RESPONDENTS' OPPOSITION EXHIBIT 19-2

Date created: 2005

Psychologists Recognize Rep. Tim Murphy for Leadership on Mental Health Issues

WASHINGTON — U.S. Representative Tim Murphy (R-PA) received the American Psychological Association's (APA) Outstanding Leadership Award last night for his advocacy on behalf of psychologists and persons with mental health disorders. Rep. Murphy, one of only three psychologists in Congress, was honored at a dinner held during APA's annual State Leadership Conference.

Rep. Murphy is an active cosponsor of the Paul Wellstone Mental Health Equitable Treatment Act, which would put insurance coverage for mental health services on par with physical health services. He has promoted that bill, and other issues such as improved mental health care for veterans, through his position as co-chair of the Congressional Mental Health Caucus.

Murphy was also praised for his work ensuring that psychologists will not be restricted in the types of services they can provide to children. During discussions in 2004 about renewing the Individuals with Disabilities Education Act (IDEA), language was proposed that stipulated only physicians or those licensed through their state's health board would be able to evaluate children with learning disabilities. Psychologists in many states are licensed or certified through state agencies other than a state's health board, and the proposed IDEA language could have inadvertently limited the ability of psychologists to provide needed mental health services to children. Working with colleagues, Rep. Murphy saw that the proposed language to IDEA was removed before a final vote.

"We are extremely pleased to have strong advocates like Rep. Murphy speaking on our behalf in Congress," said Russ Newman, APA's executive director for professional practice. "His work will help ensure that psychologists can continue to provide important mental health services to children."

APA's Outstanding Leadership Award is given annually to a United States Senator or Congressman who has prominently championed the goals of professional psychology.

The American Psychological Association (APA), located in Washington, DC, is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 150,000 researchers, educators, clinicians, consultants and students. Through its divisions in 55 subfields of psychology and its affiliations with 58 state, territorial, and Canadian provincial associations, APA works to advance psychology as a science, as a profession, and as a means of promoting health, education and welfare.

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Date created: 2004

The American Psychological Association Recognizes Ten Companies' Commitment to Employee Health and Well-Being

WASHINGTON - The American Psychological Association (APA) today recognized 10 companies for their innovative programs and policies that help create psychologically healthy workplaces. APA announced the following recipients of the second annual Best Practices Honors at the Institute for Health and Productivity Management (IHPM) conference in Phoenix, Arizona:

Bank One Corporation; Columbus, OH

Donald A. Deems, III, DDS, PA; Little Rock, AR

Liberty Precision Industries; Rochester, NY

Otsuka's Furniture & Appliances, Kauai, HI

City of Albany, Oregon, Public Works Department; Albany, OR

Silverado Senior Living-Aspen Park; Salt Lake City, UT

South Carolina Bank and Trust; Orangeburg, SC

Steelscape; Kalama, WA

Sysco Food Services of New Mexico; Albuquerque, NM

VanCity Savings Credit Union; Vancouver, BC

"In this era of skyrocketing healthcare costs, corporate scandals, and increasing workplace pressures, many organizations are struggling to stem the forces that are whittling away at their employees' morale, productivity and health," says Russ Newman, Ph.D.,

J.D., APA's executive director for professional practice. "Developing programs ranging from professional and personal growth seminars to home-cooked meals, these Best Practices Honorees are setting an example by creating strong, vibrant organizational cultures that contribute to both employee health and well-being and the company's bottom line."

The Best Practices Honors is a national program that recognizes companies for innovative programs and policies that stand out for fostering a psychologically healthy workplace. Nominees for this national award were selected from the pool of more than 180 state-level Psychologically Healthy Workplace Award winners and submitted for consideration by the psychological association of the state or province in which the company is located. Following a competitive evaluation and judging process, the top ten best practices were selected for national recognition.

Since 1999, the Psychologically Healthy Workplace Award has been presented to organizations at the state level for their commitment to programs and policies that enhance the health and well-being of their employees. The award program highlights a variety of workplaces, large and small, profit and non-profit, from diverse geographical settings. Over the past five years, participation has grown to a total of 37 U.S. states and Canadian provinces.

"By developing innovative programs, this year's honorees are doing more than simply improving their own workplaces. The programs are setting a strong example for other companies about how focusing on employee health and well-being can drive organizational performance," said Sean Sullivan of the Institute for Health and Productivity Management.

Studies show that among other benefits, psychologically healthy workplace practices can increase job retention and satisfaction as well as reduce stress. The American Institute of Stress estimates that workplace stress costs U.S. industry $300 billon per year in absenteeism, turnover, diminished productivity, and direct medical, legal, and insurance fees. According to a 2004 poll by the American Psychological Association, two-thirds of men and women say work has a significant impact on their stress level, and as a result one in four has called in sick or taken a "mental health day."

For more information about the Psychologically Healthy Workplace Awards, Best Practices Honors, and APA's publication highlighting the 2004 honorees visit APAPO.

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Date created: 2005

American Psychological Association Honors Delegate Bonnie Brown for Her Commitment to Mental Health Issues

WASHINGTON — The American Psychological Association (APA) today presented West Virginia state delegate Bonnie Brown (D) its 2005 State Legislator of the Year Award for her leadership in sponsoring H.B. 4250, a law creating a presumption of good faith for court-appointed psychologists who conduct child custody evaluations.

"Good Faith Legislation protects the practice of psychology in West Virginia by allowing psychologists to assist the courts, families, and children involved in custody disputes without the fear of unnecessary litigation," Del. Brown said at the awards luncheon held during APA's annual state leadership conference.

Del. Brown's sponsorship of H.B. 4250 addressed a serious problem: custody evaluations that often put psychologists conducting them in the middle of a contentious domestic situation that could often lead to lawsuits. West Virginia, as well as several other states, are following the example set by Florida in instituting laws that stipulate psychologists have acted in good faith if the evaluations are conducted according to APA guidelines.

Del. Brown's legislation addressed such an important need that psychiatrists asked to be included in the bill as well.

" We applaud Del. Brown's support for the mental health community and her leadership in ensuring that psychologists can provide needed mental health services without the fear of unnecessary lawsuits," said Russ Newman, APA's executive director for professional practice.

Del. Brown has a long history of supporting causes important to the mental health community. She has been a strong advocate for the rights of the mentally ill and underserved in her state, and she also sponsored West Virginia's mental health parity law.

APA's State Legislator of the Year Award is given annually to a state legislator who has prominently championed the goals of professional psychology.

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Date created: 2004

American Psychological Association Honors Connecticut State Senator for His Commitment to Mental Health Care

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mini=true&url=https%3a%2f%2fwww.apa.org%2fnews%2fpress%2freleases%2f2004%2f03%2fsullivan&title=American+Psychological+Association+honors+Connecticut+State+Senator+for+his+commitment+to+mental+health+care&summary=Sullivan%25

WASHINGTON - The American Psychological Association (APA) awarded Connecticut state Senator Kevin B. Sullivan its 2004 State Legislator of the Year Award for his strong advocacy of mental health care issues and his leadership in achieving comprehensive mental health parity in Connecticut. Sen. Sullivan was honored at a luncheon during APA's annual State Leadership Conference in Washington, DC.

"State Senator Kevin Sullivan has shown strong leadership by pushing to make Connecticut the first state to broaden its law from partial parity to full parity for mental health coverage. We're delighted to present this award to someone who has worked to stop discrimination against mental health by achieving real equality in insurance coverage for his state," said Russ Newman, PhD, JD, American Psychological Association's executive director for professional practice.

Sullivan's legislative accomplishments include full parity for mental health coverage, regulation of HMO mental health benefit administrators, state capitalization of increased supportive housing and related services, creation and funding of the statewide Community Mental Health Strategies Board, greater maximization of federal Medicaid rehabilitation option funding for community mental health services, and plans for a new geriatric mental health pilot program.

Senator Sullivan represents the 5th District towns of West Hartford, Bloomfield, Burlington and Farmington. He is currently serving as President Pro Tempore of the Connecticut State Senate. In addition to his 18 years in the state legislature, Senator Sullivan is Vice President for Community and Institutional Relations at Trinity College.

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Date created: 2004

APA Psychologists Mobilize for Red Cross Response to Hurricane Charley

WASHINGTON - Psychologists from across the nation are responding to a call by the American Psychological Association to help victims of Hurricane Charley.

The mobilization comes at the request of the American Red Cross, which has a statement of understanding with APA, to send specially-trained psychologists onsite during disasters. The psychologists are part of APA's Disaster Response Network (DRN), a national pro bono network of psychologists who complete Red-Cross-sanctioned training and then volunteer assistance to relief workers, victims, and victim's families after manmade or natural disasters.

Several DRN members have already been mobilized to assist victims of Hurricane Charley. APA has been in communication with Red Cross national headquarters throughout the weekend and with DRN members regarding relief operations.

DRN members help disaster victims cope with extremely stressful and often tragic circumstances. The more than 2,000 DRN members help problem-solve, make appropriate referrals to community resources, advocate for workers' and victims' needs, and provide information. They also focus on providing general emotional support and help people marshal their own successful coping skills in often extremely stressful and tragic circumstances.

"We anticipate that psychologists will be assisting with the Red Cross relief operations throughout September," said Russ Newman, PhD, JD, APA's executive director for professional practice. "Our experience with the trauma and distress caused by disasters like Hurricane Charley has demonstrated the need for emotional, as well as physical, relief efforts. Psychologists around the country very much want to contribute to meeting that need."

DRN members have volunteered more than 12,000 days in the past 10 years (more than $5.4 million worth of psychologists' time) helping the American Red Cross.

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Date created: 2005

Psychologists Recognize Rep. Brian Baird for Leadership on Mental Health Issues

WASHINGTON — The American Psychological Association (APA) awarded U.S. Representative Brian Baird (D-WA) its Outstanding Leadership Award last night for his advocacy on behalf of psychologists and persons with mental health disorders.

Baird is a longtime supporter of the Paul Wellstone Mental Health Equitable Treatment Act, which would put insurance coverage for mental health services on par with physical health services. One of only three psychologists in Congress, Baird was honored at a dinner held during APA's annual State Leadership Conference.

Baird has also worked on behalf of veterans and their families. He has called on lawmakers and the Bush Administration to include an additional $1.3 billion in legislation funding the War in Iraq to help support benefits for returning veterans, including increased mental health care, family services, and counseling.

In 2004, Baird worked to ensure access to mental healthcare for residents of his state. When proposed changes to Medicaid regulations in his state threatened the ability of thousands with mental health disorders to receive treatment, Rep. Baird persuaded the federal agency that handles the benefit program to delay implementing the changes through 2005 while Washington's mental health program is reconfigured.

"Rep. Baird has proven time and again that he is one of psychology's strongest voices on Capitol Hill. He is working every day to remove the stigma that often surrounds mental health disorders, and to ensure that access to care is available to those who need it," said Russ Newman, APA's executive director for professional practice.

APA's Outstanding Leadership Award is given annually to a United States Senator or Congressman who has prominently championed the goals of professional psychology.

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Date created: 2006

Americans Engage in Unhealthy Behaviors to Manage Stress

New survey findings show gender differences connections between stress and unhealthy choices affect mind/body health

NEW YORK – Americans engage in unhealthy behaviors such as comfort eating, poor diet choices, smoking and inactivity to help deal with stress, according to a new national survey released today. People experiencing stress are more likely to report hypertension, anxiety or depression and obesity. In particular, women report feeling the effects of stress on their physical health more than men. The survey results seem to tie in with what research shows, that 43 percent of all adults suffer adverse health effects from stress. Given the potential health complications related to stress, it is fair to say stress certainly is a health problem in America.

The survey, conducted by the American Psychological Association (APA) in partnership with the National Women's Health Resource Center and iVillage.com, looked at how people deal with stress and its effect on mind/body health among women and men.

Comfort Eating and Poor Diet Choices

According to the survey findings, one in four Americans turns to food to help alleviate stress or deal with problems. Comfort eaters report higher levels of stress than average and exhibit higher levels of all the most common symptoms of stress, including fatigue, lack of energy, nervousness, irritability, and trouble sleeping. Comfort eaters are also more likely than the average American to experience health problems like hypertension and high cholesterol. In addition, 65 percent of comfort eaters characterize themselves as somewhat or extremely overweight and are twice as likely as the average American to be diagnosed with obesity.

> Stress levels are higher for frequent fast-food eaters. While only 13 percent of people who did not eat at a fast food restaurant in the last week are very concerned about stress, this number rises to 21 percent of among those who ate fast food meals in the past week.
>
> 31 percent of women say they are comfort eaters versus 19 percent of men.
>
> Men are more likely than women to opt for unhealthy snacks such as potato chips.

Smoking and Inactivity

People who are "very concerned" about their stress are more likely to be smokers. A quarter (27 percent) of those very concerned about their stress smoke every day, versus 19 percent of those "not at all" concerned with stress. Interestingly, forty-nine percent of single fathers and 31 percent of single mothers smoke three or more times a week. Americans who report they are "very concerned" about stress also exercise less. Roughly a third (36 percent) said they did not exercise in the last week, versus a quarter (27 percent) of those "not at all concerned" about stress.

“People who cope with long-term stress by engaging in unhealthy behaviors and lifestyle, may very well alleviate symptoms of stress in the short term, but end up creating significant health problems in the long run,” says Russ Newman, PhD, JD, executive director for professional practice, APA.

