

Minutes
Mid-year Meeting of the Interdivisional Healthcare Committee
Zoom Conference
Saturday, January 23, 2021
10:30 AM – 6:00 PM (Eastern Standard Time)

Participants

Rob Glueckauf – Chair, Division 22
Daniel Bruns – Division 38
Barry Nierenberg – Division 22
Eileen Chaves – Division 54
Elena Eisman – Division 31
Stephen Honor – Division 40
Ravi Prasad – Division 17
Monica Kurylo – Division 31
Traci Cipriano – Division 42 and 2021 Mid-year Meeting Archivist
Doug Tynan – Division 54
Nancy Ruddy – Division 43
Annette Kluck – Division 17
Lisa Kearney – Division 38
Scott Porter – Division 40

Barbara Ward Zimmerman –BPA Liaison
Lynn Bufka – APA Liaison
Stephen Gillaspay – APA Liaison
Erin Swedish – APA Guest
Kathryn Mueller – ACOEM Guest

I. Introduction – Rob Glueckauf
(10:30 AM – 10:40 AM)

Review of procedures and introduction of Eileen Chaves, new Division 54 representative

II. Board of Professional Affairs: Update on Expanded Mission and Engagement Strategies – Barbara Ward-Zimmerman and Lynn Bufka
(10:40 AM – 11:00 AM)

BPA wants to foster communication between the IHC and BPA. Reviewed BPA mission and asked IHC to think about how both can collaborate more proactively and effectively.

Changes have been occurring in BPA. Since the sunset of CAPP in June 2019, BPA has expanded beyond its original mission on science and academia. BPA is now integrating practice issues formerly addressed by CAPP.

BPA is the strategy leader for practice within APA. IHC can help inform strategy and recommend people for slating.

BPA goals include: Policy development and implementation, practice innovation and applications (identifying needs, challenges & gaps), value promotion, workforce development and advocacy for the profession of psychology.

Addressed BPA's role within APA governance and where BPA fits in relation to other APA groups. BPA is connected to the APA Practice divisions, SPTA's, Committee of State Leaders, External Organizations, Measurement Based Care/MBHR Advocacy Committee, the CPH Advisory Steering Committee, and the Healthcare Finance Advisory Group.

BPA closely monitors emerging issues and works with these communities to advance policy within Council.

Practice Priorities:

- Strengthening APAs standing as and authoritative voice for psychology.
- Prepare discipline for the future
- Utilize psychology to make a positive impact on critical societal issues
- Elevate public understanding of, regard for, and use of psychology

Goals further include:

- Psychologists becoming the national leader of evidence-based care,
- Ensuring strong SPTAs,
- Equipping psychologists to become leaders and specialists in MH/BH care and population health; decreasing disparities,
- Promote clinical operational and financial models and policies to further the viability of the profession and access to services

BPA wants to enhance the bi-directional communication between BPA and IHC.

Asks IHC to consider:

How can BPA be helpful? Are there policy issues that IHC wants addressed this year? Are there any agenda items BPA can help IHC navigate through the APA governance process, including APA Council? What ways can the Practice Directorate & BPA be helpful to the work being done by IHC? Think about ways to work more actively together.

III. Inter-Professional Collaboration on AMA Guides to Impairment Evaluation: Current Developments and Next Steps – Dan Bruns, Kathryn Mueller, Stephen Gillaspay, Toni Vincent and Rob Glueckauf
(11:00 AM – 1:30 PM)

ACOEM is an advocate of the biopsychosocial model which undergirded the development of a strong linkage between ACOEM and APA/IHC, and has led to some significant projects over the years.

2018 – APA, ACOEM and IHC began thinking about focusing on function. 2019 – Focus on Function Symposium with NIOSH (CDC). Many medical specialty groups insurers, medical societies, business, software companies participated. A joint statement between APA ACOEM and NIOSH was published in 2020 addressing advocacy for a focus on function. Recently this work evolved into a collaboration with the AMA.

