Clinical Geropsychology News

Winter 2002 APA Div 12, Section II Volume 9, Number 1

President's Comments

Sara Qualls, Ph.D.

As I begin my term as President of this Section, I continue to be amazed at the excitement within Geropsychology, and at the way the area has moved to the forefront of public policy issues recently. Consider the following exciting developments of recent months.

- The new health CPT codes have the potential for rapidly expanding psychologists' work with midlife and older adults. Because they allow reimbursement for behavioral interventions for physical disorders, these new codes enhance access of chronic illness populations to psychological services. Already, primary health care settings have been predicted to be a major site for mental health services in the coming decade. These new codes greatly expand the opportunities for geropsychologists to work within primary health care.
- Graduate medical education funding that was previously unavailable to psychologists may become open to psychology trainees under the Older Americans Act. (APA's Education Directorate is working hard on this.)

Inside.....

- American Psychological Association for the first time has a Medicare Task Force to which Section II contributes well. Policies within Medicare are increasingly recognized as trendsetters for other insurances and, thus, warrant the full attention of our Section and national organizations. A strategy for monitoring the reimbursement policies

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APA Office on Aging Update

Deborah DiGilio, MPH
Aging Issues Officer, Public Interest Directorate, APA

In the last Section II newsletter, I described the recent CMS requirement for a more open process in the development of Local Medical Review Policies (LMRPs) by insurance carriers that process claims for Medicare. Since that time, the APA Committee on Aging (CONA), with the support of the Office on Aging, has initiated its Local Medical Review Policy Project. The Project's first step was an analysis of existing LMRPs for Psychiatric and Psychological Services. The resulting three reports are: *An Overview of Medicare Coverage for Psychological Services for Patients with Diagnoses of Dementia or Alzheimer's Disease*; *Local Medical Review Policies-Provisions for Psychology and Psychiatry Services*; and *An Overview of the Role of Psychologists in Hospice Care under Medicare*. These reports detail: typical coverage provisions and exclusions; state specific language from coverage provisions (including recently promulgated provisions for NY, MN and CT that are less restrictive and more inclusive of psychosocial interventions); and, definitions and coverage indications for CPT codes referred to in the provisions. The first report can be viewed on the APA Office on Aging website, http://www.apa.org/pi/aging/lmrp.html. The LMRP Project's next step is the development of a tool kit to assist psychologists in advocacy efforts to expand the availability of psychological services for older adults under Medicare through participation in the LMRP development process.

The Office on Aging is also working with the APA Education Policy Office to launch an appropriations initiative related to the Graduate Training in Gerontology provisions of the Older Americans Act (OAA). One component of this initiative is advocacy training to prepare psychologists who are constituents of key legislators for visits to congressional offices at home and on Capitol Hill. We are currently looking for geropsychologists who are constituents of key legislators and willing to speak to them on behalf of psychology. Key senators are: Harkin, Hollings, Inouye, Reid, Kohl, Murray, Landrieu, Byrd, Specter, Cochran, Gregg, Hutchison, Stevens and DeWine. Key Representatives are: Ralph Regula (Ohio, 16th), David R. Obey (Wisconsin, 7th), C.W. Young (Florida, 10th), Steny H. Hoyer (Maryland, 5th), Ernest J. Istook (Oklahoma, 5th), Nancy Pelosi (California, 8th), Dan Miller (Florida, 13th), Nita M. Lowey (New York, 18th), Roger F. Wicker (Mississippi, 1st), Rosa L. DeLauro (CT, 3rd), Anne M. Northup (Kentucky, 3rd), Jesse L. Jackson (Illinois, 2nd), Randy Cunningham (California, 51st), Patrick J. Kennedy (Rhode Island, 1st), Kay Granger (Texas, 12th), John E. Peterson (Pennsylvania, 5th), and Don Sherwood (Pennsylvania, 10th).

For more information on either of the above projects, copies of the LMRP reports, or to nominate yourself for OAA advocacy training, or just to share your ideas on aging issues, please contact me by e-mail: ddigilio@apa.org or by phone: 202-336-6135. In closing, I would like to thank the members of Section II for the warm welcome and support you have given me during my first year at APA.