Women and Men Experience Stress Differently

Forty-seven percent of Americans say they are concerned about stress. Nearly half of Americans, especially women, parents, and people of working age, are concerned with the amount of stress in their lives. Women say stress affects them more than men do (51 percent versus 43 percent) and are more likely than men to report more things that stress them out. Women also express concern about how stress affects their lives more than men. Women dealing with stress report feelings of nervousness, wanting to cry, or lack of energy, while men talk about trouble sleeping or feeling irritable or angry. Women are more likely than men to report health problems related to stress such as hypertension, anxiety or depression and obesity.

Stress is higher among the family’s health care decision maker. Seventy-three percent of women identify themselves as the primary decision maker in the household for health issues versus 40 percent of men.

“As the health managers of their families, women disproportionately feel the effects of stress. From taking care of children to serving as the caregivers for elderly parents, the survey found that women report more stressors and greater concern for the effects that stress has on their daily lives, said Elizabeth Battaglino Cahill, executive director of the National Women’s Health Resource Center. “Unfortunately, women are not taking the necessary steps to alleviate stress and their physical health is suffering.”

Kellie Gould, Editor-in-Chief of iVillage.com said, “Consistent with the survey findings, we hear from the women who visit our site that they are under a great deal of stress and shoulder the majority of responsibility for caretaking and for being the “COO” of their household. While women may be more vocal about the stress in their lives, we feel it is important for them to understand and appropriately improve upon how they manage it.”

Stress Affects Mind/Body Health

Stress affects overall mind/body health. Adults who experience a great deal of stress rate their mental and physical health lower than adults who are not experiencing stress. People experiencing stress are more likely to report a number of specific ailments and symptoms.

- 59 percent report feeling nervous or sad
- 51 percent report symptoms of fatigue
- 56 percent report inability to sleep or sleeping too much
- 55 percent report lack of interest, motivation or energy
- 46 percent report headaches
- 48 percent report muscular tension
- 32 percent report frequent upset stomach or indigestion
- 37 percent report change in appetite
- 29 percent report feeling faint or dizzy
- 26 percent report tightness in chest
- 23 percent report change in sex drive

What’s Stressing Us Out

We have many sources of stress in our lives; stress is generally driven by work and money followed by health concerns and children.

Leading Sources of Stress

59 percent say money

59 percent say work

53 percent say health problems affecting parents or other family members

50 percent say health concerns

50 percent say nightly news or state of the world today

48 percent say health of immediate family (spouse, partner or children)

41 percent say children

Twenty-eight percent of women call money a “very significant” source of stress, versus 19 percent of men. Twenty-seven percent of women worry about the health of a spouse or child, versus 20 percent of men, and 27 percent worry about health problems affecting parents, versus 20 percent of men. Twenty-four percent of women say children are a very significant source of stress in their lives, compared to 15 percent of men.

“Everybody experiences stress,” says Newman. “The key is how effectively people deal with and manage stress. People who turn to comfort food or smoking are starting a vicious cycle. Their attempts to reduce stress can actually lead to health problems that result in increased stress."

Take the iVillage Stress Smarts Quiz (http://quiz.ivillage.com/health/tests/stressquiz.htm) and visit APA's Help Center and the National Women's Health Resource Center (http://www.healthywomen.org) for tips on managing stress.

This random-digit-dial telephone survey was designed and administered by Greenberg Quinlan Rosner. The survey reached 2,152 adults, 18 years or older. The base sample of 1,600 was supplemented with an over sample of 552 African Americans and Hispanics. The data were weighted by gender, age, race, income, education, marital status, and region to ensure an accurate reflection of the population. The sample size with these weights applied is 1,600. The survey was conducted January 12-24, 2006 and carries a margin of error of +/- 2.1 percentage points.

The American Psychological Association (APA), in Washington, DC, is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 150,000 researchers, educators, clinicians, consultants and students. Through its divisions in 53 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting health, education and human welfare.

The National Women’s Health Resource Center (NWHRC) is the leading independent health information source for women. The non-profit organization develops and distributes up-to-date and objective women’s health information based on the latest advances in medical research and practice. NWHRC believes all women should have access to the most trusted and reliable health information. Informed women are healthier women.

iVillage is “the Internet for women” and consists of several online and offline media-based properties that seek to enrich the lives of women, teenage girls and parents through the offering of unique content, community applications, tools and interactive features. The iVillage Network was the number one “women’s community site” on the Web and reaches more than 11percent of women 18+ online in the U.S. (comScore MediaMetrix, January 2006). iVillage Inc. (NASDAQ: IVIL) was established in 1995 and is headquartered in New York City.

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Top Companies Show Investing in Employee Health and Well-Being Leads to Business Success

Six U.S. organizations receive national psychologically healthy workplace awards, ten honored for best practices

WASHINGTON-- Successful organizations know that taking care of their employees is not only the right thing to do; it also makes good business sense. Some U.S. employers are already demonstrating that investing in employee health and well-being leads to business success. The American Psychological Association (APA) recognized six organizations -- El Nuevo Dia (Puerto Rico), Green Mountain Coffee Roasters (Vermont), Healthwise (Idaho), Koinonia Homes (Ohio), the Las Vegas Convention and Visitors Authority (Nevada) and YAI/National Institute for People with Disabilities Network (New York) -- for their workplace practices that promote employee health and well-being and enhance organizational performance. These companies were presented with the 2007 National Psychologically Healthy Workplace Award (PHWA) at a ceremony in Washington, D.C. on March 3.

You may view the Multimedia News Release on the PR Newswire Web site (http://www.prnewswire.com/mnr/apa/26909/) .

Combined, these six organizations report an average turnover rate of just 14 percent that trounces the national average of 40 percent as reported by the U.S. Department of Labor, Bureau of Labor Statistics. Additionally, surveys completed by the winning organizations show that only 19 percent of employees report high levels of work stress compared to 33 percent nationally.(1)

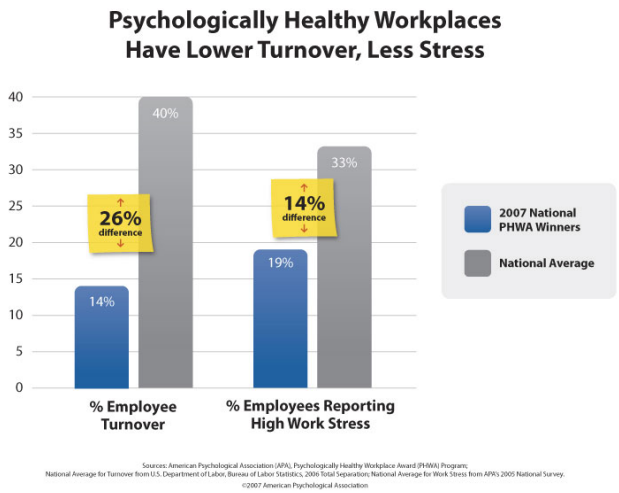
"The cost of stress to employers is huge," says Russ Newman, PhD, JD, APA executive director for professional practice. "Employers spend an estimated 300 billion dollars a year on stress-related absenteeism, turnover, lowered productivity, and direct medical, legal and insurance costs."(2)

Winners also report cost savings from their workplace practices, such as a 6.7 percent reduction in health care costs for Green Mountain Coffee Roasters and a 61 percent reduction in worker's compensation claims since 2004 for the Las Vegas Convention and Visitors Authority. YAI/NIPD's workplace practices have allowed the agency to negotiate low premiums with health plans, and costs associated with on-the-job injuries have dropped by $500,000 over the past five years.

National PHWA winners are often the employer of choice in their communities. Healthwise receives 125 to 150 applications for every job opening, giving the company an advantage in selecting the very best employees from a large pool of talent. Eighty-four percent or more of Koinonia employees say the company provides opportunities to learn new skills, gives constructive performance feedback, and

encourages teamwork and employee participation in goal setting. And when it comes to job satisfaction, El Nuevo Dia boasts an overall employee satisfaction rate of almost 90 percent.

"The link between employee health and well-being and organizational performance is clear," says Newman. "Employers who embrace that connection are better able to develop a high-performing workforce that serves as a competitive advantage in the marketplace."



Psychologically healthy workplace practices fall into five categories: employee involvement; health and safety; employee growth and development; work-life balance; and employee recognition. Employee participation in decision making, skills training and leadership development, flexible work arrangements, and programs promoting healthy lifestyle and behavior choices are just a few of the qualities that define a psychologically healthy workplace.

In addition to the National PHWA winners, ten organizations received Best Practices Honors for an innovative program or policy that contributes to a psychologically healthy work environment. The honorees are Community School (Virginia), DuBois Regional Medical Center (Pennsylvania), El Nuevo Dia (Puerto Rico), the Good Samaritan Hospital of Maryland (Maryland), the Houston Texans NFL Franchise (Texas), the Las Vegas Convention and Visitors Authority (Nevada), Next Level Cafe (Minnesota), OMNI Youth Services (Illinois), Stratix Corporation (Georgia), and Waianae Coast Comprehensive Health Center (Hawaii).

National PHWA

The Psychologically Healthy Workplace Award program has both state- and national-level components. APA's National PHWA is designed to showcase the very best from among the award winners recognized by APA's affiliated state, provincial and territorial psychological associations. Nominees are selected from a pool of previous state-level winners and evaluated on their workplace programs and policies in the areas of employee involvement, health and safety, employee growth and development, work-life balance and employee recognition. Awards are given to for-profit and not-for-profit organizations as well as government, military and educational institutions.

Best Practices Honors

The Best Practices Honors is a national recognition that highlights those state-level winners with a particularly innovative program or policy that contributes to a psychologically healthy work environment and meets the unique needs of the organization and its employees. As with the national award, nominees come from a pool of previous state-level winners and are selected through a competitive evaluation and judging process.

More information about the National PHWA winners and Best Practices honorees is available in the Press Room (/news/press) . Organizations interested in learning more about creating a psychologically healthy workplace or applying for an award in their state, province or territory can visit the Psychologically Healthy Workplace Program Web site (http://www.phwa.org/) .

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1. American Psychological Association National Survey 2005.
2. American Institute of Stress

Video: The Multimedia News Release from the PR Newswire Web site (http://www.prnewswire.com/mnr/apa/26909) .
SOURCE: American Psychological Association

Web site: The Psychologically Healthy Workplace Program (http://www.phwa.org/)

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Date created: 2007

Stress a Major Health Problem in The U.S., Warns APA

New poll shows stress on the rise, affecting health, relationships and work Americans say housing costs an added stressor in 2007

NEW YORK--One-third of Americans are living with extreme stress and nearly half of Americans (48 percent) believe that their stress has increased over the past five years. Stress is taking a toll on people — contributing to health problems, poor relationships and lost productivity at work, according to a new national survey released today by the American Psychological Association (APA).

Money and work continue as the leading causes of stress for three quarters of Americans, a dramatic increase over the 59 percent reporting the same sources of stress in 2006. The survey also found that the housing crisis is having an effect on many, with half of Americans (51 percent) citing rent or mortgage costs as sources of stress this year.

Nearly half of all Americans report that stress has a negative impact on both their personal and professional lives. About one-third (31 percent) of employed adults have difficulty managing work and family responsibilities and 35 percent cite jobs interfering with their family or personal time as a significant source of stress. Stress causes more than half of Americans (54 percent) to fight with people close to them. One in four people report that they have been alienated from a friend or family member because of stress, with 8 percent connecting stress to divorce or separation.

"Stress in America continues to escalate and is affecting every aspect of people's lives — from work to personal relationships to sleep patterns and eating habits, as well as their health," says psychologist Russ Newman, PhD, JD, APA executive director for professional practice. "We know that stress is a fact of life and some stress can have a positive impact, however, the high stress levels that many Americans report experiencing can have long-term health consequences, ranging from fatigue to obesity and heart disease."

Stress Affecting Health

Twenty-eight percent of Americans say they are managing their stress extremely well. However, many people report experiencing physical symptoms (77 percent) and psychological symptoms (73 percent) related to stress in the last month. Physical symptoms of stress include: fatigue (51 percent); headache (44 percent); upset stomach (34 percent); muscle tension (30 percent); change in appetite (23 percent), teeth grinding (17 percent); change in sex drive (15 percent); and feeling dizzy (13 percent). Psychological symptoms of stress include: experiencing irritability or anger (50 percent); feeling nervous (45 percent); lack of energy (45 percent); and feeling as though you could cry (35 percent). In addition, almost half (48 percent) of Americans report lying awake at night due to stress.

How Americans Manage Stress

While Americans deal with high levels of stress on a daily basis, the health consequences are most serious when that stress is managed poorly. Four in ten Americans (43 percent) say they overeat or eat unhealthy foods to manage stress, while one-third (36 percent) skipped a meal in the last month because of stress. Those who drink (39 percent) or smoke cigarettes (19 percent) were also more likely to engage in these unhealthy behaviors during periods of high stress. Significant numbers of Americans report watching TV for more than two hours a day (43 percent) and playing video games or surfing the Internet (39 percent). Healthy behaviors used to manage stress included: listening to music (54 percent); reading (52 percent); exercising or walking (50 percent); spending time with family and friends (40 percent); and praying (34 percent).

Motivating Factors in Lifestyle and Behavior Change

While many Americans recognize that stress has a negative impact on their health, they may lack the motivation to make lifestyle and behavior changes. Only 35 percent report that they would modify their behavior following the diagnosis of a chronic condition. Primary motivators include: a desire to feel better (60 percent); desire to reduce amount of stress (45 percent); and desire to improve self-image or self-esteem (41 percent). Encouragement from a spouse or partner would motivate 38 percent to make behavioral changes.