The Guides to Impairment, a physician reference work, are published by the AMA. AMA asked APA to help improve the Guides by reviewing the measures included for psychometric rigor and make recommendations for measurement. Mueller, Hudson, Bruns (2020) article asserted functional measures should be used when evaluating impairment and advocated for embedding measures of functional assessment in all electronic health records. Next step is to recommend measures. The question is, “How might we do this?” Once this work is completed, APA will circle back to other groups, including NIOSH and CDC. If all in agreement, can make it happen.

How can the IHC and APA help to revise this work?

Stephen Gillaspay shared APA’s perspective. This project ties into and overlays with the APA strategic plan.

Guiding principal: Building on a foundation of science. Ensure that the best available psychological science informs policies, programs, products and services.

Operating principal: Make an impact. Focus on efforts with the scale and scope to significantly advance the interests of the public, the field, and psychology professionals.

Strategic goals and objectives:

Utilize psychology to make a positive impact on critical societal issues

Elevate public understanding of, regard for, and use of psychology

Elevate psychology’s voice, and APA’s standing as an authoritative voice for psychology

These strategic objectives form the impetus of the APA – ACOEM collaborative agreement.

Dan Bruns provided an overview of the AMA Guides to Permanent Impairment, an important reference work for the AMA.

Example of use of AMA Guides: A person has a medical condition and does not fully recover. How do we measure degree of functional decline/impairment? This is the

universal system in the US, and is also recognized internationally, for rating impairment on a scale of 0-100%. This is how we quantify functional impairment.

Part of this evaluation: What is the patient's perception of their impairment? How does it impact life, work, activities? This involves psychological measurement. AMA did not quantify this aspect of measurement well. Looking for ways to quantify function that will contribute to this evaluation process.

This project can change the entire process by which impairment/disability/function is quantified.

Kathryn Mueller provided an overview of how this rating system operates and what ACOEM is trying to accomplish. (Dr. Mueller was one of the editors of the AMA Guides, provides workshops, an expert on how this system works.) She reviewed Patient Reported Outcome Measures (PROMs) & the 6th Edition of the Guides. The Guides will now be digital, which allows changes to be made in real time.

The IHC will initially focus on Chapter 17 of the Guides focusing on the spine and pelvis. There is a mental health chapter, which is being addressed by a psychologist outside the IHC. The Guides are used in many countries, used in the workers compensation system, and used in personal injury cases - litigation/settlement. When using the Guides to rate functional impairment, physicians are providing a % representing an individual's function impairment, as compared to an unimpaired individual. This allows for a medically correct % of functional impairment for individuals.

Criticism: the ratings reflect primarily focus on a medical assessment and do not include robust assessment of the impact of a specific impairment on an individual's life (I.e., same injury in a rock climber vs casual walker)

Multiple high quality studies using Patient Reported Outcome Measures (PROMs) are available for the most common procedures and conditions in the Guides. These studies generally use the most common PROMs available and would be more familiar to doctors.

In order to reflect current practice, we must review and update the recommendations for PROMs. *Only functional PROMs (fPROMs) will be used.

Measures currently in the Guides were not screened for psychometrics or usability, which is the next step (IHC Division 38 representative, Dan Bruns, is leading this initiative and asks the IHC division representatives and liaisons for their assistance)

Process for addressing functional impairment:

- Diagnosis
- Assess current function
- Revise treatment and set outcome goals

- Review progress and patient function status at follow-up

6th Ed of the Guides includes a Function Component - Includes self-assessment tools, but unclear if they assess the right things or if they are valid.

Guides encourage the provider to look critically at the measurement tool (e.g., does the patient over-report or under-report) If yes, ignore the tool and use own history for patients. Tools are optional in terms of how you decide to use them.

Self-assessment tools need to better reflect individual patient function and response to injury. Requires empirical evaluation through office exam

Basic setup (Chart):

Severity grade (%)

- 1 - History of clinical presentation
- 2 - Physical Exam or physical findings
- 3 - Clinical studies or objective test results

No function rating here. Patients are assigned a class based on one of three things as the key finding. Can move up or down between classes of impairment rating and severity grade based on three things: 1) History of clinical presentation; 2) Function; and 3) Clinical studies of objective tests.

