AMERICAN PSYCHOLOGICAL ASSOCIATION

Division of Clinical Neuropsychology

Newsletter 40

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President's Message

Dear Division 40 Members,

I am writing to you to tell you that I am very pleased to be the President of Division 40. We are the second largest division in the American Psychological Association, reaching a total of over 5000 individuals of all membership categories. We are also an extremely active division and have accomplished an enormous amount in this past year. I want to let you know what Division 40 has done for you this year and invite you to get involved directly with the division.

Unlike any other organization for neuropsychologists, Division 40 is part of APA, and the importance of being part of APA has never been clearer than in the last few years. Our alliance with APA is vital because it allows us to have a strong voice in the largest psychological organization in the world, and one that affects legal, ethical, scientific and educational policy about neuropsychology. Equally importantly, it allows us to draw on the political and informational resources of APA. This alliance is particularly important in today's political climate where our practice is continually under attack.

Some of the things that Division 40 has done for you recently:

- Successful political action to prevent states from forbidding the use of psychometrists. The Practice Directorate has taken the lead working with the state associations in order to provide the flexibility for individual neuropsychologists to choose their own practice model rather than having one imposed upon them (Division 40 Education Advisory Committee, Neil Pliskin, chair).
- Workshops planned for INS to help training sites obtain APA Accreditation for postdoctoral training programs (Division 40 Education Advisory Committee, Sandra Koffler)
- About 10 years ago Division 40 was named the first APA-recognized specialty in Psychology. Reapproval of this specialization was obtained this year through the efforts of Linas Bieliauskas and Allan Mirsky
- New website, which is easier to navigate and has an enormous amount of information; take a look at div40.apa.org (Publication Committee, Rus Bauer, chair, Michael Cole, web consultant)

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Back issues of the division 40 Newsletter are now available on line at the Division 40 Archives website at Louisiana State University.
The URL address is:
http://www.lib.lsu.edu/special/findaid/apa/print.html

From The Editor

Dear Division 40 Members,

It is always hard to believe that it is time again for another edition of *Newsletter40*. Time seems to be moving very fast. I hope this edition finds you and yours well.

In this edition we are pleased to present a letter from our new Division 40 President, Dr. Kathy Haaland, an interesting article by Dr. Mark Sherer on early recovery from brain trauma, and a paper by our Division 40 Early Career Award winner, Dr. Deborah Koltai-Attix concerning her very important work with dementia patients. I hope you find these pieces interesting and informative.

New to this edition are the reports of many Division 40 committees. These committee reports will allow you, division members and our readers, to know first hand what your division officers and various committees are doing in their efforts to promote neuropsychology within APA, to the public, and to represent and advocate for division members' interests. Among these reports, please take note of the work of the Educational Advisory Committee, which asks for members involved in the education and training of neuropsychologists to complete the attached form and return it to the address included. Members involved at the doctoral, internship, and postdoctoral level are strongly encouraged to return the completed form so that we may update our training database (which formerly appeared in TCN) and place it on our division website.

In addition, we have our usual announcements, EC committee minutes, and a very informative report on the new HIPPA regulations which members will find especially useful. I hope you enjoy this issue of *Newsletter40*.

Sincerely,

Joel E. Morgan, Ph.D.,
Editor

Maximizing Coping and Compensation in Dementia: Geriatric Neuropsychological Intervention

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Interventions: Maximizing Coping and Compensation in Dementia

Consumers of neuropsychological services challenge our field when after evaluation and diagnosis they turn and ask, “But is there anything I can do_how do I fix the problem?”. Many of our geriatric dementia patients suffer from illnesses that preclude the application of traditional rehabilitation approaches, but nonetheless they and their families continue to search for a means to treat their illness. Until prevention and cure are realities, the question remains: What can be done to treat the symptoms of dementia?

Until recently, dementia patients were not considered in the neuropsychological therapeutic arena due to beliefs that their memory deficits would preclude benefit from intervention. Intervention studies were largely limited to pharmacological agents, or subject populations involving normal elders, acute stroke or traumatic brain injury patients. Indeed, traditional rehabilitation approaches are not appropriate in most geriatric dementia cases. Fortunately though, the landscape of geriatric neuropsychological care services is evolving. Evidence of clinical efficacy using modified intervention techniques is emerging and systematically dissolving previous biases against intervention with dementia patients. This promising work encourages the clinician to move beyond diagnosis in order to maximize functioning, coping, and quality of life, even in the context of debilitating dementia conditions (Koltai & Branch, 1998, 1999o Zarit & Zarit, 1998). Because the consumers involve patients with progressive conditions or stable dementias with neuroanatomical recovery largely complete, it is not the underlying neuropathology that is targeted for modification. Rather, coping, adjustment, and the use of compensatory strategies and residual abilities is the focus of this work (Koltai & Branch, 1998, 1999o Sohlberg & Mateer, 1989).

Recent lines of inquiry utilizing memory and coping programs or specific techniques have yielded promising results. Pioneering studies are beginning to delineate what approaches, such as spaced retrieval or multiple-technique programs, will be effective.

Subjective *perceptions* of memory gains by patients and caregivers have been shown as a result of training (Koltai et al., 2001), potentially impacting both memory and emotional well-being. Specific techniques targeting distinct skills have yielded gains in *actual* memory performance as well. Spaced retrieval has been used to teach AD patients to use a calendar, perform a prospective memory task, and improve recall of everyday objects (Camp et al., 1996o Cherry et al., 1999o McKitrick et. al, 1992). Errorless learning and associative techniques also have improved learning or retention duration of face-name pairs among AD patients (Clare et al., 2002). As Camp and colleagues have outlined (1996o pg.193) “it is possible to design effective, pragmatically useful memory interventions” for geriatric patients having memory disorders.

Another promising line of research has demonstrated improved emotional functioning as a result of non-pharmacological psychotherapeutic interventions. These interventions target the “excess disability”, or greater than warranted functional incapacity (Brody et al., 1971) that results from treatable factors. Affective distress is clearly amenable to treatment, and can potentially impact cognition (Alexopoulos et al., 1993o Lichtenberg et al., 1995) as well as adaptive functioning and health care utilization (Callahan et al., 1994). The prevalence of depression in elders with dementia underscores the need for attention to this domain, with close to half in many series demonstrating minor or major forms of depression (Ballard et al., 1996o

Migliorelli et al., 1995). Even among patients without marked affective disorders, reports of less efficient processing during periods of emotional distress highlight a potentially powerful target to improve functioning. Therefore, successful treatment of depression, even in the context of a progressive neurodegenerative illness, may decrease disability, optimize the use of residual capacities and possibly even delay the need for institutionalization. Favorable outcomes have documented both patient and caregiver symptom mitigation and improved adjustment, typically as a result of behavioral interventions (Teri et al., 1994, 1997). Others emphasize the therapeutic potential of support groups for newly diagnosed AD patients to decrease the sense of isolation and facilitate grief work (Davies et al., 1995; LaBarge & Trtanj, 1995; Yale, 1989). Suggested guidelines and modifications to psychotherapeutic technique have also been offered.