The Stress in America survey is part of APA's Mind/Body Health Public Education Campaign. For information on the survey or managing stress, visit APA's Help Center homepage (/helpcenter) .

Methodology

In September 2007, the American Psychological Association commissioned its annual nationwide survey to examine the state of stress across the country. The research measured attitudes and perceptions of stress among the general public, identifying leading sources of stress, common behaviors used to manage stress and the impact of stress on our lives. The survey explored appropriate and excessive stress levels; circumstances, situations and life events that cause stress; activities, resources and behaviors people use to deal with stress; and the personal costs of stress.

This survey was conducted online within the United States by Harris Interactive between August 30 and September 11, 2007, among 1,848 adults (aged 18 and over). Interviews were conducted in English and Spanish. Figures for age, sex, race/ethnicity, education, region and household income were weighted where necessary to bring them in line with their actual proportions in the population. Hispanic respondents were also weighted based on language usage. Propensity score weighting was also used to adjust for respondents' propensity to be online.

With a pure probability sample of 1,848 one could say with a 95 percent probability that the overall results would have a sampling error of +/- 2 percentage points. Sampling error for data based on sub-samples would be higher and would vary. However, that does not take other sources of error into account. This online survey is not based on a probability sample and therefore no theoretical sampling error can be calculated.

2007 Stress Poll Press Kit

The release of new national stress survey findings revealed that Americans engage in unhealthy behaviors such as comfort eating, poor diet choices, smoking and inactivity to help deal with stress. Given the potential health complications related to these behaviors, it is fair to say that stress is a mjor a health problem in America. Learn more about these findings and ways that people can take healthy steps to managing stress in their lives.

How much do you know about stress? (http://locator.apa.org/quiz/)

Stress tip sheet (/topics/stress/tips)

Stress in America report (/pubs/info/reports/2007-stress.doc) (.doc)

The American Psychological Association (APA), in Washington, DC, is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 148,000 researchers, educators, clinicians, consultants and students. Through its divisions in 54 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting human welfare.

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National Survey Reveals Hispanics Engage In Healthy Behaviors To Manage Stress More Than General Population

Concern about family health leading source of stress; women as family health managers more stressed than men

WASHINGTON -- A national survey released today reveals that Hispanics engage in healthy behaviors to manage stress, such as exercising and seeking support from family and friends, more than the general U.S. population, but that stress is still a major health concern for this group. While Hispanics cite many sources of stress in their lives, the leading source of stress — particularly for Hispanic women — is concern for the health of family members. Similar to others in the United States, money and work are also significant sources of stress for Hispanics.

See the press kit Hispanics and Stress Press Kit (/news/press/releases/2006/10/stress)

The survey, conducted by the American Psychological Association (APA) looked at how people deal with stress and its effect on mind/body health across racial and ethnic groups. The survey was released in partnership with the National Women's Health Resource Center (NWHRC) and the National Alliance for Hispanic Health. The survey was translated into Spanish, and Hispanic respondents could choose whether to take the survey in Spanish or English.

Healthy Behaviors to Manage Stress

Survey findings show that most Hispanics report spending time with family and friends (56 percent were very likely) to manage stress and 44 percent of Hispanics say they are very likely to use exercise as a way to reduce stress. Hispanics, as a group, rely less on unhealthy behaviors like smoking (8 percent) to manage stress when compared to the general population (14 percent).

"Stress is unavoidable. The key is how effectively people deal with stress," says Russ Newman, Ph.D., J.D., executive director for professional practice, APA. "Exercising and seeking support from family and friends are good examples of healthy ways to manage stress. People who are not taking proactive actions to manage stress or who are dealing with stress in unhealthy ways like smoking or eating can actually cause more health problems for themselves which leads to increased stress in the long run."

While Hispanics are more likely to report engaging in positive behaviors to manage stress, these behaviors often include sedentary practices such as listening to music (51 percent), reading (34 percent) and watching television (21 percent).

Hispanic Women as Family Health Managers More Stressed Than Men

According to national survey results released earlier this year by APA and NWHRC which looked at how stress affects the general population, it was reported that stress is higher among family health care decision makers. This is also true of Hispanics — among Hispanics who say they make household health care decisions for their family, 61 percent report feeling concerned about the level of stress in their own lives, versus 48 percent of Hispanics who share the decisions with a spouse or partner.

The health care manager's burden is disproportionately felt by Hispanic women. Nearly three-quarters (74 percent) of Hispanic women say they make the health care decisions in their family versus one-third of Hispanic men and slightly more than half of the general public (57 percent).

"Without health insurance or access to care, many Hispanic women find the stresses of being a care provider are compounded. And even when they do have health insurance they may not have access to culturally or linguistically proficient services that can deliver the kind of quality care they need for themselves and their loved ones," says Dr. Jane L. Delgado, president and chief executive officer of the National Alliance for Hispanic Health.

Hispanic women report many more health-related sources of stress in their lives than the general public, citing the health of loved ones as a "very significant" source of stress. More than a third (35 percent) of Hispanic women call the health problems affecting their spouse, partner or children a very significant source of stress (versus 24 percent of the general public), and 36 percent call health problems affecting their parents or other family members a very significant source of stress (versus 23 percent of the general public).

"So often, women are sandwiched between taking care of their children's health care needs and those of a spouse or aging parent," said Shirley Lozano Nelson, M.S.W., minority health outreach coordinator for the National Women's Health Resource Center. "This is especially true in the family-centric Hispanic community. Unfortunately, the burden of being the health care manager of their family is compounded for Hispanic women because those in the family they may turn to for help with alleviating stress might be the same family members that are causing the elevated stress levels."

Gender Differences and Stress Among Hispanics

Interestingly, Hispanic men also find family health concerns stressful and report this as a source of stress more often than the general public. One third (32 percent) of Hispanic men (compared to 23 percent of the general population) report the health of their parents as a very significant source of stress. 26 percent of Hispanic men, compared to 24 percent of the general population, mention the health of their immediate families as a very significant sources of stress. Hispanics report being concerned about stress more often than the general public (54 percent versus 47 percent).

Hispanic men and women cite differing sources of stress. Most Hispanic men tend to report that their stress comes from work (57 percent versus 28 percent who report it comes from home).
Hispanic women, on the other hand, are equally apt to say that most of their stress comes from home and work (42 percent versus 39 percent who say it comes from work).

Symptoms of stress vary between men and women in the Hispanic community. Stressed Hispanic women are more likely than men to experience symptoms of nervousness or headaches. Hispanic men and women report symptoms like irritability, trouble sleeping and muscular tension.

Access to Mental Health Care

Survey findings showed that more than a fifth (22 percent) of Hispanics are open to seeking professional mental health care, compared to just 15 percent of the general population. Though they are amenable to seeking treatment, many lack coverage for professional help. Only 41 percent of Hispanics with health insurance say they have mental health coverage, more than 20 percent less than that of the general population.

Relatively few Hispanics reported having access to mental health care. Only 41 percent of Hispanics say they have health insurance that covers mental health care, compared to 65 percent of whites and 63 percent of African-Americans. More than one-third (39 percent) of Hispanics report being uninsured.

“It is encouraging to learn that Hispanics are amenable to seeking professional sources of support to manage their mental heath needs,” added Dr. Delgado. “Stress is an important health care issue yet access to affordable services that meet cultural and language needs continues to be a barrier for Hispanics.”

Stress Affects Mind/Body Health

Like the general population, stress impacts Hispanics’ health. Nearly one fifth (17 percent) of Hispanics concerned about stress have been diagnosed with obesity versus just 6 percent of those not concerned about stress. Hispanics concerned about stress are also more likely to report being diagnosed with anxiety or depression than those not concerned about stress (25 percent versus 13 percent).

Hispanics feel the effects of stress in both body and mind. Hispanics report many stress symptoms acting simultaneously upon them, more so than other groups. Among the most commonly reported symptoms are:

- Having trouble sleeping (51 percent)
- Feeling nervous or sad (49 percent)
- Feeling irritable or angry (42 percent)
- Headaches (47 percent)

Causes of Stress

Hispanics report many sources of stress, yet in comparison to the general public, which reports work and money as leading stressors, Hispanics say stress is most often related to concerns about family health.

Leading Sources of Stress

- 34 percent say health problems affecting parents or other family members.
- 31 percent say health of immediate family (spouse, partner or children).
- 28 percent say health concerns.
- 28 percent say money.
- 27 percent say personal safety.
- 25 percent say work.
- 24 percent say children.
- 19 percent say nightly news or state of the world today.

Take the Stress Smarts Quiz and learn more about stress and mind/body health, including tips for managing stress, at www.APAHelpCenter.org (http://www.apahelpcenter.org/) , www.healthywomen.org (http://www.healthywomen.org/) and www.hispanichealth.org (http://www.hispanichealth.org/) .

This random-digit-dial telephone survey was designed and administered by Greenberg Quinlan Rosner. The survey reached 2,152 adults, 18 years or older. The base sample of 1,600 adults was supplemented with an over sample of 552 Hispanics and African Americans. In total, the survey reached 434 Hispanics. The data were weighted by gender, age, race, income, education, marital status and region to ensure an accurate reflection of the population. The sample size with these weights applied is 1,600. The survey was conducted January 12-24, 2006, and carries a margin of error of +/- 2.1 percentage points.

The American Psychological Association (APA), in Washington, D.C., is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 150,000

researchers, educators, clinicians, consultants and students. Through its divisions in 54 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, a profession and a means of promoting health, education and human welfare.

The National Women's Health Resource Center (NWHRC) is the leading independent health information source for women. The nonprofit organization develops and distributes up-to-date and objective women's health information based on the latest advances in medical research and practice. NWHRC believes all women should have access to the most trusted and reliable health information.

The mission of the National Alliance for Hispanic Health (the Alliance) is to improve the health and well-being of Hispanics. Founded in 1973, the Alliance is the nation's oldest and largest network of Hispanic health and human service providers. Alliance members deliver quality services to more than 14 million people annually. As the nation's action forum for Hispanic health and well-being, the programs of the Alliance strive to inform and mobilize consumers; support health care providers in the delivery of quality care; promote appropriate use of technology; improve the science base for accurate decision-making; and promote philanthropy among Hispanic communities

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Don't Let Workplace Stress Ruin Your Labor Day Holiday

On labor day's 125th anniversary, APA offers strategies for managing work stress

WASHINGTON-- In today's connected world Americans are finding it increasingly difficult to switch off from the stresses of the workplace, according to the American Psychological Association (APA). One hundred and twenty five years after the first Labor Day, the role of work in American lives has changed dramatically. This year, many Americans will work, either at their workplace or by answering e-mail, phone calls or faxes while at home or on vacation. According to a 2006 APA survey work is the number one cause of stress for Americans and almost one-third of Americans have trouble balancing their work and family lives.

Originally intended as a day for relaxation and celebration of the American worker, Labor Day today is very different from the first Labor Day in 1882. Back then, a largely industrial and agricultural workforce could disconnect from work on Labor Day without the possibility of being disturbed by work-related cell phone calls, reading e-mails on-the-go or being summoned to rush back to the office. In today's 24/7 society, work frequently intrudes in to employee's personal lives during evenings, weekends, vacations and holidays. In fact, 83 percent of email users admit to checking their email daily while on vacation. Increasing work demands on employees have a significant impact on employers too -- job stress costs U.S. businesses an estimated $300 billion per year through absenteeism, diminished productivity, employee turnover and direct medical, legal and insurance fees.

"While technology has undoubtedly improved our lives in the last 125 years, constant use of technology can add to the stress levels of an already overworked nation," says Dr. Russ Newman of the American Psychological Association. "What is important is to learn how to manage your stress at work and truly balance home and workplace demands even if that means switching off your BlackBerry this Labor Day."

Increased stress can push people toward using unhealthy behaviors such as smoking, comfort eating, poor diet choices, inactivity and drinking alcohol to manage their stress. APA warns that reliance on such behavior can lead to long-term, serious health problems. The APA survey found that people expressing significant concern about stress are more likely to eat fast food, avoid exercise and use drugs or alcohol as a response to their stress than use healthier methods such as exercise, good diet, meditation or psychotherapy.

APA offers these strategies for managing your work-related stress:

Know yourself. Be aware of your stress level and know what stresses you out. People experience stress in different ways. You may have a hard time concentrating or making decisions, feel angry, irritable or out of control, or experience headaches, muscle tension or a lack of energy. Learn your own stress signals.

Recognize how you deal with stress. Do you engage in unhealthy behaviors such as smoking, drinking or eating poorly to cope with your stress? Do you lose patience with your children or spouse or coworkers when you feel overwhelmed by work pressures?

Turn off and tune in. Communication technology can take you to productivity heights never imagined, but it can also allow work to creep into family time, dinner and vacations. Set rules for yourself, such as turning off your cell phone or BlackBerry when you get home, or establishing certain times when you return calls. Be sure to communicate those rules to others, so you can manage their expectations. Let technology be a tool that works for you, rather than the other way.

Keep a "To-Do" list. Worried that you'll forget something important? Constantly thinking through all the things you need to get done? Clear your head and put those thoughts on paper (or in an electronic task list) by creating a list of work and personal tasks and marking those with the highest priority. Not only will you reduce the risk of forgetting something, you'll also be better able to focus on the task at hand.