How are classes determined? Using the three domains above. Move around between classes based on what you have left; whatever was not the key factor. In each table, one domain will be listed as the definitive criteria (i.e., physical exam, medical test, and history).

Kathryn reviewed how to get physical finding ratings with ratings within a diagnosis (herniated disk). History and clinical presentation may be the key finding that puts a person in a class. If something is used in definition cannot be used to move around the numbers. Have to rely on function instead.

Function is not a key category, but it is a key number assigned within a diagnostic category and changes the overall rating up and down, based on level of impairment and interfere with normal activities.

ADLs and IADLs

If a person has several problems in these areas, it will probably not get a rating because it so severe. Majority of ratings are in IADLs (Instrumental Activities in Daily Living). Question for provider: Did what happened affect this particular individual in some way more than someone else? Based on age, activities and activity level?

There is movement toward evaluating QoL because of complaints that if only look from medical point of view, we are not taking into account more broadly the impact of the impairment on the patient.

Advantages and disadvantages of fPROMs:

- Need to reflect patient opinion of their function
- Can be weighed against high quality studies on same condition to compare with population results. ...is the impact the same for this person as it is for someone else with similar treatment?
- Not available in most EHRs. Some MDs already track function on their own
- Many PROMs available, but only some are widely used
- Foundation for evidence-based research
- Required for opioid therapy
- Clinical registries

Need to consider: medical record, physical exam, therapy notes, job duties

If we establish the fPROMs, we just need to sell it to MDs, but if too many in EHR, will not be used. Fewer choice of fPROMs will increase use.

Dan Bruns highlighted the complexity in quantifying what psychologists do. Showed the Committee a book, *Clinimetrics*, which establishes a system addressing how to quantify complicated presentations. How to quantify a purely biological condition, i.e., carpal tunnel? How does that impact your life?

How the guides calculate a rating:

- Clinical presentation
- Physical exam findings
- Objective test results

... all feed into class and percent of impairment ...

- Modified by patients' reported function assessment – bringing patients' perspective into the rating and determination of whether patients is disabled.

Question for IHC: Can we identify measures that will do this, and provide a description of how they will be used?

Our task: Identify measures, report on how used, how scored, and what the scores mean. We will be writing a description for 4 chapters and creating items for an appendix. The 4 chapters are:

- Spine and pelvis (this is the first chapter to be reviewed)
- Upper extremities
- Lower extremities

- Chronic pain

Test case: Spine and Pelvis Chapter 17 of the AMA Guides. Looking at a measure of how a person has been impacted by a spinal condition. Want a measure that can put people in different categories, i.e., better than average or worse than average.

Can we quantify? Psychosocial perspective—is the person doing better or worse than average?

What type of measures?

Measures are only valid for a specific purpose, for example:

- Legally defensible – What is the evidence?

Frye standard –Standard used by some state courts. The theory or technique is generally accepted by the scientific community. Test selection criteria: what is commonly used in RCTs?

Daubert rule – Standard used by federal courts and many state courts. Has the measure been evaluated for reliability and validity? Does it have a known error rate? Are there standards controlling how it is administered, scored, and used, and by whom? Has it been subjected to peer review and publication? Is it widely accepted by scientific community (or other experts who are not scientists)?

- Clinically practical: Total time of administration, scoring, interpretation, and reporting is less than 12 minutes

- Evidence of validity: Does it measure what it is supposed to measure?

- Evidence of reliability: Does it provide consistent results?

- Evidence of fairness/lack of bias (i.e., race, gender)

Existing measures in Guides – no uniformity in measures or type of fPROM used, for instance,

- pain interference,
- pain interference + physical function
- pain intensity+ symptoms +physical function

AMA question for APA: How good are these tools and is there something better? For example: Pain disability Questionnaire, Strengths and weaknesses

Strengths

- Transdiagnostic measure

- Assess broad range of concerns (How does pain affect physical, social and psych function)

Weaknesses

- Pain interference assumes pain is the dominant symptom
- Every item about pain, which is a subjective symptom
- Does not assess fitness or degree to which pain stops reduces function

How do we define function? It is surprisingly complicated, and includes: Physical, pain, cognitive, social, quality of life, relationships, global function, emotional components.