Society of Clinical Psychology (Division 12)

Dolores Gallagher-Thompson, Ph.D., Section II Representative
Victor Molinari, Ph.D., President-Elect

Section II was represented in 2001 at Division 12 Board of Directors meetings by Dolores Gallagher-Thompson, Ph.D., and most recently (at the January 2002 Board meeting) by Victor Molinari, Ph.D. The ***2001 Overview*** was written by Dr. Gallagher-Thompson and the ***Midwinter Board Meeting Summary*** was written by Dr. Molinari to inform our membership about important issues that concern us as a group.

2001 Overview, Dolores Gallagher-Thompson, Ph.D.

In 2001, a primary emphasis was to increase the number of Fellows in Division 12. Each Section was asked repeatedly to nominate members for Fellow status. This is likely to continue as a goal in 2002. There are 2 categories of Fellows: "old" Fellows (meaning they are already Fellows in another APA division, so it is easier to process them for Division 12 Fellow status) and "new" Fellows (meaning the person is being considered for the first time for APA Fellow status). This Section nominated several persons for Fellow status in 2001 and would like to nominate even more in 2002! Check with any of us for specifics as to deadlines and what information will be needed.

Other key business items included:

1. Division 12 is accepting nominations for a new editor for the Division's journal "Clinical Psychology: Science and Practice" until February 15, 2002. Dr. Dave Barlow, Editor in Chief, was very receptive to papers on clinical issues in later life. It would be great to have another person in that role who will regard our work with interest and will be supportive in publishing reviews and empirical findings pertinent to our specialization. Please submit nominations to Larry Beutler, Ph.D.
2. Programming time at the APA annual convention has been altered. "Cluster programming" was adopted for the 2002 convention resulting in somewhat less time for each Section; however, we have done well overall (see Victor's report below) and Section II will be well represented!!

Finally, due to schedule & time demands, Dr. Gallagher-Thompson has to step down from the role of Section II Representative to Division 12 in 2002. Deborah King, Ph.D., of the University of Rochester Medical Center, will be taking her place. Please join us in welcoming Dr. King to this position! We are sure that she will ably represent us in our efforts to expand our membership, to make the larger membership of Division 12 *more aware* of mental health issues in later life, and to illuminate what Section II members can contribute to the overall mission of Division 12!

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Public Policy Update

Margie Norris, Ph.D., Chair, Public Policy Committee

There has been a flurry of public policy activities recently, both at the regulatory and legislative levels. The following are summaries of the important issues. A reminder to our members – updates on these issues are generally posted on the listserv and elicit good questions and discussions from those who participate in the listserv.

♦ The new Health and Behavior codes are in effect for 2002. There are two assessment and four intervention codes used for behavioral, social and psychophysiological procedures for the prevention, treatment, or management of physical illnesses. A psychiatric diagnosis is not necessary for these services to be reimbursed; however, the medical necessity requirement remains. The reimbursement for these codes will come from funding for medical rather than psychiatric services; hence, funding is not restricted by the limited mental health dollars.

The two assessment codes include an initial health and behavior assessment and a re-assessment for a previously seen patient. The four intervention codes are used for "modifying the psychological, behavioral, cognitive, and social factors affecting a patient's physiological functioning and well being." The four codes are applied to services for individuals, groups, families with the patient present, and families without the patient present.

APA has stressed the importance of the use of these codes by psychologists. CPT codes are not limited to a particular profession; however, the profession that most frequently bills a code becomes the "lead" organization for addressing future surveys and reviews of the codes. In addition, the "work value" or reimbursement rate assigned to these codes may increase over time as the codes become established and valued. Currently, these codes pay approximately 80% of comparable psychotherapy codes. The new codes are listed in the 2002 CMS physician fee schedule and are based on 15-minute intervals.

Many questions have been raised about details of the use of these codes. While Diane Pedulla and Steve McEllin of APA are already addressing individual situations, more will be learned as psychologists develop a history of billing these codes. Medicare carriers should also be contacted with questions about the use of these codes. As you gain experience with them, please share your information with the Clinical Geropsychology Section members via our listserv at wvuger-L@wvnvm.wvnet.edu.