The Role of Neuropsychology

Neuropsychologists are particularly suited not only to conduct this type of work, but also to lead the field forward in establishing geriatric neuropsychological intervention as an empirically validated therapy. In clinical practice, the neuropsychologist integrates neuropsychological data, a theoretical understanding of the neuroanatomical correlates of behavior, an understanding of the potential impact of intrapsychic and intrapersonal concerns, and various behavioral and therapeutic approaches in order to identify the most feasible goals to target and which methods to utilize (Pramuka & McCue, 2000; Sohlberg & Mateer, 1989). In research, the neuropsychologist can design and execute efficacy and cost-effectiveness studies to establish the utility of such work (Attix et al., 2003).

Maximal treatment benefit is contingent upon the development and implementation of a carefully considered treatment plan, wherein intervention *targets and strategies* are identified. The pivotal role of the neuropsychologist is best appreciated in how **neuropsychological data** informs this treatment planning process. The patient's general level of cognitive functioning sets the tone for exploration of treatment direction. Appreciating the diagnosis allows for investigation of hypotheses related to the typical cognitive, affective, and behavioral features of illness (Koltai & Branch, 1999). Further, likely patterns of future changes along these dimensions can be anticipated and incorporated into the treatment plan (Koltai & Branch, 1999). From logical and ethical standpoints, strategies are selected that will continue to serve the patient well in the future. Test results may assist the clinician in anticipating the types of complaints and goals the patient and family may have, to the degree that the relationships between neuropsychological test performance and everyday functional capacities have been established (e.g., driving, financial decision making). The neuropsychological evaluation leads to generation or revision of hypotheses about the patient's cognitive strengths and weaknesses, and assists the clinician in ruling in or out various intervention approaches, and suggests technique modifications (e.g., simplifying or eliminating more complex stepso altering the timing of the introduction of strategy sections). For instance, patients demonstrating a circumscribed memory deficit may be capable of learning and applying effortful processing strategies based on association, whereas memory disordered patients with additional executive deficits may benefit from techniques relying less on judgment and organization, such as spaced retrieval. In the most obvious sense, strategies are selected that allow the patient to use relative strengths to compensate for relative weaknesses. Beyond this, the potential influence of each area of deficit on the use of various techniques is considered. In this manner, neuropsychological intervention planning proceeds within an informed framework.

Other variables having the power to influence treatment outcome are also typically considered in the selection of targets and techniques. For example, it is essential that rational, educated **goals** be established, particularly considering the typical illness course for this patient population. The complaints that drive the search for treatment can be considered, but those that involve management, compensation, and coping are truer than rehabilitation. Understanding the source of

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Early Recovery from Traumatic Brain Injury: Post-traumatic Amnesia vs. Post-traumatic Confusional State

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Patients recovering from moderate or severe traumatic brain injury (TBI) generally experience a period of recovery that is characterized by confusion, agitation, irritability, disorientation, impaired perceptual abilities, decreased judgment, impaired memory, language impairment, decreased level of arousal, disinhibition, and inappropriate mood (Russell, 1932; Symonds, 1937). Patients with mild TBI may experience a similar period of recovery, but it is generally brief with milder symptoms. This state has been referred to as after-effects of concussion, acute traumatic psychosis, impaired consciousness, altered consciousness, and clouded consciousness (Symonds, 1937; Trzepacz, 1994). Russell (1932) coined the term post-traumatic amnesia (PTA) to describe this state. Russell noted that when patients return to "full consciousness" after resolution of PTA, they have "continuous memory" for subsequent events, but will not recall events that occurred during PTA (Russell, 1935). The term PTA has generally been adopted in the neurosurgery and rehabilitation literatures to refer to this early phase of recovery. The term PTA suggests that memory disturbance is the key symptom of patients in this state.

The psychiatric literature generally refers to this period of recovery after TBI as delirium (Trzepacz, 1994). Delirium is common in general hospital patients with an incidence of up to 20% (McEvoy, 1981; Trzepacz, 1994). In the general hospital population, delirium is associated with increased mortality and morbidity (Frances, Martin, & Kapoor, 1990). Delirium is indicated by disturbance of consciousness, cognitive or perceptual disturbance, rapid onset (hours to days), and caused by a general medical condition (American Psychiatric Association, 1994).

Agitation is common during early recovery after TBI and may interfere with compliance with rehabilitation as well as pose safety problems for rehabilitation staff and for the patient. For this reason, rehabilitation professionals have been keenly interested in assessment of agitation after TBI. Some (Fugate et al., 1997a, Fugate et al., 1997b) consider agitation to be distinct from other symptoms of early recovery from TBI. Fugate and colleagues (1997a) argued that the concepts of delirium and PTA do not adequately include agitation after TBI. They note that some patients may continue to be agitated after resolution of PTA.

More recently, Stuss and colleagues (Stuss et al., 1999) argued that disturbed attention is a key aspect of the early period of recovery after TBI and that it is attentional disturbance rather than memory impairment that is the most important component. Stuss and colleagues noted the similarity of this early phase of recovery to delirium. They proposed the term post-traumatic confusional state (PCS) to describe this period. They defined PCS "… as a transient organic mental syndrome with acute onset characterized by a global impairment of cognitive functions with a concurrent disturbance of consciousness, attentional abnormalities, reduced or increased psychomotor activity, and a disrupted sleep/wake cycle (p. 640)."

Our own research (Nakase-Thompson, Sherer, Yablon, Nick, & Trzepacz, in press) provides support for the Stuss and colleagues (1999) position that the early period of recovery after TBI is a confusional state that is similar to delirium. In an investigation of 85 consecutive patients with moderate or severe TBI who

were admitted for inpatient rehabilitation, 59 (69%) met DSM-IV diagnostic criteria for delirium (American Psychiatric Association, 1994) at rehabilitation admission. Patients meeting delirium criteria had more severe injuries as indicated by longer time to follow commands and had more parenchymal contusions on initial post-trauma CT scans. As expected, patients in delirium were more restless and more disoriented than patients not in delirium. For these patients with severe injuries, the median duration of delirium was 43 days.