Definitions of Function:

- Clinical/theoretical (WHO International Classification of Functioning)
- Psychometric/mathematical (COSMIN)

Function across ADLs:

Basic ADL's - Necessary for survival and minimal

Instrumental ADL's - Allow independent living

Advanced ADL's - Demand high cognitive function

Difficult to create a scale that reflects ADLs, IADLs and AADLs

Some items measuring function do not correlate at all ("0") with other types (i.e., ability to manage finances and ability to grocery shop)

Some items on WHODAS covary while some do not correlate ("0")

COSMIN: a mathematical approach. Very ambitious, sets very high standards. Takes some medical tests that are highly precise, but tries to apply them to more subjective function outcome measures. Measures function as unidimensional latent variable. First study defines the instrument... need to ask: Were patients involved in defining patient perspective? Is it culturally sensitive?

COSMIN recommendations for measures:

- Content validity – Is it comprehensive and comprehensible?
- Unidimensionality - Does it represent a target construct and is it easy to understand?
- Construct validity - Do the items create a continuum?

How to select measures for further review (Content and Construct Validity):

- What does this measure do?
- What is the content of the items it is assessing?
- How well does it do what it purports to do?

Frye standard: What do RCTs Use? Many RCTs use diagnosis-specific measures. Shortcomings with this approach—takes focus off person; narrowly defined. Also the needs of the Guides are different from RCTs. Rating impairment and impact on life (Guides) is different from simply measuring change (RCTs)

With diagnosis-specific measures, certain conditions are left out because no measure exists to assess that condition (i.e., no measure for scoliosis. These focus on condition, not patient. *Daubert* Rule requires a systematic reviews of measures.

What types of measures are there? Categories of fPROMs: domain of interest, physical function, mental function, pain interference, global health composite score, quality of life

Type of scale: Condition specific vs Transdiagnostic (Oswestry Low Back Pain Disability Scale vs. Brief Pain Inventory Interference Scale)

Unidimensional vs multidimensional (PROMIS 8 physical function scale vs PROMIS 27 Global function scale)

Multidimensional measures of function - Is function one thing or many? Sf 36, PROMISE 27 – too long and impractical.

Unidimensional scales are “vertical”. Rand function Items. Go from low to high. Measure one aspect. Do not look at mood or anything psychosocial. Measures of physical function are valuable but do not reflect whole person. Can have role in EHRs, but may be too limited if want to look at whole person.

What about global measures? How many problem areas are there? Don't look at a scale but look at regression equations to come up with a composite score. Use factor analysis to come up with composite scores for multidimensional factors based on unidimensional scales. Two areas of measurement: How do you perceive yourself doing physically and mentally in your world?

Excluded measures: Those that have not addressed standardization issues regularly and recently (e.g., Oswestry - growing number of modified versions, no standardization, nonequivalent versions with different factor structures, copyright violations – major studies ended up using tests that are not the original test. Cannot use the standardization cutoff scores. Psychometrics were not considered when conducting major studies. Sometimes don't know what versions were being used within a study. Standardization issues need to be addressed and psychologists are positioned to do this.

Reasons for exclusion: Lack of standardization, high cost of software, too long or complex to interpret, too narrow and limited in scope of assessment.

Global Candidate Measures:

- VR-12 (Veterans Rand 12): 2 global measures – physical and mental health
- PROMIS 10 Global: 2 global measures physical and mental health
- WHODAS: One scale, 2 factor scores

Unidimensional Candidate Measures:

- Brief Pain Inventory
- PROMIS Pain inventory Scale
- Rand 36
- PROMIS 6/8/10 Physical Function
- Pain Disability Questionnaire

*Note: with exception of pain interference measures, all of these measures are transdiagnostic and could be used for any chapter for any condition, because focus is on patient and function tasks, not the disease

Next Steps: Have raters review fPROMs and pertinent background and psychometric articles and respond to questions. At least 2 reviewers per test. Training session in advance. Information will be tabulated and presented. Reviewers will be listed as contributors.