♦ CMS will no longer allow carriers to automatically deny services for patients based on a diagnosis of dementia. Paper reviews and subsequent denials are still possible. CMS is asking for providers to use primary and secondary diagnoses. This change is not specific to psychological services; rather, it applies to all health care services provided to patients with a diagnosis of dementia.

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M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology: *Martha Storandt, Ph.D.*

Antonette Zeiss, Ph.D.

As the former Chair of the Awards and Recognition Committee (my term ended January 1, 2002), I am very pleased to announce that **Martha Storandt, Ph.D.** is the first recipient of the M. Powell Lawton Award for Distinguished Contributions to Clinical Geropsychology. The Board decided at its fall meeting to name our distinguished contributions award in honor of Powell, who did so much to foster Clinical Geropsychology. Dr. Storandt's selection as the first recipient of this award was a unanimous decision of the Awards & Recognition Committee (which included, in addition to myself, Steve Zarit and Mick Smyer). Her work also has done much to create the field of Clinical Geropsychology and to move us forward. She has nurtured the field both through her own research and through her training of generations of leaders and contributors to the field. Dr. Storandt will receive this award at the APA convention in Chicago this August. We also have been able to obtain program time for an award address by Dr. Storandt at the convention. I will be in the front row, eager to hear her talk, and I hope to see a full audience of other members (and prospective members) of Section II there as well.

The Student Voice:

Clinical Geropsychology and 12/II: A Student's Perspective

Sherry Beaudreau, M.A., Washington University

As a neophyte in clinical geropsychology, I was looking forward to presenting my first graduate research project as a poster session at the annual APA convention in San Francisco this August. The topic of my poster was on age differences in storytelling. I had presented at conferences in the past and was expecting a similar experience—stand in front of my poster, attend other poster sessions and symposia, go out at night, spend time with friends and then return home to St. Louis. Little did I know that this year was going to be a fun and rewarding experience.

I had been a member of the 12/II clinical geropsychology section for a couple of years at this point and noticed a graduate student research award in the summer newsletter. It was at that time that I had completed a manuscript for my master's project and I submitted my manuscript via e-mail. Never in my wildest dreams would I have guessed what good things were to come.

I received notice in July that I won the research award and that it included a monetary stipend and a meal at the Cliff House restaurant. I attended the student breakfast and was surprised to see how open and friendly many of the members were with students. The professional members were interested and engaged with the student members of the group. I was surprised to see familiar names on people's nametags from clinical geropsychology chapters and

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Profile on: *Michelle Gagnon, Psy.D.*
Director, Nova Southeastern University Geriatric Institute

As I contemplated writing this column, I struggled a bit to convey, in a concise manner, what is so unique or interesting about my work as an early career geropsychologist. What I arrived at is the tremendous on-the-job training I've received in administration coupled with work with seriously mentally ill elders, a population that is not well understood. Both are the result of my nearly two-year directorship at the Geriatric Institute, which I will describe shortly.

A brief chronology: I am a South Florida native and have always had elders in my life thanks to my grandparents and my mother's charity work, so I guess that a desire to specialize in working with older adults seemed natural. I am a graduate of Nova Southeastern University, where I received my first experience in administration while coordinating the university's specialty outpatient clinic for older adults directed by Michel Hersen, Ph.D. I was a geropsychology intern at the Miami VAMC and subsequently moved to become a clinical geropsychology fellow at the Philadelphia Geriatric Center (PGC).

Following training, I became the director of a PGC research project in New York City in which we studied how trauma survivors (Holocaust survivors) fared in nursing home and community-based LTC settings. American-born Jewish elders in both LTC settings served as the comparison groups. The quantitative piece has been completed, and the findings are interesting. Very Briefly, two interesting findings: 1) these survivors have significantly smaller families than American-born counterparts, which translates into less support; 2) professional caregivers (CNAs and Social Workers) reported a significantly greater amount of empathy for survivors, which could lead to greater tolerance of difficult behaviors when providing services for this population. Qualitative analysis is now underway, and the hope is that funding will be secured to produce a best practices manual. For more information on the study, please contact the principal investigator, Allen Glicksman, Ph.D., at: aglicksm@pcaphl.org.