Conceptualization of early recovery after TBI as PTA vs. delirium vs. PCS has implications for the approach taken in assessing patients. Russell (1932) described a retrospective method for assessing duration of PTA. He recommended that after the patient has returned to full consciousness (has ongoing memory for recent events), the patient should be asked when he/she woke up following the injury. Russell considered the interval from the time of injury to the time the patient stated that he/she woke up to be a "… not inaccurate indication (p. 554)" of PTA duration. More recently, PTA duration has been assessed prospectively. The most commonly used instrument is the Galveston Orientation and Amnesia Test (GOAT; Levin, O'Donnell, & Grossman, 1979). Other instruments are the Orientation Log (Jackson, Novack, & Dowler, 1998), the Oxford Scale (Artiola Y Fortuny, Briggs, Newcombe, Ratcliff, & Thomas, 1980), and the Westmead Scale (Shores, Marosszeky, Sandanam, & Bachelor, 1986). These scales all assess orientation to person, place, and time. The GOAT and Oxford Scale also have items that require the patient to give retrospective estimates of durations of retrograde and anterograde amnesia. The Oxford and Westmead scales include items that require encoding and later recall and recognition of new memories.

Delirium has generally been assessed with clinician rated scales. Such scales include the Organic Brain Syndrome Scale (Gustafson et al., 1988), the NEECHAM Confusion Scale (Neelon, Champagne, Carlson, & Funk, 1996), and the Delirium Rating Scale (Trzepacz, Baker, & Greenhouse, 1988). As an example, the Delirium Rating Scale includes items that rate temporal onset of symptoms, perceptual disturbances, hallucinations, delusions, psychomotor behavior, cognitive status, physical disorder, sleep-wake cycle disturbance, lability of mood, and variability of symptoms. An alternative approach to assessment of delirium is provided by Hart and colleagues (Hart, Levenson, Sessler, Best, Schwartz, & Rutherford, 1996). Their scale, the Cognitive Test for Delirium (CTD), consists of objective measures of cognitive functions that may be impaired in patients in delirium. Areas assessed include orientation, attention span, memory, auditory comprehension, and vigilance (sustained attention). Since many acute medical patients in delirium may be in an intensive care unit and intubated, the CTD was designed so that no verbal responses are required. The CTD was originally validated on acute, general medical patients, but more recently the CTD was validated for use in assessing delirium after TBI (Kennedy, Nakase-Thompson, Nick, & Sherer, 2003).

In their research on PCS after TBI, Stuss and colleagues (1999) used the Toronto Test of Acute Recovery after TBI (TOTART). TOTART items assess orientation and retrograde and anterograde amnesia using items adapted from the GOAT and Westmead Scale. Other items assess auditory vigilance, recall and recognition of previously presented words, attention, and mental control (working memory). Sample items of attention include counting to 20, counting backwards from 20, and reciting the months forwards and backwards. The primary distinction between the TOTART and previously used measures of PTA is the addition of several items that assess various aspects of attention.

For our research on PCS (Sherer, Nakase-Thompson, & Yablon, 2003), we have combined elements of objective cognitive measures, PTA scales, agitation scales, and delirium rating scales. This research has resulted in a new measure of PCS, the Confusion Assessment Protocol (CAP). We began development of the CAP by administering the GOAT, Agitated Behavior Scale (ABS, Corrigan, 1989), CTD, Delirium Rating Scale – Revised (Trzepacz, Mittal, Torres, Kanary, Norton, & Jimerson, 2001), and elements of the TOTART to a sample of 62 consecutive patients with TBI at

admission to inpatient rehabilitation. Participants were also evaluated to see if they met DSM-IV diagnostic criteria for delirium (American Psychiatric Association, 1994). Descriptive data for the participants are presented in Table 1. Participant responses to each item from each scale were examined by 2 clinicians for clinical relevance and relationship to the diagnosis of delirium. Items that did not appear relevant or did not discriminate were eliminated. For example, memory items from the TOTART were eliminated as virtually all participants failed this task. Based on this analysis and previous research, 7 key symptoms of PCS were identified. These symptoms are: (1) Disorientation, (2) Cognitive impairment, (3) Fluctuation of presentation, (4) Restlessness, (5) Nighttime sleep disturbance, (6) Daytime decreased arousal, and (7) Psychotic-type symptoms. Items were selected to measure each symptom. Since the same Delirium Rating Scale-Revised item captures both nighttime sleep disturbance and daytime decreased arousal, this item was revised to only capture nighttime sleep disturbance and a new item for capturing daytime decreased arousal was written. Finally, scoring criteria were developed based on clinical judgment and discrimination of patients meeting DSM-IV delirium criteria from those not meeting delirium criteria. Participants with 4 or more symptoms of confusion were classified as in PCS and participants with 3 symptoms were classified in PCS if one symptom was disorientation.

Findings revealed that 40 (64%) participants met delirium criteria at rehabilitation admission. Of these, 38 (95%) also met our criteria for PCS. 44 participants met criteria for PCS and, of these, 38 (86%) also met delirium criteria. Overall agreement was 87%. These findings are preliminary and require replication with a new sample.

In conclusion, based on our review of this area and our own investigations, we agree with Stuss and colleagues (1999) that this early period of recovery after TBI is more accurately called PCS than PTA. Conceptualization of this state as a multifaceted confusional state rather than a state primarily marked by memory disturbance has practical advantages. The symptoms of this state that most contribute to management problems (agitation, psychotic-type symptoms, disturbed level of arousal, fluctuation) may be missed if one is focusing on memory functions and orientation. These symptoms may have a significant impact on patient and staff safely in rehabilitation settings and these symptoms may be more upsetting to family members than memory impairment or disorientation. If successful clinical trials are to proceed, it will be important to assess the full array of possible treatment targets. Symptoms such as restlessness, nighttime sleep disturbance, decreased daytime arousal, and psychotic-type symptoms may be more amenable to medical intervention that would be memory impairment or disorientation.

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Table 1.

Descriptive Data for 62 Patients with TBI	
Age – Mean (SD[1])	38.1 (18.2)
GCS[2] – Mean (SD)	8.7 (4.0)
Chronicity[3] – Mean (SD)	24.0 (13.3)
% Male	77%

Note.

[1] SD = Standard deviation.

[2] GCS = Glasgow Coma Scale score at Emergency Department admission.