Rating process basic areas: scale demographics, content validity, evidence of construct validity, norms and scoring, fairness/ bias/ cultural issues?

General psychometrics: Test-retest reliability, Norm groups, Fairness – race/gender/etc., Patient-centered

Content Validity: What does scale measure? Too difficult to say “Does it assess mostly instrumental or advanced ADLs?” PROMIS 4 and PROMIS 10 both have substantial evidence of validity, however PROMIS 4 all items are about physical function and all are basic ADLs. PROMIS 10 global - all items reference physical function, pain, mood, cognition, energy, social function – may have 1 or 2 items in a whole bunch of categories

Construct Validity: Correlations with gold standards, Group comparisons i.e., healthy vs disabled, Sensitivity/Specificity (ROC), Unidimensional? Sound studies or weak studies?

Other types of Questions – Efficiency of Administration, How many words in the test? Some are more verbose and confusing. General Impressions of Test- Impressive or weak? Overall opinion. General description of measure. Content – what is being

tapped into w measurement? Does it work well (construct validity) What are the Norm groups? Look Fair?

Also discussed considering translation to other specialty areas, such as diabetes, and making recommendations.

Dan and Kathryn are seeking self-nominations to review measures and make recommendations.

Looking at short measures. Try to match which is the best measure for this purpose

Lunch Break

(1:30 PM – 2:30 PM)

IV. Collaborative Care Legislation: Implications for Psychological Practice in Integrated Care – Doug Tynan

(2:30 PM – 3:00 PM)

American Psychiatric Association to years ago developed model legislation, federal as well as for all 50 states. Collaborative care bill drafted for each state, with goal to submit in all state legislatures in 2019. Preamble states the only way to provide evidence-based care is through the collaborative model and defines the model with central role of psychiatrist reviewing cases, social worker or NP managing cases. Codifies collaborative care model and insurance reimbursement of the first 3 codes—for psychiatrist, NP or psychiatric PA (all prescribers).

Delaware – added what they wanted to the proposed state legislation, including a 4th code that psychologists can use to bill, as well as H&B codes and screening codes. Psychologists in Delaware not fighting the bill, but moving it toward inclusion of psychologists.

Doug suggests SPTAs follow Delaware's lead and add to what is already there (proposed collaborative care model language), instead of reinventing the wheel. AIMS Center – University of Washington, where collaborative care was invented. They recommend including psychotherapy codes, consulting psychiatric codes, brief intervention referral for treatment for substance abuse, all screening codes, all 4 collaborative care codes, and suggest billing H&B codes, while referencing American Psychological Association. AIMS recommendation does not exclude psychologists. Recommendation from Doug Tynan is to expand on existing legislation and use the AIMS Center document for support. Asking APA to come up with a set of guidelines for how to move forward, recommending this approach.

Stephen Gillaspay reported APA is doing what Doug suggested. Since the time of a pre-pandemic discussion between Stephen and Doug, APA has been partnering with states as this comes up, taking what psychiatry is proposing and adding in support codes, screening codes, behavior codes. SPTAs are messaging through DPA's and CESSPA.

Each state wants to do things a little differently, but APA is positioned to provide support and help SPTA's partner with psychiatry.

Doug reports that state insurance commissioners can require insurers to pay for codes, without the need for state legislation. There needs to be an emphasis on the role of non-physicians in healthcare.

V. APA Office of Health Care Financing: Medicare Changes and Coding Updates –
Stephen Gillaspay
(3:00 PM – 3:30 PM)

Changes to physician E&M codes to go into effect in 2021. Need to maintain budget neutrality so Medicare will make reductions in one area to make room for new areas. Since 2019 APA has been advocating for psychologist reimbursement. Rumors that CMS would reduce conversion factor from \$36 to \$32, in an approx. 11% decrease. APA advocating against this.

Big effort. CMS proposing to increase values for E&M codes, and also asks—Should there be other codes which values should be raised because they were E&M-like? APA advocated for increase in psychotherapy codes, Health Behavior and Intervention codes. As well as psych testing and neuropsychology testing. Final rule/result: CMS said will raise value for psychotherapy but not for other codes. Cannot waive budget neutrality, so conversion factor will decrease to \$32. Only congress can change neutrality provision.