Take short breaks. Stay energized and productive by taking a minute or two periodically throughout the day to stand up, stretch, breathe deeply and shake off the accumulating tension. Short breaks between tasks can be particularly effective, helping you feel like you've wrapped up one thing before moving on to the next. Take a 10-15 minute break every few hours to recharge and avoid the temptation to work through lunch. The productivity you gain will more than make up for the time you spend on break.

Find healthy ways to manage stress. Work to replace unhealthy coping strategies, such as eating junk food, smoking or drinking alcohol with healthy behaviors, like exercise, meditation or talking with friends and family. Keep in mind that unhealthy behaviors develop over time and can be difficult to change. Take it slow and focus on changing one behavior at a time. Some behaviors are very difficult to change and may require the help of a licensed professional such as a psychologist.

Take care of yourself. Eat right, get enough sleep, drink plenty of water and engage in regular physical activity. Ensure you have a healthy mind and body through activities like yoga, taking a short walk, going to the gym or playing sports that will enhance both your physical and mental health. Take regular vacations. No matter how hectic life gets, make time for yourself -- even if it's just simple things like reading a good book, listening to your favorite album or enjoying a leisurely Sunday brunch at your favorite cafe.

Ask for professional support. Accepting help from supportive friends and family can improve your ability to manage stress. Your employer may also have stress management resources available through an Employee Assistance Program (EAP), including online information, available counseling and referral to mental health professionals, if needed. If you continue to feel overwhelmed by work stress, you may want to talk to a psychologist, who can help you better manage stress and change unhealthy behaviors.

To learn more about stress and mind/body health, visit the APA Help Center (/helpcenter) .

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SOURCE: American Psychological Association

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Hawaii gains new ground in quest for prescriptive authority

by Legal and Regulatory Affairs and Communications Staff

May 9, 2006 — Leaders of organized psychology in Hawaii and their advocates made substantial strides during the 2006 legislative session toward gaining prescriptive authority legislation for licensed psychologists in that state.

The Hawaii House of Representatives and the Senate Health Committee approved a bill that would have authorized qualified psychologists to prescribe psychotropic medications in federally qualified health centers and other designated settings. However, after a spirited hearing before the Senate Committee on Commerce, Consumer Protection and Housing in early April, the chairman held back the bill from further consideration.

The full legislature followed up by passing a concurrent resolution calling for a study on authorizing qualified psychologists "to prescribe a limited formulary of psychotropic medications for treating mental illness while practicing in federally qualified health centers or licensed health clinics located in federally designated medically underserved areas or in mental health professional shortage areas."

This year was the first that a prescriptive authority bill in Hawaii cleared the full House.

According to Jill Oliveira-Berry, PhD, co-chair of the Hawaii Psychological Association's (HPA) prescriptive authority initiative along with Robin Miyamoto, PsyD, the 2006 session saw greater support among state legislators for organized psychology's quest than in previous years. The issue of psychologists gaining prescriptive authority in Hawaii has been debated periodically since the first state bill was introduced in the mid-1980s.

Dr. Oliveira-Berry noted Rep. Joshua Green as a "new champion who demonstrated unwavering commitment to prescriptive authority [for psychologists]." According to Oliveira-Berry, Green is a physician who practices in a rural area and "knows intimately what happens to patients when mental health care is not available."

Dr. Oliveira-Berry also credits heightened media coverage of the prescriptive authority bill with increasing public visibility of access to care problems in the state and the valuable health services that Hawaii psychologists are providing in rural areas and community health centers. Meanwhile, psychologists, primary care physicians and community health center executive directors joined together during legislative hearings to speak firsthand about the serious access issues and psychiatry shortage problems that plague the state. HPA's legislative efforts gained further support this year from the state's largest insurance provider, Hawaii Medical Service Association, which submitted positive written and oral testimony.

The study called for by the state legislature is directed to include:

- a comparison of the education required of psychologists and other categories of nonphysician health professionals who prescribe medications, including advanced practice nurse practitioners and physicians' assistants, as well as psychiatrists
- evidence of patient safety where psychologists have experience with prescribing
- trends in other states related to conferring prescriptive authority for psychologists
- a review of the arguments for and against granting prescriptive authority to psychologists
- an evaluation of any barriers or obstacles to hiring psychiatrists at federally qualified health centers as well as solutions

a review of the U.S. Department of Defense psychopharmacology training program for psychologists.

The report is due no later than 20 days before Hawaii's 2007 legislative session begins.

The Legislative Reference Bureau conducting the study is a nonpartisan agency that provides research and analysis for the state government. The legislative resolution calls for HPA, the Hawaii Primary Care Association (a vocal supporter of HPA's prescriptive authority bill) and the Hawaii Psychiatric Medical Association to authorize representatives to consult with the bureau. According to Dr. Oliveira-Berry, the state psychological association will be actively involved in providing relevant and accurate data reflecting the study objectives and will closely monitor the study's progress.

Psychology proponents are hopeful that the study results will bolster prospects for success when HPA again champions prescriptive authority legislation in 2007. They note that the legislative resolution calls for specific, detailed information to be included in the study findings and recommendations. That should result in a comprehensive report with data and other information that psychology advocates can cite in making their case with state legislators.

State psychological association leaders anticipate that the study results may be particularly helpful for countering arguments that the opposition continues to make with legislators. For example, the resolution indicates that the study should include evidence of patient safety when psychologists prescribe psychotropic medications. The resulting information should help debunk organized psychiatry's persistent claims that allowing psychologists to prescribe will put patients' lives at risk.

"The most important part of the steady progress we've made in recent years is that prescriptive authority for psychologists is on the radar screen of all legislators and most of the health care community in Hawaii," says Oliveira-Berry. These same individuals, she says, are mindful of the "biases, distortions and unkept promises that the opposition continues to put forth."

The upshot, says Oliveira-Berry, is that, even with the well-entrenched opposition, organized psychology in Hawaii is well poised to build on its strong foundation of support.

National psychology leaders credit Hawaii for gaining ground through perseverance and determination. According to APA Executive Director for Professional Practice Russ Newman, PhD, JD, "Psychologists in Hawaii deserve high praise for their continued success in moving the prescriptive authority debate forward and for taking significant next steps in their effort to pass prescriptive authority for psychologists in Hawaii."

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Final report to SSA: No board certification requirement for psychological consultants

In a victory for Social Security Administration psychologists and continuity of patient care, psychological consultants at the SSA will not be required to attain board certification

Government Relations and Communications Staff

March 29, 2007 — A final report from the Institute of Medicine (IOM) about making improvements in the U.S. Social Security Administration's (SSA) disability determination process does not include a recommendation from the interim report requiring board certification for psychologists working in the SSA system. APA had advocated that IOM should not make the board certification requirement mandatory for psychologists.

Psychological consultants for SSA function as employees in state disability determination offices or as independent contractors in making determinations about disability applicants' mental impairments. Psychologists represent the largest specialty among all SSA consultants and are found in every state office, giving SSA beneficiaries and applicants access to psychological consultants throughout the United States.

In 2004, SSA asked IOM to develop recommendations related to strengthening the disability determination process. The federal agency asked IOM to focus on two areas: improvements in the criteria for determining severity of impairments and the use of "medical expertise" (including psychological expertise) in the disability determination process.

The IOM interim report, released in December 2005, included a recommendation that SSA should make board certification mandatory for physicians as well as psychologists working in its system. Psychologists who wished to continue in their positions as SSA consultants would have been required to attain board certification within five years.

APA took issue with this recommendation in a letter to the IOM director. APA Executive Director for Professional Practice Russ Newman, PhD, JD, argued that existing SSA standards for a psychological consultant ensure that psychologists selected for this position are fully

qualified. Federal regulation requires that SSA psychological consultants hold a doctoral degree in clinical psychology and be licensed or certified by a state at the independent practice level of psychology.

“While board certification may be a common credential in the field of medicine, it is not so in psychology,” Newman explained in his letter. “For psychologists, the doctoral degree and state licensure are the appropriate benchmarks for establishing their qualifications.”

APA cautioned that if SSA required board certification for psychologists it would quickly fail to meet the agency’s needs because there simply are not enough psychologists who hold this designation. Dr. Newman’s letter warned that individuals with mental health impairments would face long delays if experienced psychologists were lost from the disability determination process simply because they lacked board certification. This is at odds, he said, with SSA’s goal of making the current system more efficient and reducing the time it takes for a disability determination.

The IOM released its final report, “Improving the Social Security Disability Decision Process,” in February. The preface to the report explained, “The committee has reviewed and affirmed 13 recommendations in the interim report, except for a revision in...recommendations that [would] require board certification of physicians and psychologists who serve as medical consultants for the state disability determination service agencies . . . . Implementing a board certification requirement for psychologists in the near term could seriously limit SSA’s ability to obtain enough qualified experts in psychology. The committee therefore has modified its position.”

The preface also noted that while SSA should continue the current requirements for psychologists participating as medical consultants, the agency should establish a long-term goal requiring that psychologists be board certified. However, this recommendation was not reflected in the body of the report, including the final recommendations. Further, there was no indication as to when the IOM considers it appropriate for SSA to revisit the issue of board certification for psychologists.

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Putting HIPAA into Practice

Taking the Necessary Steps

An Interview with a HIPAA-Compliant Practitioner

Dr. Charlie Cooper of Chapel Hill, NC, heads up a multidisciplinary group practice consisting of 28 providers in two cities. His practice is compliant with both Privacy and Security regulations of the Health Insurance Portability and Accountability Act (HIPAA). Because the process he went through can work for psychologists in a wide range of practices, *Good Practice* (GP) asked him about what it takes—and why it's important—to become HIPAA compliant.

Privacy Rule Compliance

GP: *What steps have you taken to become compliant with the HIPAA Privacy Rule?*

Dr. Cooper: So much of HIPAA compliance depends on context. How one implements the Privacy Rule is conditioned on the size and complexity of one's practice or institution. Here are some of the steps we took in our practice:

1. We appointed a Privacy Officer (me).
2. We studied the Privacy Rule to understand what we needed to do to become compliant.
3. We prepared Policy and Procedures for the practice.
4. We created a Notice of Privacy Practices to distribute to our patients.
5. We trained clinical and support staff in our policies and procedures.
6. We had contractors who work with our practice sign Business Associate Agreements.

GP: *Where did you find the resources you needed?*

Dr. Cooper: We looked around for resources and selected the Privacy Rule product that was created by the APA Practice Organization. It provided state-specific templates for all the essential documents we used to articulate policies, inform patients, set up contracts with business associates and record the relevant data that must be maintained in order to demonstrate compliance. The four hours of continuing education credit were an added bonus.

GP: *How long did it take to put your Privacy Rule process in place?*

Dr. Cooper: In our practice, the process required between 15 and 25 hours of my time as the privacy officer, including

(continued on page 2)

IN THIS ISSUE

Introducing a New Resource

A Focus on HIPAA Compliance

Dear Practitioner:

This newsletter is the first in a planned series of topical editions of *Good Practice* from the APA Practice Organization that supplement our annual magazine. This issue focuses on HIPAA compliance and contains information of particular interest to our members.

The federal Health Insurance Portability and Accountability Act (HIPAA) is intended as a major step toward making our health care system more efficient through the use of information technology. But the voluminous rules resulting from this act—the Privacy and Security Rules in particular—have added to the complexity of practice.

Both of these rules are equally important for practitioners, and each requires a separate set of compliance activities. Practitioners have turned to us for guidance to help ensure that they implement HIPAA fully and appropriately.

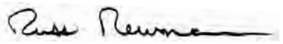
In this issue, one of our peers describes the steps he took to make his practice compliant with the HIPAA Privacy and Security Rules. You'll also learn how these two HIPAA rules differ, how psychotherapy notes are afforded heightened privacy protection under HIPAA, how to apply for your National Provider Identifier (NPI), potential penalties for non-compliance with HIPAA, and more.

This newsletter contains information about HIPAA compliance of particular interest to practicing psychologists. Learn more at APApractice.org.

We at the Practice Organization remain committed to serving you in numerous ways through this and other resources. We hope you'll keep this newsletter handy and share it with colleagues.

The APA Practice Organization is constantly seeking ways to help members with the challenges and opportunities of practice in the current health care delivery system. As always, we invite your comments and suggestions. Please feel free to call us toll-free at 800-374-2723 or send your email to practice@apa.org.

Sincerely,



Russ Newman. PhD, JD
Executive Director for Professional Practice

P.S. Look for the next issue of *Good Practice* magazine in the spring of 2007.

QUESTIONS ABOUT HIPAA?

Staff for the APA Practice Organization are available to help members with questions about HIPAA. Contact us toll-free at 800-374-2723 or send an email to practice@apa.org.

Taking the Necessary Steps

(continued from page 1)

staff training. However, in a typical small practice of two to four clinicians with one support staff, I would estimate a much smaller amount of time would initially be required; perhaps eight to 12 hours. For a solo practitioner it would be even less.

Security Rule

GP: *What steps did you take to become compliant with the HIPAA Security Rule?*

Dr. Cooper: Our efforts toward Security Rule compliance included the following:

1. We designated a Security Officer (again, that honor fell to me).

2. We conducted a risk analysis, identifying risks we needed to abate through administrative, physical and technical measures.

3. Following the risk analysis, we prepared the required documentation of our compliance policies and procedures.

GP: *What resources helped you create the documentation necessary for compliance?*

Dr. Cooper: We utilized the online compliance workbook from the APA Practice Organization. As with the Privacy Rule resource, the workbook provided templates that simultaneously walked us through a risk analysis and, for each standard and implementation specification, suggested language we could use—and action steps we could take—to address potential risks.