My current position as Director of the Geriatric Institute (GI) has allowed me to become a quasi-expert in both serious mental illness (SMI) and business administration. The program serves adults ages 55 and older with SMI and is comprised of two components: a 44-bed residence and a day treatment-type program. The program is based on a psychosocial rehabilitative model and residents come to live with us for up to two years, and sometimes more. The ultimate goal is that individuals grow and develop sound enough coping skills to live a more independent lifestyle within the community. This is a sizable feat since many come to us from long stays in the state hospital and others have been in and out of psychiatric hospitals their whole adult lives.

GI services include group and individual therapy, 24-hour supervision and nursing care, transportation, recreational activities, psychiatric and medical care, meals, and assistance with ADLs. On a typical weekday, our residents and community clients come to STEP (skills training enhancement program), which runs from early morning to mid-afternoon. Each day at STEP, every client attends one social rehabilitation group and one basic living skills group, and is able to select up to two recreational activities such as sewing, book club, and exercise. There are a variety of group topics every hour and across days to ensure that each person's care is fitted to

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President's Comments, *Continued from page 1*

of separate Medicare carriers has been implemented.

- The Section initiated an inter-divisional task force to bring together the shared expertise and political clout of divisions that care about aging issues. Currently, under the directorship of Steve Rapp and Paula Hartmann-Stein, the Task Force is working to develop a communication web that can effectively and efficiently share information about policy aspects of practice issues.
- Aging research continues to do well in the federal arenas. A growing number of foundations also include aging within their funding priorities.
- Practice standards and empirically supported treatments for older adults are an important policy arena. Section 2 members are actively involved in summarizing the research literature that is unique to older adults. The Section also has members working with the American Association of Geriatric Psychiatry on their effort to develop guidelines for dementia care in long term care settings.
- The American Bar Association has included a representative from APA (one of our members) on their elder law initiatives regarding exclusion of dementia patients from reimbursement for health care.
- Cross-carrier variations in implementation of Medicare rules are becoming increasingly evident to policy makers. Strategies for addressing these problems include efforts to enhance CMS oversight of the carriers, and lobbying to include psychologists on the carriers' medical review panels.

As is evident, geropsychology has come of age. Our concerns are neither hidden nor considered irrelevant to the mainstream. With visibility comes responsibility for members of our Section to provide leadership.

I challenge each of you to take a minute to email me an idea, concern, or suggestion for ways in which this Section can provide meaningful leadership to our discipline, to health care initiatives, to academic institutions, or to any other target we need to address. Where should we have an impact? Where can we productively invest our efforts? What can we realistically do to promote the well-being of older adults? My email is squalls@mail.uccs.edu. Please take a moment and share your thoughts.

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Don't Forget!
Complete and return a New Membership Form today,
and encourage colleagues and students to join!
New Members may contact Dr. Michele Karel:
Michele.Karel@med.va.gov

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Society of Clinical Psychology (Division 12), *Continued from page 3*

Midwinter Board Meeting Summary, Vic Molinari, Ph.D.

The Midwinter Board Meeting of Division 12 was held in Miami and presided by President Larry Beutler, Ph.D. Despite the unusually cold weather in Miami, the meeting was cordial and productive. There were a number of issues that were discussed that are pertinent to Section II:

1. With the reduced programming hours due to the reduction in the amount of time for the APA convention and the new cluster system of programming, there was concern over the number of program hours allotted to the sections. The sections were able to draw from the non-substantive hours allotted to Division 12. As a result, we will be able to allot time for a business meeting, an executive meeting, a presidential address, a Lawton award address, a symposium on models of practice in LTC settings, and a possible joint symposium with Section 4 on "Women & Aging: Challenges & Rewards."
2. There was a discussion about the number of seats that Division 12 is allotted. If most of the Division 12 members just gave 1/10 apportionment votes to the Division, we would have more representation on the APA Council. Division 12 will aggressively market this fact to our membership.
3. By-laws were clarified regarding membership status. Non-APA members can be members of the divisions and can hold offices in the sections (but can't vote on divisional matters). Changes regarding the nomenclature of affiliate status were approved.
4. There was a call for nominations for multiple positions within APA governance. Please submit names to Larry Beutler. Ph.D..
5. The Division endorsed a proposal for Serious Mental Illness to be considered a proficiency.
6. The Division endorsed a position paper on cultural and gender awareness in international psychology.
7. In an effort to increase ethnic minority participation on APA council, the Division endorsed a motion to "consider a dedicated slate for ethnic minorities for each election whenever there is more than one position available."
8. Implications for the expansion of the number of sections in the Division were discussed. Although new sections may attract new members, hours allotted for programming time for each section might have to be decreased to accommodate new sections.
9. As Section II representative, I made a motion that public policy issues be considered as important to attract new members and as a future area of emphasis for the Division. This motion was approved, and the Division Board appeared very interested in the work of Section II's public policy committee. They asked about the possibility of becoming a part of our public policy dissemination mechanism.
10. Date for next Midwinter meeting: 1/9/03-1/11/03. Top 2 sites to be considered: San Juan & Santa Fe!

Public Policy Update, *Continued from page 4*

- The Labor-HHS Appropriations Bill was passed by both Houses of Congress and is on its way to the President to be signed into law. It includes a brand new funding program that will provide $5 million to the Center for Mental Health Services (CMHS) under the Substance Abuse and Mental Health Services Administration (SAMHSA) for evidence-based mental health outreach and treatment to the elderly. Congressman Patrick Kennedy (D-Rhode Island) expressed concern that only a small percentage of older Americans who require assistance currently receive specialty mental health services. He has stated that this $5 million is intended to begin to address this problem.

- Unfortunately, the Mental Health Equitable Treatment Act, which passed in the Senate, did not pass in the House of Representatives. A weaker version was passed that will restore the expired mental health parity law, prohibiting differences in annual and lifetime limits on mental and medical insurance benefits.

- Alas, the Medicare Physician Payment Fairness Act is also not law. This bill would have reduced the decrease in the conversion factor used to calculate all Medicare payments. According to the APA Medicare Task Force members, this reduction for 2002 is the largest seen in several years, reflecting the current down swing in the nation's economy. Nevertheless, Steve McEllin of APA reported to the Medicare Task Force that APA, AMA, and numerous other health profession organizations are still lobbying against this reduction in payment for services. The conversion factor is re-calculated annually and depends heavily on the current economic conditions.

Profile On: Michelle Gagnon, Psy.D., *Continued from page 6*

his or her needs. Some clients receive individual therapy from staff or practicum students in addition to group interventions. Clients also have access to a psychiatrist and internist during STEP hours, as well as outings and seasonal activities. For the dually-diagnosed client, we have AA groups and individual substance abuse counseling provided by a county run program (there appears to be a growing need in South Florida for specialized treatment of dually diagnosed elderly). During free time at the residence, clients are offered outside activities such as ceramics, beach rides, and AA groups. Further, residents are assigned basic "chores" in typical milieu fashion. To accomplish the tasks of the whole operation, I oversee a staff of over 40 employees ranging from non-professional, to paraprofessional, to professional.

Overlaying this system are myriad internal and external systems, including graduate practicum training, outside case management, the legal system, and county, state, and federal agencies and funding sources. Interestingly, back in the 1980s there were over 10 such systems in Florida because state legislation dictated a comprehensive approach for deinstitutionalized older adults. Most programs have folded over the years due to the expense and dwindling funding sources. Currently, the GI treatment system is the only one of its kind in Broward County, FL, and one of only two in the state. Our operation is not-for profit, care is around-the-clock, and needs are vast, so finances are a constant concern. Making matters more difficult is

the recent economic downturn in Florida, a state that relies heavily on tourism dollars. The growing fiscal concerns of politicians have resulted in further tightening of "social service" program guidelines and dollars.

My daily work routine is varied, which I prefer. On any given day, I may need to consult with staff to resolve a clinical crisis, haggle with the local mechanic who repairs our vans, reassign staff to cover duties left open by an ill employee, supervise doctoral practicum students and senior staff, attend a county HUD meeting, report to my boss on our current census, and develop a database to better track reporting demographics. So, I do a bit of this and a bit of that with the hope that all will amount to a smooth running, therapeutic program that helps individuals who often have been deemed to be impossible to help.