[3] Chronicity = Time from injury to assessment in days.

Scientific Advisory Committee

The main activities of the SAC centered around the awards programs and the initiatives with the Practice advisory committee and Dr. Pliskin (the HIPAA fact sheet, the fMRI task force). Here is the section from the minutes that is pertinent:

The SAC selected the award winners with the assistance of the Program committee.

The winners this year are:

Paula Alhola
Dept of Physiology, University of Turku, Sleep Research
Finland

Jane E Booth, MA
James A. Haley VA Medical Center,
Tampa, FL

The Psychological Corporation generously contributed $2000.00 to fund two Student Scholarships. Preliminary indications are that they will continue to fund these awards for the foreseeable future. The awardees this year are:

Lisa Holme, Psy.D.
Dept of Neurosurgery, Neuropsychology Service,
School of Medicine, Yale University
New Haven, CT

Aiko Yamamoto, MA
Dept of Behavioral Medicine and Psychiatry,
West Virginia University, WV

The committee is recommending changes to the award process. While the Award committee, the SAC, and the Program awards (e.g., the Blue Ribbon awards) are consolidated under the SAC for budgetary purposes, there is no centralized process for other aspects of the awards such as printing certificates, notification of winners, distributing the award checks and certificates, etc. Since all of the awards fall under the SAC budget, it makes sense to consolidate the other aspects of the award as well. It is recommended that the Awards committee assume responsibility for production of certificates and other aspects of the awards in the future.

Other Activities

Dr. Bonny Forrest worked with Dr. Pliskin to develop the Division 40 HIPAA Fact sheet for Neuropsychologists, which has been made available to the EC for review and comment. Also, the SAC will have representation on other initiatives that cross practice/science domains, such as study of the role for Neuropsychology in emerging technologies like fMRI.

Dr. Heaton's COESP was sunsetted, after getting two solicited review articles published in TCN

In addition, Greg Lee can give you a rundown on the activities of the Awards Committee that do NOT involve the Student awards, like the Benton Lecture, etc...

While there were other "activities" these were the only concrete accomplishments. The other activities

include working on the "science-of-practice/practice-of-science" initiative of gathering evidence ased practice articles to post as a reference list for members.

I should add that we are endeavoring to have a closer liaison with the APA Science Advisory group this year, and I made contact with the relevant APA person at this year's convention.

New members of the committee are welcome. Please send a cv and a brief paragraph describing interests to me.

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Announcement

The American Psychological Association (APA) Ad Hoc Committee on End-of-Life Issues is interested in finding out what psychologists are doing in the areas of dying, suicide, bereavement, traumatic loss, and end-of-life issues. Please take a few moments to go to the following website (http://watson.apa.org/eol/divmem/) and complete the committee's five-minute, online survey.

Results from the survey will be summarized and posted on the APA website at the following location: (http://www.apa.org/pi/eol). It is important to note that individual responses to the survey will be confidential and only aggregate data will be made available to the public. It is also important to note that this survey is being disseminated through multiple communication channels and thus it is possible that you might receive it more than once. We ask that you complete the survey only one time.

If you have any questions, please contact: John R. Anderson, Ph.D. Staff Liaison for End-of-Life Issues, at janderson@apa.org, or at 202-336-6051. By mail: American Psychological Association, 750 First Street, NE Washington, DC 20002-4242

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Division 40 Ethnic Minority Affairs (EMA) Committee
(A subcommittee of the Public Interest Advisory Committee)

Consistent with the American Psychological Association's *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003), the mission of the Divison 40 Ethnic Minority Affairs Committee is to promote the integration of diverse populations into the fabric of neuropsychological practice, research, teaching, and training in order to provide neuropsychologists with the knowledge and resources to better understand and serve an increasingly diverse U.S. population, and to reduce historic inequities present in the field of neuropsychology. The specific diverse populations, which are targeted by this committee, include those who have been historically marginalized or disenfranchised within and by neuropsychology based on their ethnic/racial heritage and social group identity or membership (APA, 2003), including African-Americans, Asians, Latinos, Native Americans, and other biracial/multi-ethnic, multiracial groups. As such, this committee has three overarching objectives. The first objective is to promote the provision of culturally competent neuropsychological services to persons of color through increasing awareness and provision of training opportunities on cross-cultural/multicultural assessment issues among all neuropsychologists. The second objective is to stimulate the highest quality of neuropsychological research among minority populations via increased awareness for the need for such research among the neuropsychological community, as well as by the provision of research resources and facilitation of consultation and mentoring on cross-cultural/multicultural research related issues. The final overarching objective of this committee is to strongly encourage the career development of neuropsychologists with diverse ethnic or racial backgrounds since increasing the numbers of competent, culturally diverse neuropsychologists will likely broaden the field's conceptualization and implementation of practice, research, and training.

Two important and ongoing initiatives have been established by this committee to facilitate the above mission:

A mentoring program/database to encourage the career development of neuropsychologists of diverse backgrounds. For information on or to be included in this database, contact Desiree Byrd, Ph.D., at dab2006@columbia.edu.

A listserve for all who are interested in crosscultural/multicultural issues in neuropsychology. To join the listserve, contact Jovier Evans, Ph.D., at jevans2@iupui.edu.

Plans for this committee in the coming year include: the development of an article or position statement to encourage the proper use of norms, including ethnic/racial normative corrections; and the development of a web page to provide resources and information on the EMA committee.

Those interested in joining the committee should contact the co-chairs, Monica Rivera Mindt, Ph.D. (riveramindt@fordham.edu) or Tony M. Wong, Ph.D. (twong@unityhealth.org), and submit a current CV.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): FACT SHEET FOR NEUROPSYCHOLOGISTS

Division 40, American Psychological Association

DISCLAIMER

This general information fact sheet is made available by Division 40 of the American Psychological Association to outline the requirements of HIPAA regulations that may be of special interest to neuropsychologists. The information is not exhaustive or definitive, nor considered to be guidelines or standards of practice. It has not been endorsed or approved by APA.. One should consult State Laws and the American Psychological Association Principles of Psychologists and Code of Conduct (2003) regarding additional specifics of compliance as the fact sheet does not integrate ethical requirements or non-preempted state laws. The fact sheet may not be applicable to every situation, and is not intended to provide legal advice. Neuropsychologists should seek appropriate legal advice when necessary. The fact sheet is based on an understanding of current information, but the administrative and legal process may result in new information concerning its requirements due to the new and evolving nature of HIPAA. More detailed information, including state-specific information can be obtained through the APA Practice Directorate's course, HIPAA for Psychologists, that can be accessed at their website listed below. Additional resources include the United States Office of Civil Rights, the Centers for Medicare and Medicaid Services, and the Department of Health and Human Services for more specific information. This fact sheet has not been endorsed or approved by these agencies.