GP: *How long did it take you to complete both the risk assessment of your practice and the compliance documentation?*

Dr. Cooper: It took 10 to 12 hours. However, I would estimate for a solo or a two- to four-person practice, the time requirement would be far shorter because the compliance process would be less complex due to things such as fewer employees and practice locations.

Dr. Charlie Cooper

GP: *Which actual Security Rule compliance activities did you implement in your practice?*

Dr. Cooper: Interestingly, we found that most implementation standards were already being met within our practice. For example, we had already installed computers with password-protected access controls and thorough backup procedures. We had firewalls and anti-virus protection. We had taken physical measures to assure that protected health information was secured in locked areas. And we already had begun to outline disaster-recovery procedures.

So in our case, the bulk of activities necessary for compliance were focused on documentation and training. As a result, for our practice, becoming compliant involved conducting a formal risk assessment, documenting our solutions to identified risks, creating all necessary policies and procedures and, finally, giving an orientation and training for staff. We had a computer consultant on retainer, so we had him sign a Business Associate Agreement.

After studying the Security Rule, our computer consultant told us, "The good news is that HIPAA's requirements are largely measures that any business should take to protect data in the first place."

GP: *Do you have any recommendations for psychologists who feel they may need assistance understanding the technical issues involved in the Security Rule?*

Dr. Cooper: My nearly blanket recommendation for anyone attempting to comply with the Security Rule is to form a reliable relationship with an information technology expert who can provide assistance in an emergency and is willing to sign the Business Associate Agreement so he or she can work on your computers, PDAs, etc., as needed.

Compliance Issues

GP: *What were your biggest challenges in becoming HIPAA compliant, and how did you address them?*

Dr. Cooper: The biggest challenge was drafting, updating and maintaining the documentation required by each rule. We dealt with the initial documentation process almost exclusively by using the templates included in the APA Practice Organization's online products.
The long-term challenge will be to update our documents, especially those pertaining to the Security Rule. Because while the Privacy Rule compliance steps remain largely unchanged, Security Rule implementation is continually subject to change as technology renders past solutions obsolete. It has proved difficult, even in a large practice like ours, to exert the oversight and discipline to document all the evolutionary changes that occur—usually technology-driven—such as when we acquire and install new software.

GP: *Is it really that important to be HIPAA compliant?*

Dr. Cooper: Yes, and there are many reasons for investing in HIPAA compliance. Perhaps most important, in an increasingly technologically sophisticated era, HIPAA rules can be highly protective of our clients. I can give you one example: I had a palm device that contained a small amount of unencoded, client-specific information on it. Neglectfully, I left it behind in a store where I was shopping. While I discovered the loss within five minutes and recovered the PDA immediately, the lesson was pounded in and has stuck indelibly. Now my PDA has automatic data encoding and fingerprint recognition as a password.

Additional reasons for compliance include the fact that many privacy and security decisions often surface suddenly, as when sensitive records are requested or when there is a security breach. To attempt compliance after the horse has jumped the fence could jeopardize not only patients but also one's practice standing with licensing authorities or in litigation. HIPAA is getting so well-known that it surely will be the basis for legal actions in the future. In my view, it's important to be HIPAA compliant even for practices that do not transmit electronically, and

(continued on page 7)

"The good news is that HIPAA's requirements are largely measures that any business should take to protect data in the first place."

Computer Consultant to Dr. Cooper

Six Reasons Why HIPAA Matters

Have you ever wondered if HIPAA compliance is really vital to you as a practicing psychologist? If there's ever been a doubt in your mind, the following considerations may help you reconsider the matter.

1 Compliance is a matter of law.

The most obvious consideration is if you as a health care practitioner take actions that trigger HIPAA, you must comply *fully* with the HIPAA rules. This includes all health care professionals who electronically transmit health information in connection with standard transactions designated under HIPAA. (See "What Triggers the Need to Comply?" on page 6 for a list of the standard transactions that trigger HIPAA.) There are potential substantial penalties associated with failure to comply with HIPAA. (See the article, "Final HIPAA Enforcement Rule Takes Effect," page 16).

The following considerations apply even if a psychologist does not technically trigger HIPAA.

2 The health services delivery industry is fast moving toward electronic transactions.

Increasingly, participation in health insurance programs requires electronic claims submission and other electronic transactions that trigger the need for HIPAA compliance. Payers are creating incentives for such participation, for example, by reimbursing more quickly for claims submitted electronically than for paper claims. Even health professionals who do not yet engage in electronic transactions can ensure that their future actions do not put them in violation of HIPAA by complying now. For example, should they decide at some point to employ an electronic billing service or to take a client whose health insurance plan requires electronic billing, these practitioners will have no "grace period" for meeting HIPAA requirements. Full compliance will be required beginning at the moment electronic billing is initiated.

3 HIPAA helps protect your patients.

The Privacy and Security Rules entail requirements that help protect the integrity and confidentiality of the therapist-client relationship. These should be matters of central concern to mental health professionals. Following the Privacy and Security Rules—for example, by keeping HIPAA-compliant psychotherapy notes (see "Practitioners: Take Note," page 8) and by using safe email practices—can protect client confidences from insurance companies as well as computer hackers.

Even health professionals who do not yet engage in electronic transactions can ensure that their future actions do not put them in violation of HIPAA by complying now.

4 HIPAA requirements constitute sound business practice.

Consider the example of "contingency planning" as required by the HIPAA Security Rule. Taking steps to ensure that electronic protected health information (EPHI) can be recovered and restored in the event of an emergency can lessen interruptions to your practice.

For example, there were practitioners affected by Hurricane Katrina who needed to recover lost electronic patient data. Those who had backed up and stored their patient records in a location safe from flooding, consistent with the HIPAA Security Rule, were prepared to recover what they needed. Taking this important step in advance helped minimize disruptions to continuity of patient care. Others who lacked backup files were not as fortunate.

HIPAA requirements could be invoked in legal and professional disciplinary proceedings.

5 Following HIPAA specifications can help you avoid potential risks.

As one example, the Security Rule requires practitioners to implement policies and procedures to address the final destruction and/or disposal of EPHI and computers or other devices in which EPHI is stored. Disposing of a computer without using software that completely removes patient records is contrary to HIPAA requirements.

There are reports of computer programs being used to recreate patient files that a psychologist thought he or she had "deleted." The use of such programs may jeopardize confidential patient health information and increase the psychologist's risk of liability.

6 The Privacy and Security Rules are likely to be invoked as setting the standard of care in the health care industry.

Many health care analysts have advanced this argument. HIPAA requirements could be brought to bear in legal and professional disciplinary deliberations, even in situations where HIPAA compliance technically has not been triggered.

Consider a scenario where a practitioner faces disciplinary action for failing to take reasonable steps to protect patient confidentiality after improperly throwing out his practice computer and then having his patient records retrieved.

The attorney for the complaining patient might assert that the practitioner was actually violating the "customary standard of care," and therefore the psychologist was negligent, by not adhering to HIPAA's standards for disposing of computer equipment.

What Triggers the Need to Comply?

Both the HIPAA Privacy Rule and Security Rules are triggered when a psychologist, or an entity such as a billing service acting on behalf of the psychologist, transmits information in electronic form in connection with any designated standard transactions (items 1 through 10 at right).

Transmission in "electronic form" includes transmission via the Internet, extranets (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, computer-generated faxes (not traditional paper-to-paper faxes), private networks and electronic protected health information (EPHI—see footnote 2, page 7) that is physically moved from one location to another using magnetic tape, disk or compact-disk media.

Following are the standard transactions. For psychologists, the transactions most likely to trigger HIPAA are communications from the practitioner related to insurance claims or eligibility (items 1, 3, 4, 5, 6 and 8). The definitions that appear below are summaries of the definitions provided by the U.S. Department of Health and Human Services in 45 C.F.R. Sections 62.1101-162.1802.

1. Health Care Claims
Requests to obtain payment and the necessary accompanying information from a health care provider to a health plan, for health care services rendered.

2. Health Care Payment and Remittance Advice
Payment information about the transfer of funds or payment processing information from a health plan to a health care provider's financial institution; or either the explanation of benefits or remittance advice from a health plan to a health care provider.

3. Coordination of Benefits
Inquiries from any entity to a health plan for the purpose of determining the relative payment responsibilities of the health plan regarding either claims or payment information (e.g. whether payment should be made instead by another insurer, Medicaid, etc.).

Once a psychologist—or an entity such as a billing service acting on behalf of the psychologist—triggers HIPAA, the Privacy Rule applies to all protected health information in the psychologist's practice.

4. Enrollment or Disenrollment in a Health Plan
Inquiries regarding subscriber enrollment information provided to a health plan to establish or terminate insurance coverage.

5. Health Care Claim Status
Inquiries used to determine the status of a health care claim or a response about the status of a health care claim.

6. Eligibility for a Health Plan
Either: (1) an inquiry from a health care provider to a health plan or from one health plan to another health plan to obtain information about a benefit plan for an enrollee regarding eligibility to receive health care under the plan, coverage of health care under the plan, benefits association with the plan; or (2) a response from a health care plan to the provider or other health care plan regarding the same.

7. Health Plan Premium Payments
The communication of either payment, information about the transfer of funds, detailed remittance information about individuals for whom premium payments are being paid, or payment processing information such as payroll deductions, associated group premium payment information or other group premium payments.

Taking the Necessary Steps (continued from page 3)

8. Referral Certification and Authorization
Communications including: a request for the review of health care to obtain an authorization for the health care, a request to obtain authorization for referring an individual to another health care provider, or a response to one of these requests.

The following two transactions have yet to be formally defined by the Department of Health and Human Services, so we have provided a basic definition below.

9. First Report of Injury
Communication where an injury is reported to the worker's compensation carrier for any potential workers compensation claim.

10. Health Claims Attachments
An extraction of relevant information from the medical record to demonstrate the reason for the service provided and the subsequent health care claim.

Once a psychologist—or an entity such as a billing service acting on behalf of the psychologist—triggers HIPAA, the Privacy Rule applies to all protected health information[1] in the psychologist's practice. Once HIPAA is triggered, the Security Rule applies to all **electronic** protected health information[2] in a practice.

[1] Under HIPAA, "protected health information," or PHI, is information that: is transmitted or maintained in any form or medium; relates to the past, present or future: physical or mental health condition of an individual; the provision of health care to an individual; or payment for providing health care to an individual; and identifies the individual or could reasonably be used to identify the individual. For psychologists, this generally means information about a specific patient, client or person you are evaluating.

[2] Electronic protected health information, or EPHI, is PHI that is transmitted or stored in electronic form.

thus have not "triggered" HIPAA. This is because compliance with the Privacy Rule assures sound treatment of confidential information and clear communication with clients regarding that information. Compliance with the Security Rule is consistent with good business-information practices. And it is increasingly easy to trigger that rule inadvertently through an emergency action such as transmission of an email or computer-based fax.

GP: *What are the biggest misconceptions practitioners may have about HIPAA compliance?*

Dr. Cooper: From my experience fielding calls regarding HIPAA issues as Director of Professional Affairs in the North Carolina Psychological Association, the biggest misconception among practitioners may be that HIPAA is largely irrelevant to practice. It often may seem true—until the moment it becomes not only relevant but indispensable in resolving some unforeseen privacy or security issue.

Another common misconception is that many practitioners think if they're compliant with the Privacy Rule they've satisfied all of their HIPAA obligations, which is absolutely not true.

GP: *Is it important to comply with both the Privacy and Security Rules?*

Dr. Cooper: Yes, because they're synergistic: you can't fully implement one without the other. Without the Privacy Rule, you don't know what to protect. Without the Security Rule, you don't know if you have "holes" in the protective shield.

GP: *What advice would you give to other practitioners about becoming HIPAA compliant?*

Obtain the tools for each rule, designate several blocks of time and persevere. With the confidence the Practice Organization's tools provide, the process is not only achievable, it can actually become interesting.

Once you're compliant, it's also important to be aware that if aspects of your practice change, such as hiring a new staff person, you may need to revisit and update your policies and procedures to ensure ongoing compliance.

GP: *Is there any other advice you can give to practitioners who have not yet taken steps to become HIPAA compliant?*

If you did not meet the deadline for HIPAA compliance, you still should implement. It's an important aspect of risk management for your practice, and compliance can definitely be accomplished in small steps.

The HIPAA compliance information and resources mentioned in this article can be found on APApractice.org.
See page 20 for a list of additional resources for help with HIPAA.

Practitioners: Take Note *HIPAA provides extra privacy protection for psychotherapy notes*

Practitioners face a number of issues in considering how to create and maintain their client records. When the focus is on psychotherapy notes as defined by the Health Insurance Portability and Accountability Act (HIPAA), several questions typically come to mind: Should I create psychotherapy notes? If I do so, what information should I include? Where should I keep the notes? What happens if I don't create separate psychotherapy notes?

The HIPAA Privacy Rule does not mandate what health care professionals must put in their patient records. But it does confer special privacy protections when mental health professionals keep psychotherapy notes that are separate from the clinical record.

The following issues and considerations for practitioners pertain to psychotherapy notes and HIPAA:

How HIPAA defines "psychotherapy notes"

According to the text of the HIPAA Privacy Rule, "psychotherapy notes" means:

> *... notes recorded (in any medium) by a health care provider, who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.*

The HIPAA rule also stipulates what psychotherapy notes *exclude*:

> *... medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.*

Typically, these "excluded" items comprise the other part of the patient record (often referred to as the clinical record) that is separate from psychotherapy notes.