APA continues to advocate to congress and CMS. Working with a large coalition of physician and non-physician providers, including radiologists. Some of the last-minute legislation passed Dec 27, 2020 (passed senate, congress, Trump eventually signed) had a provision to address those reductions in the conversion factor. Proposed increase conversion factor by 3.5%. As a result, conversion factor will drop to \$34.89. Increase in Medicare for psychotherapy codes, with psych testing and other codes seeing small decreases. Will continue to advocate for not reducing any of the values, in end, huge reduction has been greatly diminished.

Telehealth advocacy with CMS regarding proposed rule; all psychotherapy and testing can be done by telehealth, incl audio-only, made possible by public health emergency and emergency waivers (COVID). Before could not do telehealth for neuropsychological testing. CMS created temporary list of codes that would allow billing during public health emergency through end of calendar year in which the Public Health Emergency ends. APA goal is to get psych testing and neuropsychological testing on those codes. APA can then make the case to continue these codes with empirical evidence. Psychological testing and neuropsychological testing will be reimbursed until the end of this year via telehealth.

APA is advocating to do away with originating site restriction in telehealth – passed. Site restriction will be waived. No need to go to clinic for telehealth, can receive in own home. CMS will have to create rules around it. There will be a comment period in which APA will be involved. Focused on mental health, so concern will only focus on therapy and not H&B assessment and intervention.

APA advocating for several bills. Telehealth audio and video. Huge benefit to some populations to access telehealth through audio only. Will need congressional action to allow audio-only after public health emergency passes.

IOPC – brings together neuropsychology groups – useful website pulls together guidelines for psychological and neuropsychological testing during PH emergency/telehealth.

37 SPTAs submitted letters to CMS, had almost 10k letters submitted. Goal next year to get divisions to submit letters as well. Also wants to partner with SPTAs and Divisions to advocate and educate about the relevance of CMS reimbursement to commercial insurance reimbursement.

Psychology & neuropsychology testing billing and paying guide – Goal to work with payors to get them to adopt billing and paying guide for testing. Initiated a contract with a consultant to get APA to the table with big insurers to discuss this.

Guidance needs to be updated every year. APA plans to continue working in this area to influence the regulations that are adopted.

Stephen wants to reach out to division presidents and IHC liaisons for support in next round of letters to congress and CMS. Stephen will follow up with complete letter, so all that has to be done by division is “review it, bless it and send it”.

VI. Center for Psychology and Health: Strategic Initiatives in Healthcare Financing, Integrated Care and Telehealth Advocacy – Erin Swedish and Stephen Gillaspy
(3:30 PM – 4:00 PM)

Erin Swedish. – Projects at APA related to integrated primary care and Center for Psychology and Health and Center for Psychology and Health Healthcare Financing.

- Psychologists in integrated primary care: Psychologists play a crucial role. APA needs to organize and develop plan around reimbursement, as well as respond to psychiatry’s collaborative care model. APA wants to create a space for psychologists in integrated care. Stephen has spoken to with American Psychiatric Association discussing options for possible codes and to make sure these codes are based on data.

- Stephen and Erin formed the IPC Advisory Group to collaborate with Center for Psychology and Health to address issues specific to behavior health in primary care. Model articulation, payment structures, reimbursement, including non-face-to-face work. Reached out to key divisions, BPA, CRH at APA, to submit 2-3 nominees. Want to be inclusive, diverse, reaching relevant groups. Have 30 nominations. Selected 15 members, with eye toward diverse backgrounds regarding practice setting, practice population, and career state. Two-year working group will meet monthly initially. First call this coming Monday.

Made a conscious effort to focus on early and mid-career folks; seeking to get new people involved in process.

Advisory Committee on Colleague Assistance (ACCA) – APA committee rooted in Legal and Ethical issues. Focuses on self-care and wellness for psychologists. Working with committee to report a series of self-care and wellness articles in practice update. Reconceptualizing self-care from individual to organizational and leadership responsibility.

