fee Reductions:
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A second bit of unfinished business is a proposed rule that would dramatically increase the payment to Medicare Fraud Whistleblowers, from a current maximum of $1000 to nearly $10 million. In addition to fueling the wrath of an already frustrated client or employee, these foreseeable dictums provide a powerful incentive for plaintiffs and their attorneys to closely monitor covered entities and business associates for HIPAA violators.

Before implementation of the Final Rule, there was no obligation for business associates to act as “watchdogs,” but now they must take action if a covered entity appears to be violating HIPAA. Covered entities are now required to scrutinize themselves, giving notice to patients and DHHS if they discover that “unsecured” Protected Health Information (PHI) has been breached, such as stolen or improperly accessed. The law stipulates, however, that HHS must be notified only if the breach poses a “significant risk of financial, reputational or other harm to the individual.” In one such case, a small hospice in northern Idaho self-reported that an unencrypted laptop computer containing unsecured PHI had been stolen from a worker’s car, which eventually resulted in them being assessed a $50,000 fine.

The risk of a reported HIPAA violation has multiplied since 2013 simply because the number of individuals required to report them has increased. While DHHS could inspect complaints at its discretion prior to 2013, they are now required to investigate them if the covered entity appears to have willfully neglected the law.

Consider this scenario: an unhappy client, co-worker or business associate lodges a HIPAA complaint against you or your organization. They are savvy enough to suggest you have engaged in Willful Neglect, or in the course of this process, it comes to light there are no policies and procedures, risk assessments, or workforce training standards. This, in turn, triggers a mandatory DHHS investigation. You could be facing an unwaivable fine, which in many cases would have been avoided altogether with some basic leg work before the complaint and minimal changes to procedure following it.

What to Do
The good news is that the risk of a mandatory DHHS investigation can be greatly reduced by:

- Implementing written policies and procedures as set forth in 45 CFR part 164, including those dealing with uses and disclosures rules; electronic security; patients’ rights; breach notification; and administrative requirements.
- Training workforce members concerning your policies and procedures and documenting the training. Texas Code 300 mandates that covered entities must provide mandatory customized employee training regarding State and Federal regulatory requirements.
- Identifying and correcting any potential HIPAA violation with documentation of such actions, including the imposition of sanctions against those who violated HIPAA.
- Re-evaluating policies and procedures periodically.
- Notifying clients and HHS of privacy breaches, if necessary.
- Cooperating with OCR during any investigation.

As the director of a behavioral health clinic in west Texas, I developed a policy and procedure manual in 1999. It had grown to be a six-inch thick, unsystematic, hit-or-miss compilation of do’s and don’ts, which had modest practical utility. Yet, when thoroughly investigating the HIPAA requirements 2 years ago, it was alarming to find I hadn’t directly addressed the 18 Administrative Safeguards required by the Security Rule; recorded a single risk assessment; or incorporated a standard workforce training program and sanction policy. Oops.

Upon consulting with colleagues, it seemed that most psychologists had unexceptional knowledge of HIPAA and the consequences for non-compliance. Our team worked over 18 months to understand and implement basic compliance requirements in our practice, which were then applied to the development of an online program. Hopefully it will help other therapists incorporate the HIPAA basics into their practices “without pulling their hair out.” Maintaining client confidentiality and privacy is a core value of our profession and thus HIPAA is natural to our ethical inclinations. The government insists that we willfully engage in the process as a work in progress, without expecting us to perfect it. Hopefully we can promote patient privacy and minimize risk by responding in the spirit of our noble profession, and taking the basic steps to avoid Willful Neglect.

* This document is not intended to provide legal advice.
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# Future of Practice in the Era of Health Care Reform

**June 12-13**  
Omni Southpark  
Austin, Texas

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**Conference Schedule**

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<td><strong>Towards Us and Us: Creating shared worlds and understandings with culturally diverse clients</strong>  - Dr. Martha Ramos Duffer</td>
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Includes three ethics and three cultural diversity PD hours!  
Register at [www.texaspsyc.org](http://www.texaspsyc.org).