Patient authorization required to release psychotherapy notes

The Privacy Rule requires psychologists and other entities covered under HIPAA to obtain specific patient authorization for the disclosure and use of "psychotherapy notes." Under HIPAA, disclosing psychotherapy notes to others calls for more than just notice or general consent. Explicit patient authorization—written permission from the client that meets specific Privacy Rule requirements—is needed to release psychotherapy notes to, or let them be viewed by, anyone other than the therapist who created them.[1]

This authorization requirement applies to records requests from managed care and other health plans. It even protects clients from having other mental health professionals in the same group practice view the psychotherapy notes unless the client has authorized it.

Insurance companies barred from access to psychotherapy notes

Before the HIPAA Privacy Rule took effect, insurance companies sometimes requested entire patient records, including what are now called psychotherapy notes, in making "medical necessity" decisions. Patients could decline to have this type of information released, but the insurance company might deny coverage for related services.

Now health plans cannot refuse to provide or authorize reimbursement to the patient or psychologist if a patient does not agree to release psychotherapy notes. The HIPAA Privacy Rule forbids such refusal to pay. Further, managed care companies may not require you to turn over psychotherapy notes during an audit of your patient records. Even so, insurers can refuse to pay for services if medical necessity is not sufficiently documented in the clinical record. So it advisable for the clinical record to provide adequate rationale for medical necessity.

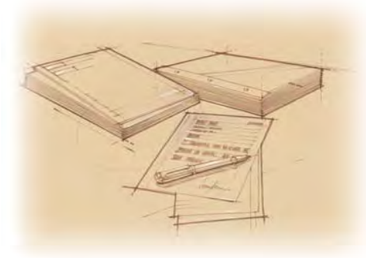
Patient access to information in the client record

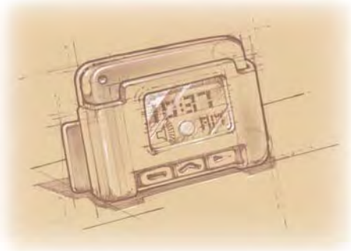
The HIPAA Privacy Rule also generally protects psychotherapy notes from being viewed by the patient. However, because this federal regulation does not preempt state laws that give patients greater access to their records than HIPAA does, patient access to psychotherapy notes varies from state to state.

In some states, the Privacy Rule prevails and the patient has no right to access psychotherapy notes. In other states, the psychologist has greater discretion to withhold psychotherapy notes than to withhold the clinical record. In a third group of states, psychotherapy notes have no greater protection from patient access than the clinical record.[1]

Keeping "separate" psychotherapy notes

The HIPAA definition of "psychotherapy notes" explicitly states that these notes must be kept "separate" from the rest of





the patient record, but does not specify what "separate" means. It seems clear, however, that if the psychologist maintains the notes in a general chart along with other clinical information, the notes would *not* qualify for the heightened privacy protection that HIPAA provides for psychotherapy notes.

In light of the HIPAA rule wording, practitioners should consider whether someone else would be able to readily "distinguish" their psychotherapy notes from the rest of the record. If another person could do so, the psychotherapy notes likely would be considered as separate from the clinical record. As one approach, psychologists separate their psychotherapy notes by keeping them on one side of the patient's file folder, while putting the clinical record on other side.

When keeping separate records electronically, the psychotherapy notes should be located in a separate electronic file, or separate part of the electronic file, and preferably labeled as "confidential" and/or "psychotherapy notes." In addition, they should have a higher level of security, such that only the therapist who created them has access (unless the patient has authorized broader access). Keep in mind that maintenance of electronic records also raises important issues related to HIPAA Security Rule compliance.

The HIPAA Privacy Rule does not mandate what health care professionals must put in their patient records. But it does confer special privacy protections when mental health professionals keep psychotherapy notes that are separate from the rest of the clinical record.

Why "psychotherapy notes" are offered special privacy protection

During the rule-making process, APA successfully advocated to the U.S. Department of Health and Human Services (HHS) that the final Privacy Rule should provide heightened protection for psychotherapy notes. In doing so, the Privacy Rule recognizes that the kinds of information contained in psychotherapy notes need a higher level of privacy protection than other types of information kept in patient records.

HHS accepted APA's arguments that psychotherapy notes reflect communications whose confidentiality is essential to successful psychotherapy and that these notes serve as the therapist's private notes for his or her own use. As such, they are not needed by or to be shared with others in the health care delivery system such as third party payers and other health care professionals.

(continued on page 12)

[1] State-specific patient authorization forms as well as state-by-state information about patient access to psychotherapy notes is part of *HIPAA for Psychologists*, the online Privacy Rule compliance tool from the APA Practice Organization designed for practicing psychologists. Visit the "HIPAA Compliance" and "APApractice.org Store" sections of APApractice.org for details and ordering information.

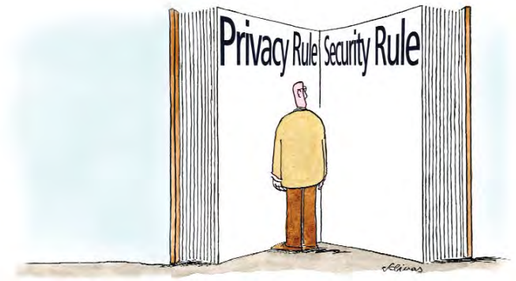
The HIPAA Privacy and Security Rules *A Side-by-Side Comparison*

Sorting through the complexities of the various HIPPA rules is no simple matter. The federal regulations related to these rules are voluminous.

Some health care professionals have mistakenly believed that, by complying with the requirements of the HIPAA Privacy Rule, they have met most or all of their obligations under HIPAA. Although there is a bit of overlap between the HIPAA Privacy and Security Rules, each rule is distinct and requires its own compliance process.

A fundamental distinction is that the Privacy Rule focuses on *intentional* releases of protected health information, while the Security Rule focuses on safeguarding your practice against *unintentional* disclosures. Another difference is that the Privacy Rule calls for a thorough comparison of the rule with your state laws related to confidentiality of patient records; the Security Rule does not require such a comparison.

The table below highlights several of the major differences and similarities in the HIPAA Privacy and Security Rules.



	HIPAA PRIVACY RULE	HIPAA SECURITY RULE
Focus	Applying policies and procedures to control when, under what circumstances and to whom to release protected health information, or PHI[1]. The Privacy Rule focuses on *intentional* releases of PHI.	Protecting "electronic protected health information," or EPHI[2], from *unintended* disclosure through breaches of security and from *unintended* loss, for example, through fire or flood.
What triggers the rule[3]	The Privacy Rule is triggered when a psychologist transmits PHI in electronic form in connection with any of the following types of transactions: • Health care claims • Health care payment and remittance advice • Coordination of benefits • Health care claim status • Enrollment or disenrollment in a health plan • Eligibility for a health plan • Health plan premium payments • Referral certification and authorization • First report of injury • Health claims attachments Further, the Privacy Rule is triggered when an entity acting on behalf of the psychologist, such as a billing service, transmits PHI in electronic form.	The same transactions as listed for the Privacy Rule.
What the rule applies to	Once a psychologist triggers HIPAA, the Privacy Rule applies to all PHI in the psychologist's practice.	Once a psychologist triggers HIPAA, the Security Rule applies to all EPHI in a psychologist's practice.
Major steps toward compliance[4]	• Determine what state laws related to privacy are more stringent than the Privacy Rule. • Develop a notice of privacy practices and authorization form (shaped by the interaction of state privacy laws and the Privacy Rule), as well as a Business Associates Contract and other forms you may need for compliance. • Designate a "Privacy Officer" responsible for ensuring that appropriate privacy procedures are adopted and followed (also see section below on "Scalability"). • Document and implement policies and procedures in light of the rule's requirements, for example, a patient complaint process. • Train employees to carry out their functions under the Privacy Rule.	• Conduct a formal risk analysis of your practice. The risk analysis is a thorough assessment of the practice's potential security risks and vulnerabilities related to EPHI. • Designate a "Security officer" responsible for ensuring that appropriate privacy procedures are adopted and followed. In a solo practice, this will be the individual psychologist. In a small or large group practice, one of the psychologists or office staff can be designed as the Security Officer. • Implement safeguards to minimize any risks you have identified. • Develop security policies and procedures in light of your risk analysis and the safeguards you have chosen. • Document measures that the practice has taken to comply with the Security Rule.
Scalability	The administrative requirements of the Privacy Rule are "scalable," meaning that a health professional covered by HIPAA must take "reasonable" steps to meet the requirements according to the size of practice and type of activities. A key example: while a hospital might be required to create a full-time staff position to serve as a "Privacy Officer," a psychologist in solo practice may identify himself or herself as the Privacy Officer.	Many provisions of the Security Rule explicitly allow the compliance process to be tailored to the size and complexity of one's practice. As with the Privacy Rule, requirements for solo or small practices are generally far less extensive and complicated than for a large health care facility. Nonetheless, even if your practice is small, you must document your rationale for any tailoring you do as allowed by the rule.
Interaction with state law	The HIPAA Privacy Rule establishes a minimum set of requirements for protection of PHI. The federal rule does not preempt, or override, state laws that are stricter in safeguarding an individual's PHI or that give the patient greater access to his/her PHI. Practitioners need to determine for their particular state whether HIPAA preempts state law, or whether stricter state law applies.	Not applicable to the Security Rule. Compliance with the rule does not vary because of state law.
Responsibility for violations by business associates	HIPAA requires health professionals to enter into contracts with business associates[4] (such as accountants, lawyers or a billing service) with whom they share PHI as defined under HIPAA. In essence, the psychologist needs to contractually obligate the business associate to follow all HIPAA compliance requirements that the psychologist must follow. Having an appropriate business associates contract protects the psychologist from liability if the business associates violate HIPAA obligations.	Same as for the Privacy Rule

1 Under HIPAA, "protected health information," or PHI, is information that: is transmitted or maintained in any form or medium; relates to the past, present or future: physical or mental health condition of an individual; the provision of health care to an individual; or payment for providing health care to an individual; and identifies the individual or could reasonably be used to identify the individual. For psychologists, this generally means information about a specific patient, client or person you are evaluating.

2 Electronic protected health information, or EPHI, is PHI that is transmitted or stored in electronic form.

3 For additional information, see "What Triggers the Need to Comply?" on page 6.

4 Step-by-step guidance is provided in two online products from the APA Practice Organization: *HIPAA for Psychologists Online Privacy Rule Compliance Course*, developed in collaboration with the APA Insurance Trust, and the *HIPAA Security Rule Online Compliance Workbook*. These products also include a business associates contract tailored to psychologists that may be customized. Visit the APApractice.org Store online at **APApractice.org** for additional information.

Practitioners: Take Note *HIPAA provides extra privacy protection for psychotherapy notes* *(continued from page 9)*

Kinds of information included in psychotherapy notes in line with HIPAA

Psychotherapy notes are designed to protect information whose sanctity is important to maintaining the therapeutic relationship. Some practitioners reflect in these notes the patient's intimate confidences and sensitive information about persons other than the patient, along with the psychologist's speculations and unformed opinions.

Making decisions about what to keep, and what not to include, in psychotherapy notes may be found in the rationale embraced by HHS in finalizing the Privacy Rule—namely, that psychotherapy notes are the therapist's private notes that are not typically used by or shared with other professionals or with third party payers.

If the information should be shared with other health professionals involved with the patient's care, this constitutes a reason to put it in the clinical record. For example, a notation that the patient reported feeling irritable after taking psychotropic medication would fall into this category. And if the information is among the "exclusions" to the HIPAA definition of psychotherapy notes, that information should be included in the clinical record.

Sometimes the decision about what to record where is a matter of detail, as the psychologist keeps in mind who might ultimately have access to the information. For example, a practitioner might note in the clinical record the symptom that the patient is having night terrors. But the details of those nightmares and the psychologist's initial musings about their significance, which are less important to other health care professionals, would go in the psychotherapy notes.

Although placing information in the psychotherapy notes always protects information from health insurers and may bar patient access, keep in mind that there are a variety of situations where outside parties may have access to psychotherapy notes. For example, a client might have to authorize their release for a military or government job application, or a court may order the disclosure of records. Accordingly, the psychologist should consider such potential disclosures when making psychotherapy note entries.

What if a practitioner does not keep separate psychotherapy notes?

Practitioners subject to HIPAA need to consider the practical effect if they choose not to keep separate psychotherapy notes. In contrast to the clear protections for psychotherapy notes, psychologists who keep their records combined have only the Privacy Rule's vague "minimum necessary disclosure" standard to rely on when arguing that insurers and others should not see the entire record.

When "protected health information" is disclosed or used, the Privacy Rule requires psychologists to share the minimum amount of information necessary to conduct the activity. The requesting party will often argue that the entire record is the "minimum" that they need, while the psychologist counters that a much narrower set of records is appropriate to release. It is conceivable that the final arbiter of what is "minimum necessary disclosure" in a case such as this could be a court of law in the event that a legal dispute ensued.