General Information

What is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act of 1996. It is a statute and set of Federal rules governing the use and disclosure of health information. The rules involve four components: Privacy Rule (effective 4/14/03), Electronic Transaction Standards and Code Sets (effective 10/16/03), Security Rule (effective 2/21/05), and Employer Identifier Standards (effective August 1, 2005). HIPAA also establishes criminal and civil penalties for improper use and disclosure.

Is HIPAA relevant to Neuropsychologists?

Neuropsychologists may be required to follow HIPAA regulations in their clinical and research practice, whether they are in private practice or employed by an agency (e.g., Medical School, University, Mental Health Center, or Hospital). Any neuropsychologist who is a covered entity had to be compliant with the Privacy Rule by April 14, 2003. Not everyone will meet the definition of a covered entity. According to HIPAA, covered entities include but are not limited to Healthcare Providers, Health Care Plans, and Healthcare Clearinghouses. A neuropsychologist would become a covered entity if he or she is a healthcare provider who: 1) furnishes, bills, or receives payment for healthcare; 2) conducts one of the 8 covered transactions (such as checking billing claims status, checking authorization for payment, etc.); and 3) conducts any of those 8 transactions electronically (for example via computer, internet, transfer of disks, CDs). If someone does not meet all three of these criteria, then they are not a covered entity and the HIPAA Privacy Rule does not apply to them. However, they may have to interact with other covered entities and therefore it mught be advisable to be aware of the Privacy Rule to properly provide treatment to clients while protecting their health information. If a neuropsychologist engages exclusively in forensic private practice in which no electronic transmission of client information is conducted, then that neuropsychologist would not be a covered entity.

What is the difference between the Privacy Rule and Security Rule?

The Privacy Rule focuses on the application of effective policies, procedures, and business service agreements to control the access to and use of patient information. The Security Rule addresses the provider/organization's physical infrastructure to assure secure and private communication and maintenance of confidential patient information. The Privacy Rule applies to all protected health information regardless of the medium in which it is kept and also includes security requirements. The Security Rule applies only to protected health information stored electronically.

How will the HIPAA Privacy Rule affect neuropsychologists?

HIPAA generally requires that neuropsychologists provide information to patients about their privacy rights and how that information can be used. One way to meet this requirement is to adopt clear privacy policies and procedures, train employees and supervisees so that they understand privacy procedures, designate an individual responsible for addressing HIPAA privacy questions and complaints, and secure patient records (e.g., test reports, raw data, clinical interview notes). The policies and procedures must be documented in either written or electronic form. HIPAA requires that the neuropsychologist also mitigate any known harmful effects in the unauthorized use or disclosure of patient health information. In addition, the Privacy Rule establishes the conditions under which Protected Health Information (PHI) may be used or disclosed by covered entities for research purposes. PHI consists of information in the records that could identify the patient. Please refer to the glossary for a more detailed definition of PHI.

How will the Security Rule affect neuropsychologists?

The Final Rule adopting HIPAA standards for the security of electronic health information was published in the Federal Register on February 20, 2003. This final rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information. The standards are delineated into either required or addressable implementation specifications. HIPAA requires that neuropsychologists develop clear written policies and procedures to establish physical safeguards to guard data integrity, confidentiality, and availability; employ technical security services to guard data integrity, confidentiality, and availability; and establish technical security mechanisms to guard against unauthorized access to data that is transmitted over a communications network. HIPAA also indicates that neuropsychologists are given some discretion in deciding the feasibility of implementations beyond those that will be required.

Do the patient rights of the Privacy Rule apply to neuropsychologists too?

The HIPAA Privacy Rule may grant the client (or their personal representative) a broader access than prior to HIPAA depending on state law. Only under a few well defined circumstances can the healthcare provider deny this request for access and even then in some of these cases, the denial can be reviewable by a third party. One unreviewable reason for denial is a request for the client to review their "psychotherapy notes" as defined by HIPAA However, test reports and raw test data do not fall under the provisions pertaining to "psychotherapy notes." Additionally, individuals may request restrictions as to how a covered entity will use and disclose PHI about them for treatment, payment, and health care operations (one doesn't have to agree to these restrictions but must comply with any agreements made). Individuals may also request to receive confidential communications from a covered entity, either at alternative locations or by alternative means. Finally, any use or disclosure of PHI must be consistent with the covered entities' practices, and the covered entity is required to provide the individual with adequate notice of its privacy practices and a list (called an accounting) of disclosures of PHI.

What is an accounting under HIPAA?

The Privacy Rule gives individuals the right to request an accounting of certain disclosures of PHI

made by a covered entity. This accounting must include disclosures of PHI that occurred during the six years prior to the individual's request or the compliance date (whichever is sooner), and must include specified information regarding each disclosure. A more general accounting is permitted for subsequent multiple disclosures to the same person or entity for a single purpose. Disclosures made pursuant to an individual authorization or disclosures of a limited data set under a data use agreement are exempt from this accounting requirement. Additionally, for disclosures of PHI without individual authorization that involve at least 50 records, the Privacy Rule allows for a simplified accounting procedure. Under the simplified procedures, a covered entity may provide individuals with a list of all protocols for which the patient's PHI may have been disclosed.

Are there consequences for failure to comply?

Yes, there are posted fines and penalties (some substantial) for failure to comply with HIPAA rules. There are scaleable penalties, with consideration for reasonable effort.

Clinical Information

Do patients have access to and can they obtain a copy of their neuropsychological reports?

Under HIPAA regulations, patients generally now have access to their records, including neuropsychological reports, test responses, and raw data. This is regardless of the referral party (e.g., IME, Worker's Compensation) or reason for referral. (What about if the referral is for litigation purposes?) However, there are some limited defined instances for denying such access within the HIPAA Privacy Rule, and there may be additional guidance from applicable state laws and the American Psychological Association Principles of Psychologists and Code of Conduct (2003). In general, when HIPAA rules are in conflict with other applicable rules, laws, standards, statutes, etc., the more stringent rule (with regard to safeguarding PHI) takes precedence.

Does HIPAA require patient authorization to send a neuropsychological report to another provider who is treating the patient?