Working on the Revision of the healthcare delivery guidelines. Designed to assist psychologists and other healthcare providers on understanding the role and responsibilities of psychologists.

Obesity Care Advocacy Network – Erin Swedish and Laurel Stine are members of group working on legislation for access to obesity codes in Medicare legislation.

Primary care Collaborative – Erin Swedish and Stephen Gillaspay are members of group pushing for alternative payment models in primary care, with focus on behavioral health. Workgroup on mental health and digital platforms.

Increasing involvement in sickle cell disease coalition.

Creating project plan for promoting psychologist medical staff privileges.

Hopes to develop a project plan for addressing alternative payment models, changes in reimbursement and healthcare climate overall.

Vail Wright's group is focused on digital therapeutics, collaborating with Stephen Gillaspay's group.

Telehealth advocacy continues.

Pain management workshop. Bruns, Prasad, Kelly. Piloted at Ohio Psych Assoc. PLC last year. With COVID, everything went on a hiatus. Plan is for APA to give it to the states. Videotape the 6-hour training. Give it away to state associations in 2021,

partnership and let states take the lead. Use at their annual conventions. Opportunity for collaboration with state associations.

VII. State, Provincial and Territorial Psychological Association (SPTA) Updates: Preserving the Viability of SPTAs and Health Care Advocacy for Psychological Practice – Elena Eisman

(4:15 PM – 4:45 PM)

CESSPA surveyed SPTAs Fall 2020 to see how they were doing. Most doing okay. Struggling with Convention income. Virtual conventions seemed to do okay. Smaller SPTAs and those that did not go virtual were struggling. Since dues were in January, membership income was there for 2020.

This year (2021) is a greater concern. Unclear how psychology community is doing. Some doing very well, some struggling, especially independent practitioners. Will solicit creative ways for doing CE's and fundraising. Collaboration between APA and SPTAs is crucial, especially this year, for survival of SPTAs in every state and province.

Pain management workshop viewed as a way for workforce development being spread quickly throughout the country, and also collaboration between APA and SPTAs. APA good at advocating at national level, but some lost in translation at state level. Striking disparities in telehealth reimbursement across states.

Questions have arisen about different platforms and how safe they are, some rumor mills needed to be educated and redirected.

Issue of whether psychologists can be included in first round of vaccinations as healthcare workers. A focus of Div31 is ensuring SPTAs remain healthy and closely aligned with APA. Varies across states. Important to have SPTAs and states remain in sync and implement federal policies at state level.

VIII. IHC Division-Specific Reports and 2021 Annual Meeting – IHC representatives
(4:45 PM – 6:00 PM)

**IHC Representatives and Liaisons
2020-2021**

Division 17 – Counseling Psychology

Ravi Prasad, Ph.D.

Annette Kluck, Ph.D.

Division 17 focused on social justice, creating an emergency fund for students, large international group within division with advocacy around Trump exec orders. Despite multiple black psychologists on ballots, none elected. Hiring outside consultant to help address why a division that cares about DE&I, it does not seem to be playing out in elections. Equity in 2020 broadly.

Division 22 – Rehabilitation Psychology

Barry Nierenberg, Ph.D., ABPP

Rob Glueckauf, Ph.D.

- Increasing concern about healthcare inequities, especially around COVID-19, and rationing care for COVID as hospitals become full. Trying to pull together advocacy organized response.
- Stresses on frontline hospital care workers dealing with COVID. Also, dealing with long-haulers who are experiencing symptoms long after test negative.
- New York State is limiting CE credit only to providers that are accredited by them. All members from New York State are unable to get any CE credit.

Division 31 – State, Provincial and Territorial Psychological Association Affairs

Elena Eisman, Ph.D.

Monica Kurylo, Ph.D., ABPP

In addition to Elena's report above, in general the division is focused on reinforcing need for APA to continue to attend to state practitioner issues

Division 38 – Health Psychology

Daniel Bruns, Psy.D.

Lisa Kearney, Ph.D.