Additional Considerations

Also be mindful of the following additional considerations related to keeping psychotherapy notes and other elements of patient records:

- Insurance company employees may not understand that HIPAA precludes them from looking at psychotherapy notes. Some practitioners report having interactions with managed care company representatives who are seemingly unaware of the HIPAA privacy protections that apply to psychotherapy notes.
- A number of other important considerations have a bearing on record keeping, including: applicable state law; APA's Record Keeping Guidelines (which are being revised); APA's ethical principles; and institutional policies governing record keeping (for example, policies that apply to psychologists employed in a health care facility).

FIND OUT MORE

To learn more about the HIPAA rules and how to comply, visit the "HIPAA Compliance" section of APApractice.org.

Applying for Your National Provider Identifier

A Q&A for Psychologists

As of **May 23, 2007**, all health care professionals will be required to have a National Provider Identifier (NPI) to use when billing electronically any government or private health insurer. The creation and use of the NPI raise a number of questions for practicing psychologists. This question-and-answer article addresses several common inquiries.

Q. *What is the NPI?*
A. The NPI is a unique 10-digit number assigned to every health care provider or entity that applies for it. This number will replace other provider identification numbers, such as Medicare's Unique Physician Identifier Number (UPIN), that have been assigned to health care professionals by government and private insurers for use in billing. Once a health professional receives an NPI, that number is assigned to that health professional for his or her entire career, regardless of whether the health professional relocates, changes employers or even changes health professions.

Q. *How is the NPI used?*
A. The NPI is intended for use in identifying practitioners when they transmit health information electronically —for example, in submitting claims for payment and referral authorizations.

Q. *Who must apply for an NPI?*
A. All "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA), which includes all health care professionals who are required to comply with this federal law, must obtain an NPI no later than the May 23, 2007 deadline. In essence, the need to comply with the Privacy Rule is triggered when a practitioner transmits protected health information in electronic form in connection with health care claims and other transactions as specified in the rule.

The "HIPAA Compliance" section of **APApractice.org** contains further information about what constitutes a"covered entity" under HIPAA. In addition, the Centers for Medicare and Medicaid Services Web site includes "tools" for determining if you're a covered entity. The relevant Web site is **http://www.cms.hhs.gov/apps/hipaa2decisionsupport/default.asp**.

Any private health insurer can require that health professionals who bill the insurer use an NPI, even if the billing is done by mail rather than electronically. This means that even psychologists who are not considered "covered entities" under HIPAA likely will be required to get an NPI.

Therefore, **the APA Practice Organization encourages all psychologists who bill private and/or public health insurance plans, including federal and state programs, to obtain an NPI**.

Q. *If I am not currently covered under HIPAA and I apply for an NPI, will I automatically be required to comply with HIPAA?*
A. No. Applying for an NPI does not "trigger" your having to comply with HIPAA.

Q. *Do I apply for an NPI as an individual or organization?*
A. Every individual and organization covered under HIPAA must obtain an NPI. The overarching rule is that if you have an organization that your state views as separate from the individual, the organization should obtain its own NPI. Sole proprietorships, which are unincorporated businesses, generally are not considered separate and distinct from the individual owner. For that reason, sole proprietorships should apply as individuals, using a social security number, not their employer identification number (EIN). On the other hand, corporations are usually seen as separate and distinct, so they should apply for a separate NPI apart from the individual health care professionals who work for the corporation.

A group practice (that is not a sole proprietorship) should obtain its own NPI, and all the psychologists who work in that group should get their own unique NPIs. The group practice's NPI and the individual psychologists' NPIs are not linked in any way. This allows the individual psychologists to bill for services rendered at other places such as in a hospital or in another group practice—for example, if they work part-time in more than one setting. Further, it allows individuals to leave one group practice and join another without having to worry about changing their NPI.

Psychologists may complete and submit the NPI application form online by accessing https://nppes.cms.hhs.gov.

Q. *What will health insurers and others know about my practice based on the NPI assigned to me?*
A. Unlike identifiers used by the government and health insurers in the past, the NPI is a random number. The 10-digit number does not reveal any information about the health professional, such as geographic location or type of practice. Yet, while no such information can be gleaned from the NPI itself, insurers may have access to certain information included in your NPI application, such as your choice of taxonomy code (discussed further in this article).

Q. *What steps do I take to apply?*
A. The steps you take depend on whether you file electronically or submit paperwork to obtain an NPI.

Electronic Application Process

Psychologists may complete and submit the NPI application form online by accessing **https://nppes.cms.hhs.gov**. You will be able to complete the application quickly, so long as you have all the required information ready before you begin. The list of information needed for individuals applying for an NPI includes:

- Health practitioner name
- Health practitioner date of birth
- Country of birth
- State of Birth (if birth was in the United States)
- Health practitioner gender
- Social Security Number or other proof of identity
- Mailing address
- Practice location and phone number
- Taxonomy (see the question-and-answer section on pages 18 and 19)
- State license information (required for certain taxonomies only)
- Contact person name
- Contact person phone number and email

The Web site listed above will walk you through the steps involved in completing the application. The Center for Medicare and Medicaid Services (CMS) advises that electronic submission is the fastest way to obtain your NPI.

Paper Application Process

For any health care professional who wishes to complete a hard copy version of the application form and send it via regular mail, the application can be downloaded from **www.cms.hhs.gov/cmsforms**. When you access the site, click on "CMS Forms." Doing so will take you to a list of forms that includes the NPI application—CMS Form #10114. The application form is three pages long followed by instructions for completing the form. Individuals who render health care services are asked to complete Sections 2A, 3, 4A and 5.

Application Form Submitted by an Employer

In some cases, a psychologist who is employed by a health care entity may find that the entity is willing to submit the NPI application on his or her behalf. For example, a hospital may do so for its

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Final HIPAA Enforcement Rule Takes Effect

If you thought that the federal Health Insurance Portability and Accountability Act (HIPAA) lacked the "teeth" of enforcement, think again. The federal government has issued regulations that establish how the U.S. Department of Health and Human Services (HHS) will determine liability and calculate fines for health care professionals who violate any of the HIPAA Rules.

The HIPAA Enforcement Rule took effect in March 2006. The rule makes enforcement regulations applicable to all of the major HIPAA rules, including the Privacy and Security rules.

The HIPAA regulations pertain to covered entities including health care professionals whose activities "trigger" HIPAA. This happens, for example, when a psychologist transmits protected health information in submitting health care claims electronically. (See the article "What Triggers the Need to Comply?" on page 6 for additional information about actions that trigger HIPAA.)

This article highlights additional important aspects of the new Enforcement Rule that are important to psychologists: the general enforcement approach, liability for the acts of agents, fines and defenses available to a covered entity that is facing a penalty.

General Enforcement Approach

In deciding where to direct its enforcement efforts, HHS will rely primarily on complaints brought to the agency's attention. However, HHS can conduct compliance reviews on its own if there has been no complaint. When acting on complaints, HHS is not limited to complaints by patients. For example, HHS can act on complaints from other covered entities.

Enforcement actions will remain private until a final penalty is imposed. So the fact that you may not have heard about HHS conducting investigations does not mean they are not taking place.

The Enforcement Rule generally favors a voluntary approach to HIPAA compliance whereby HHS would work with a psychologist at issue to make sure that the practitioner understands and corrects the violation. However, if such voluntary efforts fail, the rule calls for the agency to resort to investigations, hearings and fines.

Liability for Actions of Your Agent

The Enforcement Rule explains the circumstances under which you could be held liable for HIPAA violations of your agent—that is, someone acting on your behalf and at your direction. You can be subject to this type of "agency liability" if a member of your "workforce" commits HIPAA violations. The rule defines "workforce members" as including not only your paid employees, but also trainees and volunteers who are under your direct control.

You can also be held liable for violations by your agents who are not under your direct control but who are still carrying out HIPAA-related functions on your behalf. This kind of agent is generally considered a "business associate" under HIPAA, a person or company with whom you share protected health information as part of running your business. Examples include a billing service or accountant.

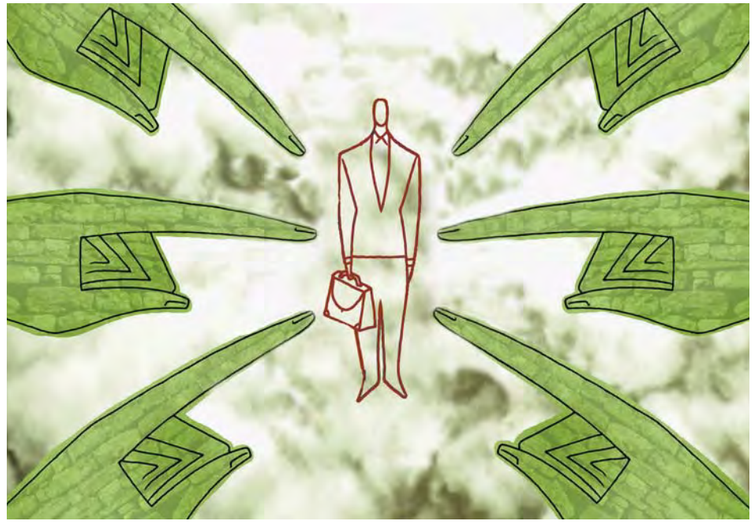
There is an important exception to HIPAA liability provided by the Enforcement Rule. You generally are not liable for the HIPAA violations of your business associate if you are in compliance with the business associate provisions of the Privacy and Security Rules as they apply to your practice. Essentially, this means that you have in place "business associate contracts" that comply with those rules. Importantly, however, this exception will not protect psychologists who are aware that their business associates are violating the privacy or security obligations under their contracts and fail to take reasonable steps to remedy the problem.

One place to find a business associate contract that satisfies both the Privacy Rule and Security Rule is in the ***HIPAA Security Rule Online Compliance Workbook*** available online at APApractice.org.

Fines

The new Enforcement Rule allows HHS to impose fines of up to $100 per violation, to a maximum of $25,000 for violations of an identical requirement during one calendar year. A continuing violation is deemed a separate violation for each day it occurs. Thus, a continuing violation found to have lasted most of the year (at least 250 days) would reach the $25,000 limit for that one violation. In calculating the number of violations, HHS can rely on statistically valid sampling. However, the rule gives the accused entity a procedure for challenging those statistics.

The federal government has issued regulations that establish how the U.S. Department of Health and Human Services (HHS) will determine liability and calculate fines for health care professionals who violate any of the HIPAA rules.



HHS indicates that one act could give rise to several violations. The agency gives the example that the single act of disposing of a computer without first "scrubbing" the hard drive to remove electronic protected health information would violate several different HIPAA provisions.

In considering the amount of the fine, HHS will consider the nature and circumstances of the violation, the health professional's history of prior compliance and his/her financial condition. More detailed considerations under the last category include the size of the covered entity and whether the fine would put the entity out of business.

When a proposed penalty becomes final, the enforcement process finally becomes public. HHS must notify the public of the fine imposed and the reason for imposing the penalty. HHS will also give notice to various other entities, including the appropriate state or local licensing agency and "the appropriate state or local medical or professional association."

Available Defenses

The Rule provides several defenses that are available to someone facing a fine. If these defenses are established to HHS' satisfaction, the agency will not impose a fine. The two most significant defenses for psychologists relate to not knowing about the violation and being unable to comply. The first of these defenses applies when covered entities who would be liable for penalty did not know that they were in violation, and by exercising reasonable diligence would not have known of the violation. The rule defines reasonable diligence as "the business care and prudence expected from a person seeking to satisfy a legal requirement" under similar circumstances. Obviously, practitioners could not reasonably rely on this defense if they failed to take steps to comply simply because they thought the federal government would not enforce the HIPAA rules.

The fact that you may not have heard about HHS conducting investigations does not mean they are not taking place.

The second defense applies when circumstances make it temporarily unreasonable for the entity to comply with the HIPAA requirement at issue, despite the exercise of ordinary business care and prudence. Under this defense, the entity knows they are violating a HIPAA rule and must normally correct the violation within 30 days of knowing about it.

For example, a devastating tornado destroys a psychologist's practice, including paper and electronic copies of the privacy notice required by the HIPAA Privacy Rule. The psychologist sees new clients in the aftermath of the natural disaster but is unable to give them a copy of her privacy notice. She is able to correct the situation within 30 days by recreating the notice and distributing it to her new clients. If she were subject to an enforcement action, she could argue that she was temporarily unable to comply with this HIPAA requirement, despite the exercise of ordinary business care and prudence.

The entire text of the enforcement rule is available at **http://www.hhs.gov/ocr/hipaa/FinalEnforcementRule06.pdf**.

PLEASE NOTE: The information in this article does not constitute legal advice and should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding your individual circumstances.

Applying for Your National Provider Identifier *(continued from page 15)*

employed providers. However, the health care entity is required to obtain your permission before filing an NPI application for you. If applicable, you could check with your billing or human resources department to find out whether your organization is planning to submit NPI applications for its employees.

Q. *What is a "taxonomy code"?*

A. As part of the application process, the Centers for Medicare and Medicaid Services (CMS) requires that all types of health professionals list a "taxonomy code" or codes. A taxonomy code is a 10-digit alphanumeric identifier separate from the NPI used to describe your health care practice and the professional services you provide. According to CMS representatives, the purpose of including the taxonomy code as part of the application process is to help distinguish among health professionals—for example, where multiple providers have the same name. APA was not included in the process of developing the psychology-related codes for the taxonomy code list and believes that these codes do not accurately portray the practice of psychology.

Q. *Where do I find the taxonomy code list?*

A. The electronic version of the application lists the available taxonomy codes. First you will be asked to choose among general categories of health care professionals. The applicable category for psychologists is "Behavioral Health and Social Service Providers." Then you will be asked to choose among more specific categories. Two of the categories are "Psychologist" and "Neuropsychologist." The remaining categories include 19 specialties listed under "Psychologist."