No, the HIPAA Privacy Rule permits the neuropsychologist to disclose PHI about an individual without the individual's authorization to another provider for treatment of the individual. However, agency or organizational policies (e.g., hospital, mental health center, or university) or state laws that are more stringent regarding the release of information should be followed. If their policies require patient consent, consent must be obtained.

Are parents allowed access to their minor child's neuropsychological reports?

Yes, HIPAA generally allows a parent to have access to the records concerning his or her child as the minor child's personal representative when such access is not inconsistent with state or other applicable laws. However, there are three circumstances under the HIPAA Privacy Rule in which the parent is not considered to be the personal representative of a minor child: (1) the minor has consented to care and the consent of the parent is not required by state or other applicable law; (2) the minor has obtained the testing at the direction of the court or an appointee of the court; or (3) the parent of the minor has agreed that the neuropsychologist and the child may have a confidential relationship. In addition, HIPAA allows a neuropsychologist (or provider) to choose not to treat a parent as a personal representative in the case of suspected abuse, neglect, domestic violence, or endangerment to the child.

Are e-mail correspondences with patients or referral parties covered under HIPAA?

All electronic transmission of health information by covered entities is covered under HIPAA. Electronic transmission is not necessarily considered a confidential means for use and disclosure of patient information, including electronic transmission with patients themselves, without the consideration of the use of encryption or other security measures. HIPAA requires neuropsychologists to take special care in mitigating any harmful effects and limitations of confidentiality with electronic transmission.

What is the difference between authorization and consent under HIPAA?

Prior to using PHI to carry out treatment, payment, and health care operations health care providers under HIPAA are not required but may choose to obtain consent although many states may have a consent requirement. Consent is a general document that gives health care providers permission to use and disclose all PHI for treatment, payment, and health care operations. It gives permission only to that provider, not to any other person. Health care providers may condition the provision of treatment on the individual providing this consent. One consent may cover all uses and disclosures by that provider, indefinitely. Consent need not specify the particular information to be used or disclosed, nor the recipients of disclosed information. Generally, a "direct treatment provider" is one that treats a patient directly, rather than based on the orders of another provider, and/or provides health care services or test results directly to patients. Other health care providers, health plans, and health care clearinghouses may use or disclose information for treatment, payment, and healthcare operations without consent, or may choose to obtain consent. However, many states may have a consent requirement.

An authorization is permission above and beyond the general consent that permits further use for specified purposes. It is required by the Privacy Rule for use and disclosure of PHI for marketing or research, for disclosure of psychotherapy notes, and for any other uses/disclosures that are not for treatment, payment or healthcare operations.

Is informed consent for testing the same as HIPAA consent?

No. Informed consent for testing and any consent obtained under HIPAA for treatment, payment, and health care operations are not the same. Although the final Privacy Rule allows for these two types of consents to be obtained in the same document, the two consents must be visually separate. In addition, the privacy notice must be a separate document. Informed consent regarding testing, treatment, or any other procedures still must be obtained from patients as specified in state statutes or the APA Ethical Code. HIPAA does not mandate such consents as PHI may be used or disclosed for the purposes of treatment, payment, or healthcare operations as long as this has been explained in the Notice of Privacy Practices given to the client by the covered entity at their first contact. But HIPAA also does not prevent the use of consents for treatment, testing, etc., if that is required by other local rules. Minors pose special issues, with need for assent and defined designated representative.

Can patients make amendments to their neuropsychological reports?

Patients now may make requests to amend (not change) their records, but there is no obligation for the neuropsychologist to agree to the request. HIPAA requires neuropsychologists to have written policies and procedures that describe the process for making such requests and the conditions under which such requests can be denied and that are consistent with state laws. Under HIPAA, the client has the right to disagree with this denial and the covered entity then can provide a rebuttal of the notice of disagreement. All of this documentation must be appended to the record, even if the original request to amend was denied. Neuropsychologists may want to consider allowing patients to amend incorrect information in their records if the neuropsychologist is the originator of the records. However, HIPAA does not allow patients to request changes to other information that is not PHI, such as interpretation or documented history. Patients may request restrictions as to how information is used or disclosed.

How are psychotherapy notes treated differently under HIPAA?

HIPAA specifically excepts "Psychotherapy notes," which are narrowly defined in the Privacy Rule as personal interpretive notes of discussions during therapy sessions that are kept separate from the medical record, from the rules governing patients' access to their records. Information about session start/stop times, and summary of diagnosis, treatment plans, progress with treatment, results of clinical tests, symptoms, functional status, and prognosis are not considered psychotherapy notes.

Any notes placed in the patient's record regardless of content are no longer considered psychotherapy notes and are available to be accessed by the patient. Again, state laws regarding how psychotherapy notes are treated must be followed.

What Must Providers include in a Notice Form?

Under the Privacy Rule, only doctors or other health care providers with a direct treatment relationship with a patient are required to use reasonable efforts to obtain a written acknowledgment from the patient of receipt of the provider's notice of privacy practices. In that notice, direct providers are required to describe in specific detail their uses and disclosures of health information that they will make. So, while the final rule did not require consent, in effect, given the detailed requirements of the notice of privacy practices, direct providers must use their reasonable efforts to obtain acknowledgment that the patient understands the instances under which PHI may be disclosed for treatment, payment and health care operations.

Research Information

How is research defined under HIPAA?

The Privacy Rule defines research as "a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge."

What are the HIPAA regulations that impact neuropsychological research?

In the course of conducting research, researchers may obtain, create, use, and/or disclose individually identifiable health information. Under the Privacy Rule, covered entities are permitted to use and disclose PHI for research with individual authorization, or without individual authorization under limited circumstances set forth in the Privacy Rule.

Are there specific procedures for using PHI in research?

Yes. Under HIPAA, use and disclosure may occur without patient authorization if the information has been de-identified by someone not involved in the research, there is an approved waiver from an institutional review board (IRB), the information is being used only as a preparatory form of research, or the PHI being used is that of deceased individuals. In other cases, PHI may be used in research when a research participant authorizes use of his or her PHI, providing the authorization satisfies certain specified requirements.

What specific steps may a neuropsychologist take to use PHI in research without authorization?

According to HIPAA, to use or disclose PHI without authorization by the research participant, a covered entity must obtain one of the following: 1) documentation that an alteration or waiver of research participants' authorization for use or disclosure of PHI for research purposes has been approved by an Institutional Review Board (IRB) or Privacy Board, 2) representations from the researcher (written or oral) that the PHI is being used or disclosed solely for the purpose of designing or assessing the feasibility of a study, 3) representations from the researcher that the use or disclosure is being solely sought for research on PHI of decedents (the PHI must be necessary for the research and at the request of the covered entity documentation of the death of the individuals must be provided), 4) a data use agreement between the covered entity and the researcher, pursuant to which the covered entity may disclose a limited data set to the researcher for research, public health, or health care operations.