Last 4 years revealed a great deal of racial tension. Division 38 organizational chart did not have any language reflecting commitment to DE&I. Dan recommended amending charter to include language, as well as a diversity officer on the executive board. Recommended a temporary position should be put in place with an appointed person, whose tenure would expire with the election of a diversity officer whose tasks will include monitoring Division 38 website (i.e., do the images on website reflect diversity?). Membership was surveyed to gain understanding of what their needs are – practical resources, more CEU opportunities with 4 main content areas: 1) healthcare disparities and diversity; 2) special ethical focus on health psychology, 3) practical practice management, 4) how to reach special populations in rural areas. Partnering with Division 31 to offer free CEUs.

Division 40 – Clinical Neuropsychology

Steve Honor, PhD

Scott Porter, Ph.D.

NY behind the times regarding CE regulations. Organizations that want to provide CE's need to register with NYS and pay the state, somewhere around \$900. Division 40 wants to do more to help public understand what neuropsychologists do and how a neuropsychological evaluation differs from a psychological evaluation. There are also

issues around reimbursement and how to define services, as they do not fit neatly under behavioral health. In addition, NY Workmen's Compensation Board in response to the pandemic has been changing codes and regulations, creating a great deal of confusion for neuropsychologists, with bills being rejected for a new code. Group therapy no longer included (by accident), so brain injury patients getting their bills rejected. Steve advocated successfully for re-inclusion of group therapy in codes.

Teletesting – research occurring re validity, which is important both in terms of patient care and forensic context. Sports concussion issues and advocacy have taken a back seat to COVID.

Division 42 - Psychologists in Independent Practice

Traci Cipriano, J.D., Ph.D.

Kevin Arnold, Ph.D.

The division has focused on supporting members during this challenging year. The pandemic has necessitated an increased focus on telehealth, which the division believes is important to continue to address going forward, as it appears to be a vehicle for increasing access to care, particularly in rural populations. The division will be participating in the APA summit to define the scope of the doctoral degree and is particularly interested protecting and differentiating the doctoral scope of practice with the pending influx of Master's level providers. The division continues to be interested in the promulgation of specialty and subspecialty certifications and wants to ensure that independent practitioner generalists who have specialized training and experience (without a particular certification) continue to be recognized as competent providers in such areas.

Division 43 – Family Psychology

Ruth Morehouse, Ph.D.

Nancy Ruddy, Ph.D.

A lot of focus on what is meant by the definition by the name of the division. There is a desire for the division to be seen as systemic as opposed to just family. Intention toward thinking about ways to use a systemic lens in ways to improve our healthcare system.

Division 54 – Pediatric Psychology

Eileen Chaves, Ph.D.

Doug Tynan, Ph.D.

Division 54 is very focused on Issues of health disparity and systemic racism. General call this summer, out of which developed many subgroups focused on DE&I innovative work. Anti-racism funding mechanism was established and invited nominations for funding for independent projects. Upcoming workshop topics include deep poverty, childhood obesity, disparities.

American Diabetes Association has a patient bill of rights, with specific demands that everyone with diabetes have their medication paid for, which Doug believes should be a goal for psychology. Many Division 54 members involved in primary pediatric integrated care. Division focuses on normal child development as well as pediatrics in general.

Meeting adjourned 6:00 PM.

APPENDIX of Acronyms

ACOEM – American College of Occupational and Environmental Medicine

ADL – Activities of Daily Living

BPA - Board of Professional Affairs

CAPP – Committee for the Advancement of Professional Practice

CDC – Centers for Disease Control and Prevention

CESSPA – Council of Executives of State, Provincial and Territorial Psychological Associations

DPA – Directors of Professional Affairs

E&M Codes – Evaluation and Management Codes

CPH – Center for Psychology and Health

EHR – Electronic Health Record

H&B – Health and Behavior

IADL's – Instrumental Activities of Daily Living

IOPC – Interorganizational Practice Committee

IHC – Interdivisional Healthcare Committee

NIOSH – National Institute for Occupational Safety and Health

PROMs – Patient Reported Outcome Measures

fPROMs – Functional Patient Reported Outcome Measures

QoL – Quality of Life

RCT – Randomized Control Trial

SPTA – State, Provincial and Territorial Psychological Associations