Overall, the challenges have been great, but so have the rewards. In addition to the on the job training, I am pleased with the changes that my staff and I have been able to make to enhance the program. Because I have missed doing direct clinical work, I have started doing a few hours of private practice at night to better balance my work activities. I also try to stay active by editing this newsletter and participating in various organizations (e.g., GSA). Other geropsychologists and I are currently writing aging questions for the EPPP exam; we will meet in Tampa in mid-February for a workshop. My next step is likely to become more involved in our state politics; areas I am interested in are elder abuse and services reimbursement.

In closing, my advice to budding geropsychologists is to avail yourselves to varied experiences, be willing to take on professional challenges, and, because older adults critically underutilize mental health services, be an outspoken advocate for the value of psychology within the context of aging.

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Any questions or comments?: Please email me at mgagnon123@aol.com or phone me at (954) 262-5800

The Student Voice, *Continued from page 5*

articles that I had read for school. This cast a different light on the dry, intangible world of academia into an interesting, engaging field where people are passionate about their work and advocating for older adults through clinical work and research. As a result of this experience, I've made some invaluable connections with prominent clinical geropsychologists.

As an added benefit to the research award, networking, and the social events, I was recently asked to serve as the student representative for the Section. I hope that other students will take full advantage of the opportunities within the Section. As a third year graduate student in clinical aging, I'm looking forward to serving the 12/II student members and welcome any ideas or feedback that you have for the Section (sbeaudreau@hotmail.com). As student representative I hope to increase student interest and to make students aware of what 12/II has to offer. It is a fun way to promote your own professional development as you are welcomed into a circle of your future colleagues.

Call for nominations: Division 12, Section II Officers

William E. Haley, Ph.D., Past-President

*T*o prepare for elections this year, we need nominations for two offices :

- ♦The office of **President** has a 1-year term, but with obligations that span 4 years, including Program Chair while President-elect, Elections Chair while Past-President, and Chair of the Committee on Nominations and Elections while Past-Past President.
- ♦The office of **Secretary** has a three-year term that will run from 2003-2005.

Please send nominations to me either by mail or email:
William E. Haley, Ph.D.
University of South Florida
Department of Gerontology, SOC 107
4202 Fowler Avenue
Tampa, FL 33620-8100
Email whaley@chuma1.cas.usf.edu

♦♦

Call for submissions: Clinical Geropsychology student Research Award

Greg Hinrichsen, Ph.D., Past-Past President

*G*raduate and post-doctoral students may submit a completed project relevant to clinical geropsychology. Deadline for receipt of submission is **June 14, 2002**.

The award ($250 and a plaque) will be presented at the 2002 APA meeting in Chicago during the Section II business meeting. The award recipient also will be invited to appear at the Division 12 awards ceremony. Submissions will be accepted from student members of Section II and from students of members of Section II. Manuscripts should be 10-15 pages of text, plus tables and references. Manuscripts that are being presented as posters or in symposia at the APA convention will be accepted and are encouraged; please let us know if the manuscript you submit is being presented. For further information: hinrichs@lij.edu

Send submissions to:
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Did you know....

- If you need to **change your address** for the newsletter, please contact Barry Edelstein, Ph.D. at e-mail: u21b4@wvnet.edu or by phone: (304) 293-2001, Ext. 661.
- Stay connected with your colleagues in clinical geropsychology by joining our **e-mail network**. Simply send an e-mail to Barry Edelstein at Barry.Edelstein@mail.wvu.edu (Be sure to include your name, e-mail address, and express your interest in joining the 12/2 e-mail network).
- Division 12, Section 2 has a **website**. Check in out at http://bama.ua.edu/~appgero/apadiv12.htm.
- Encourage your colleagues and students to **join Division 12, Section II**. Contact Michele Karel, Ph.D., Psychology Service, 3-5-C, Brockton VAMC, 940 Belmont Street, Brockton, MA 02301; e-mail: Michele.Karel@med.va.gov; or phone: (508) 583-4500, ext. 3725 regarding membership.