If I receive federal funds for my research and comply with the regulations of the FDA and Common Rule, are there additional requirements to comply with HIPAA?

Yes. Most research involving human subjects operates under the Common Rule (45 CFR Part 46, Subpart A) and/ or the Food and Drug Administration's (FDA) human subject protection regulations (21 CFR parts 50 and 56), which have some provisions that are similar to, but separate from, the Privacy Rule provisions for research. These human subject protection regulations, which apply to most Federally funded and to some privately funded research, include protections to

help ensure the privacy of subjects and the confidentiality of information. The Privacy Rule builds upon these existing Federal protections and creates equal standards of privacy protection for both research governed by the existing Federal human subject regulations and for research that is not.

How do you obtain documentation of a waiver of authorization by an IRB or Privacy Board?

In the case of a waiver or authorization pursuant to the Privacy Rule, a covered entity may use or disclose PHI if the covered entity has documented all of the following: 1) identification of the IRB or Privacy Board and the date on which the waiver or authorization was approved, 2) a statement that the IRB or Privacy Board has determined that the alteration or waiver of authorization satisfies three criteria specified in the rule, 3) a brief description of the PHI for which use or access has been determined to be necessary by the IRB or Privacy Board, 4) a statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures, and 5) the signature of the chair or other member, as designated by the chair, of the IRB or the Privacy Board.

What criteria must be satisfied for an IRB or Privacy Board to approve a waiver of authorization under the Privacy Rule?

A waiver of authorization may be used to conduct records research when researchers are unable to use de-identified information, and the research could not practicably be undertaken if research participants' authorization were required. For an IRB or Privacy Board to approve such a waiver of authorization under the Privacy Rule, the following criteria must be satisfied: 1) the use or disclosure of PHI involves minimal risk to the privacy of individuals based on the presence of three criteria: a) an adequate plan to protect the identifiers from improper use and disclosure, b) an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law, and c) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the project, or for other research for which the use or disclosure of PHI would be permitted; 2) the research could not practicably be conducted without the waiver or alteration; and 3) the research could not practicably be conducted without access to and use of the PHI.

What provisions must a data use agreement contain?

Under the Privacy Rule, a data use agreement may be used to allow the covered entity to disclose a limited data set to a researcher or public health or health care operator. The data use agreement must: 1) establish the permitted uses and disclosures of the limited data set by the recipient consistent with the purposes of the research (which may not include any use or disclosure that would violate the Privacy Rule if done by the covered entity), 2) limit who can use or receive the data, and 3) require the recipient to agree to the following: a) not to use or disclose the information other than as permitted by the agreement or as required by law, b) use appropriate safeguards to prevent the use or disclosure of the information, c) report any uses or disclosures not provided for in the agreement of which the recipient becomes aware, d) ensure that any agents, including a subcontractor, to whom the recipient provides the limited data set agrees to the same restrictions and conditions that apply to the recipient with respect to the limited data set, and d) not identify the information or contact the individual.

How do I obtain individual authorization for research use of PHI?

The Privacy Rule permits covered entities to disclose PHI for research purposes when a research participant authorized the use or disclosure of information about her or himself. For most clinical trials and some records research, the principal investigator of the study will seek authorization. The Privacy Rule has a general set of authorization requirements that apply to all uses and disclosures, including for research. However, several special provisions apply to research authorizations.

How do research authorizations differ from other authorizations required by HIPAA?

An authorization for research purposes, unlike other authorizations, may state that is does not expire, that there is no expiration date or event, or that the authorization continues until "the end of the research study," and the authorization may be combined with a consent to participate in the research, or with any other legal permission related to the research study.

What do I do if I started my research study prior to the HIPAA compliance dates?

A covered entity may use and disclose PHI that was created or received for research, either before or after the compliance date, if the covered entity obtained any of the following prior to the compliance date: 1) individual authorization to use PHI for research, 2) informed consent, or 3) a waiver of informed consent by an IRB in accordance with the Common Rule or an exception under FDA's human subject protection regulations. However, if a waiver of informed consent was obtained prior to the compliance date, but informed consent is subsequently sought after the compliance date, an individual authorization must then be obtained.

Glossary

Authorization= use of PHI for purposes other than treatment, payment, or health care operations also requires written patient authorization to release the information.

Consent = patient's consent may be obtained prior to using PHI to carry out treatment, payment, and health care operations; must include patient's right to revoke consent in writing; separate from informed consent for treatment or testing.

Covered entities= health plans, healthcare clearinghouses, business associates, and health care providers who electronically transmit any health information in connection with transactions for which the Department of Health and Human Services (HHS) has adopted standards. Researchers are covered entities if they are also health care providers who electronically transmit PHI in connection with any transaction for which HHS had adopted a standard.

Contrary state laws= state laws that conflict with HIPAA; laws offering less privacy protection are superceded by the Privacy Rule of HIPAA. (Note: There are 4 exceptions.)

De-identified information= data that contain no identifiers of an individual, of relatives, employers, or household members. This information is removed from a data set.

Disclosure= release, transfer, provision or access to, or divulging in any other manner of information outside the entity holding the information.

Electronic transmission= internet, extranet, leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another (via magnetic tape, disk, or compact disk medium), faxes generated on a computer or sent via a computer, any fax received since electronic source is unknown.

Limited data set= data that exclude specified direct identifiers of the individual or relatives, employers, or household members of the individual.

Health information and Protected health information= HIPAA defines health information as any information (oral or recorded in any form or medium) that is: 1) created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

While HIPPA's primary privacy concern is health information transmitted by or maintained in electronic media, the Privacy Rule also reaches to data transmitted or maintained in any other form or medium by covered entities. That includes paper records, fax documents and all oral communications. (HIPAA security, identifier, and transaction and code set rules, by contrast, only cover electronic information.)

Protected health information (PHI) under HIPAA means individually identifiable health information. Identifiable refers not only to data

that is explicitly linked to a particular individual (that's identified information). It also includes health information with data that reasonably could be expected to allow individual identification.

Psychotherapy Notes= Personal interpretive notes of discussions during therapy sessions.

Use= sharing, employment, application, utilization, examination, or analysis of individually identifiable health information within an entity that maintains such information.