The paper version of the application form does not list the taxonomy codes. To obtain the list of available codes, the application instructs you to go to the following Web site: **http://www.wpc-edi.com/taxonomy**.

At the main page for this Web site address, you need to click on "Individual or Groups," then click on "Behavioral Health and Social Service Providers." That will take you to two codes applying to psychology—"psychologist" and "neuropsychologist." If you click on the term "psychologist," you will see the list of specialty codes that have been assigned to psychology.

Q. *What guidance does the APA Practice Organization provide about choosing a taxonomy code?*

A. Practitioners who apply for their NPI need to decide which and how many taxonomy codes to choose. As previously noted, as of October 2006, there are two "general codes" included in the taxonomy code list—"psychologist" and "neuropsychologist"—as well as 19 "specialty" codes associated with the general code "psychologist."

Unfortunately, there is no published guidance from CMS regarding how to choose a code. Should practitioners choose a general code only, or one or more of the specialty codes? How do practitioners decide whether they "specialize" in an area of practice enough to identify themselves by one of the specialty codes?

Adding further confusion to this issue is that a practitioner's choice of taxonomy code may carry reimbursement or credentialing implications. This is the case even though the Centers for Medicare and Medicaid Services (CMS) included the taxonomy codes in the NPI process to help distinguish among health professionals, not for use by insurers in governing reimbursement. Officials with CMS have assured us that the agency does not intend for the Medicare or Medicaid programs to use the taxonomy codes to restrict the kinds of services that a health professional may bill and be reimbursed for providing.

Even so, it is likely that CMS will share your taxonomy code information with private health insurers and/or that these insurers will ask you for your taxonomy code(s). Because these codes have not routinely been used by private insurers for psychology, it is difficult to predict the impact of these codes on reimbursement. We do not yet know of any specific situations where insurers are using the taxonomy codes in connection with reimbursement.

The APA Practice Organization remains wary that third party payers may limit or deny reimbursement based on a psychologist's choice of taxonomy codes (see sidebar, page 20). For example, an insurer might deny payment for services that a psychologist provides to children if that practitioner has not chosen the specialty code for "child, youth, and family" from the taxonomy code list. Alternatively, insurers could decide not to pay for services that they believe are represented by certain specialties. For example, an insurer may not cover counseling and decide that all of the services furnished by psychologists who chose "counseling" as one of their taxonomy codes represent uncovered counseling services.

The APA Practice Organization is actively monitoring the potential for misuse of taxonomy code information and intends to take necessary actions to address any unintended uses of the taxonomy codes. But the fact of the matter is that, at the present time, we just do not know how payers may use this information.

With this as background, the APA Practice Organization evaluated the issue of choosing taxonomy codes and has identified at least three strategies.

Choosing Your Strategy

One strategy would be to choose all the taxonomy codes that represent any area in which you practice. (You may opt to pick only the specialty codes and not a general taxonomy code.) This might have the advantage of protecting psychologists from being denied reimbursement or admission to a panel on the grounds that they did not choose a specific specialty. However, if an insurer sees any of the taxonomy code areas as representing services that the insurer does not cover, there is the risk that the company would argue that all of your services relate to that taxonomy code and deny payment for the services. In addition, if a psychologist selects a long list of specialty taxonomy codes, insurers might consider the practice so broad that they would question the practitioner's expertise in any one of the specialty areas chosen.

> *Because [taxonomy] codes have not been routinely used by private insurers for psychology, it is difficult to predict the impact of these codes on reimbursement.*

A second strategy would be to list only the general "psychologist" or "neuropsychologist" code. This may protect you against being pigeonholed into a particular specialty area. However, there could be a risk of payment denials if an insurer decided to only pay for services in a particular practice area when the services were furnished by psychologists who identify themselves as specializing in that area—such as only paying for services to children when a practitioner chose the "child, youth and family" taxonomy code.

A third strategy would be to choose the code or codes that most accurately reflect your practice in its entirety, that is, the services you spend the majority of your time providing. For example, licensed psychologists with a broad-based practice might elect to choose just the "psychologist" code. On the other hand, psychologists who focus in specific practice areas may want to choose a specialty code or codes in addition to a general code. For example, a neuropsy-

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Applying for Your National Provider Identifier *(continued from page 19)*

chologist who focuses on providing services to geriatric clients may wish to choose the general "neuropsychologist" code as well as the specialty code, "adult development and aging." If that neuropsychologist also furnishes services such as psychotherapy, feedback and/or cognitive rehabilitation, he or she may also want to choose the "clinical psychologist" code.

The APA Practice Organization generally advises practitioners to take the third approach. Though no strategy is risk-free, this option represents a balance of the first two strategies and may minimize the risk of negative reimbursement consequences until we have a better sense of how insurers will use these codes.

> The APA Practice Organization is wary that third-party payers could use taxonomy code information to limit or deny payment for services. We need your help as we work to mitigate the risk that the codes might be used adversely by insurers. Please let us know if you learn that your insurer is using your taxonomy code for any purpose, such as for making reimbursement decisions or credentialing. Call us toll-free at 1-800-374-2723 x5886, or send an email to practice@apa.org.

Guidance from the APA Practice Organization may change when it becomes clearer how insurers will handle the codes. The NPI process permits practitioners to add or delete codes at any time.

The APA Practice Organization has expressed our concern to the organizations involved that the taxonomy code list in its present form is inconsistent with the way that psychology is practiced. We are continuing to communicate with these groups in seeking appropriate revisions to the code list. We will apprise our members of future changes. We also stand ready to respond to any instances in which insurers use the taxonomy codes in inappropriate ways, so please notify the Practice Directorate if you encounter this situation.

Q. *May I change my choice of taxonomy code?*
A. Yes. Psychologists who have an NPI can change their taxonomy code designation at any time. The APA Practice Organization will update members if there are changes in taxonomy codes and/or our guidance for practitioners about selecting a code.

Do you have a question about the NPI that is not answered in this article? If so, contact legal and regulatory affairs staff for the APA Practice Organization by sending an email to **practice@apa.org** or calling 1-800-374-2723, ext. 5886. Further, please let us know if you become aware of situations where health care payers use the taxonomy codes to make reimbursement decisions.

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Online Resources for More Help with HIPAA

APApractice.org, the APA Practice Organization's site, has a section with information and resources devoted to HIPAA compliance. In addition to the HIPAA Privacy and Security Rule, this section of APApractice.org includes information about a third rule that applies to practitioners: the **HIPAA Transaction Rule**. Click the button for the **APApractice.org Store** to access the following step-by-step compliance products developed specifically for practicing psychologists: *HIPAA for Psychologists Online Privacy Rule Compliance Course* (developed in collaboration with the APA Insurance Trust) and the *HIPAA Security Rule Online Compliance Workbook*.

The **U.S. Department of Health and Human Services** has a Web page located at **http://www.hhs.gov/ocr/hipaa** with answers to frequently asked questions about HIPAA privacy and other educational materials.

The **U.S. Centers for Medicare and Medicaid Services** devotes a portion of its Web site to HIPAA. Begin your search for general information at the following link: **http://www.cms.hhs.gov/HIPAAGenInfo.** For particular help determining whether you are a "covered entity," type in the following address once you open your Web browser: **http://www. cms.hhs.gov/apps/hipaa2decisionsupport/default.asp.**

The following online resources are useful for practitioners in applying for a National Provider Identifier (NPI; see "Applying for Your National Provider Identifier," page 14). Psychologists may complete and submit the NPI application form online at **https://nppes.cms.hhs.gov.** For those who wish to complete a hard-copy version of the application form and send it via regular mail, the application can be downloaded from **www.cms.hhs.gov/cmsforms**.

California court reverses lower court order on client records

Psychotherapist-client privilege is successfully defended in a California case, thanks in part to APA advocacy

Communications and APA Monitor Staff

February 8, 2007 — APA and the California Psychological Association (CPA) recently succeeded in confronting a judicial action that placed psychotherapist-client privilege at risk. As urged by the two psychological associations, the California Court of Appeal reversed a lower court's order for a psychologist to disclose confidential communications with a patient.

Organized psychology became involved when Charles Faltz, PhD, CPA's director of professional affairs, received a call from a member who had been asked to release a client's records as part of a civil suit. The client began psychotherapy after an automobile accident in which another person's property was badly damaged. The property owner filed suit for emotional distress and negligence, claming that the client, who was legally intoxicated at the time of the accident, had a history of alcoholism. A Superior Court judge ordered the therapist to release his client records, saying that they were "directly relevant" to the case.

Dr. Faltz contacted APA, which became involved in the case along with CPA by filing an amicus (friend of the court) letter arguing that the Superior Court had disregarded California's privilege law in ordering the disclosure of confidential patient records. The letter also emphasized that the court's order would have an adverse impact on mental health treatment.

California's privilege law states that a patient "has a privilege to refuse to disclose and to prevent another from disclosing a confidential communication between patient and psychotherapist." State law provides for 12 designated exceptions to this privilege. APA attorneys say there is no "relevancy" exception in California law.

The defendant filed a motion to quash the subpoena ordered by the Superior Court, but the judge denied the motion. The defendant then appealed to the California Court of Appeal. The higher court sent the plaintiff (the property owner) a Palma notice, a procedure used in California law to give notice that the court intends to set aside the lower court's action without a hearing. Shortly after the plaintiff

submitted a written response to the notice, the Court of Appeal reversed the lower court judge's ruling, thereby protecting the confidentiality of the patient records.

Professional psychology leaders applauded the action. "The need to protect and preserve confidentiality is a central underpinning of the psychotherapy process," says APA Executive Director for Professional Practice Russ Newman, PhD, JD. "Issues and developments like this recent case in California involving therapist-patient privilege have always been among the APA Practice Directorate's high priority activities."

"We considered it urgent to confront the lower court's action" adds Billie Hinnefeld, JD, PhD, senior director of legal and regulatory affairs for the APA Practice Directorate. "If the ruling were allowed to stand, it could set a dangerous precedent."

Hinnefeld credits Dr. Faltz for bringing the legal development in California quickly to APA's attention. "This is a nice example of how state, territorial and provincial psychological associations and APA can work together to achieve shared goals."

She also noted that the Court of Appeal's decision could be appealed, but she considers it unlikely. "We're not aware of any such plans," says Hinnefeld.

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Senate passes Mental Health Parity Act

The Senate bill requires full parity between mental health and medical benefits for all aspects of health insurance plan coverage, including day/visit limits, dollar limits, coinsurance, copayments, deductibles and out-of-pocket maximums

by Government Relations Staff

September 26, 2007 — The U. S. Senate passed the Mental Health Parity Act of 2007 by unanimous consent on September 18. The bill requires group health insurance plans that offer mental health coverage to apply financial requirements to mental health benefits that are no more restrictive than the requirements pertaining to medical/surgical benefits. S. 558 requires full parity between mental health and medical benefits for all aspects of plan coverage, including day/visit limits, dollar limits, coinsurance, copayments, deductibles and out-of-pocket maximums.

As such, the legislation closes loopholes in the Mental Health Parity Act of 1996. The 2007 act would extend protections to over 113 million Americans, including 82 million individuals in self-insured employer plans who do not currently benefit from mental health parity protection through state laws. The Senate bill applies to both in-network and out-of-network services in all private employer health plans covering more than 50 employees.

“Senate passage of the Mental Health Parity Act of 2007 brings us a step closer to equal treatment for millions of Americans with mental health and substance use disorders,” said APA Executive Director for Professional Practice Russ Newman, PhD, JD. “For more than a decade, APA has been working to put an end to insurance practices that discriminate against those with mental health disorders.”

Forty three (43) states have passed legislation that provides varying levels of mental health parity. S. 558 establishes a “floor” of minimum standards for states, while maintaining the power of states to exceed the protections afforded by the federal legislation.

Introduced by Senators Pete Domenici (R-NM), Edward M. Kennedy (D-MA) and Michael B. Enzi (R-WY), the Mental Health Parity Act of 2007 has broad bipartisan support. For the first time, businesses and insurance companies such as Aetna and BlueCross BlueShield have

joined a broad coalition of mental health advocacy organizations, including the American Psychological Association, to support mental health parity legislation.

S. 558 resulted from months of compromise with representatives of the employer and insurance industries -- traditional opponents of full parity legislation. The APA Practice Organization (APAPO) played a critical role in negotiating and drafting the legislation and was instrumental in gaining a provision that would extend parity coverage to out-of-network services when a health plan provides these services. Importantly, representatives of APAPO also participated in negotiations that resulted in the Senate bill deferring to the Health Insurance Portability and Accountability Act (HIPAA) preemption model. Under this model, state laws that are more protective of consumer rights are allowed to prevail over federal law.

"The progress [psychology] made last week was a testament to the determination of the Senate sponsors, the effective mobilization of APAPO's sophisticated network of grassroots psychologists, direct lobbying by the Practice Directorate's government relations office and engagement of elected officials through the Association for the Advancement of Psychology/Psychologists for Legislative Action Now's (AAP/PLAN) political giving" said Marilyn Richmond, J.D. assistant executive director for government relations.

The Congressional Budget Office projects that achieving mental health parity will increase average total plan costs by only 0.4 percent.

Organized psychology's attention now turns to the House of Representatives, where a mental health parity bill is moving through the committee process.

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