For more information:
http://www.cms/hhs.gov/hipaa/hipaa2/regulations/transactions/finalrule/txfinal.pdf
http://www.hhs.gov/ocr/combinedregtext.pdf
http://www.APApractice.org
http://cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp

Membership Committee

The Membership Chair serves as an information resource to those interested in the neuropsychology in general and Division 40 in particular. Interested parties include psychology students, psychologists, and members of the non-psychology community. The committee also oversees the clerical tasks performed by APA Member Services regarding address updates and dues payment.

As most of the duties are now informational, the Membership Committee has remained "lean" with the Chair as the only committee member.

For the coming year, I will continue to work with Division Services to maintain maximal retention of members and recruitment of new members. Our division has not only grown to be one of the largest, but we also had demonstrated continued growth when other divisions have seen a decline in membership.

For more information, please contact me.
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Education Advisory Committee

Sandra Koffler, Ph.D., Chair

Dear Site Director:

This form has been prepared by the Educational Advisory Committee of APA Division 40 (Clinical Neuropsychology). The Division is compiling an updated list of doctoral, internship, and residency programs that identify themselves as providing training in clinical neuropsychology. The new listings will replace those previously assembled by Dr. Lloyd Cripe. Information regarding your program will be made available via the Division's website and in its publications. Disclosure of the neuropsychology curricula available at your site will help students in meeting the criteria for specialty training and education in clinical neuropsychology as proposed in the Policy Statement of the Houston Conference (*Arch. Of Clinical. Neuropsychology*, 1998, 13 (2), 157-250). The policy recognizes that specialty knowledge and skills are acquired throughout one's training and that the opportunities available at each site will vary. The final exit criteria for completing training in the specialty are to be met at the end of the residency program. Please return the completed form to: Sandra Koffler, PhD, ABPP, Hahnemann Univ. Hospital- Neuropsychology Service - Mail Stop 341, 245 N. 15th Street - Philadelphia, PA. 19102. You may also send an electronic file to: sk46@exchange1.drexel.edu. We also anticipate that this form will be available on the Division 40 website soon (www.div40.org). It can be downloaded, completed and then returned.

A. Professional Program - General Information

Please identify the training level of your program.

_____**Doctoral**: Clinical____ Counseling____ School___ Other (please specify)_____

_____**Internship**: General Clinical Track _____ Rotation _____

Separate Full Time Track_____ Other (please specify)_____

_____**Residency:** Setting: University_____ Hospital_____ Other (please specify)_____

Department: Psychiatry_____ Neurology_____

Free Standing____ Other (please specify)_____

Accreditation: Regional _____ APA ___ CPA___

Program Address: _____

_____

_____

Program Director: _____

Address: _____

_____

EMAIL: _____ **Fax:** _____**Phone**_____

Number of students accepted into the program each year (inclusive)

Is there a separate admission for neuropsychology

Doctoral students Yes____No____

Interns Yes____ No____

Application Deadline: _____

B. Professional Program - Doctoral

Type of Program: **Track** _____ **Freestanding** _____
Number of neuropsychology students accepted into program each year _____
Number of neuropsychology faculty
Full-time _____ **Part-time (**20 hrs.+) _____ **Part-time (< 20 hrs.)** _____

Other consulting faculty

Discipline _____ **Specialty** _____
Discipline _____ **Specialty** _____
Discipline _____ **Specialty** _____

Number of faculty board certified in Clinical Neuropsychology _____
Certifying Board(s) _____
Is there a defined, sequential neuropsychology curriculum? Yes No
Please indicate credit-earning coursework:

		Optional	Required
___	**Foundations of clinical neuropsychology**	_____	_____
___	**Functional neuroanatomy**	_____	_____
___	**Clinical neurology/neuropathology**	_____	_____
___	**Neuropsychology of behavior**	_____	_____
___	**Neurodiagnostic techniques**	_____	_____
___	**Techniques of Neuropsychological assessment**	_____	_____
___	**Techniques of neuropsychological consultation**	_____	_____
___	**Techniques of neuropsychological intervention**	_____	_____
___	**Neuropsychology research training**	_____	_____
___	**Ethics in clinical neuropsychology**	_____	_____
___	**Diversity in clinical neuropsychology**	_____	_____
Other			
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Are practica in clinical neuropsychology available
None ____ **Child** ____ **Adult** ____
Are there specific exit criteria for students completing the clinical neuropsychology program?
Please specify.

_____

_____

Please add additional information to be included in your listing.

_____

_____

_____

_____

B. Professional Program - Internship

Program Setting: University _____ Hospital _____ Clinic _____ Other _____

Program Accreditation None____APA_____CPA____

Number of neuropsychology interns accepted into program each year _____

Is there a separate selection process for neuropsychology interns? Yes _____ No _____

List specific doctoral coursework and training required for selection:

_____

_____

_____

_____

Number of Neuropsychology faculty.

Full-time _____ Part-time (20 hrs.+) _____ Part-time (< 20 hrs.) _____

Other consulting faculty

Discipline _____ Specialty _____

Discipline _____ Specialty _____

Discipline _____ Specialty _____

Number of faculty board certified in Clinical Neuropsychology _____

Certifying Board(s) _____

Stipend ($)/annum ___

Time in neuropsychology rotation or track _____0-3mos _____3-6mos _____12mos

Percent time in neuropsychology activities: _____

Variable, depending on training needs _____

Minimal time _____0-25% _____26-50% _____51-75%_____76-100%

Percent time/week in neuropsychological assessment _____

(testing; scoring; supervision; report)

Is there specialty coursework for neuropsychology interns? Please specify.

Type	**Frequency**
_____	_____
_____	_____
_____	_____

Please list the rounds/seminars/conferences the neuropsychology intern is required to attend:

Type	**Frequency**
_____	_____
_____	_____
_____	_____

Please specify other didactic training:

Type	**Frequency**
_____	_____
_____	_____
_____	_____

Is additional training available in Neuroanatomy _____

Neurodiagnostics_____ Behavioral Neurology_____

Other _____

Patient population Child _____ Adult _____ Both _____

Please name the primary disorder(s) in your patient population.

_____

_____

_____

Are there opportunities for socialization with psychology faculty _____

other faculty _____ other medical trainees _____

Are research activities mandatory _____ optional _____unavailable _____

Are there specific exit criteria for students completing the clinical neuropsychology internship? (if yes, please indicate criteria below).

_____

_____

Please add additional information to be included in your listings.

_____

_____

_____

_____

B. Professional Program - Postdoctoral Residency

Name of Program: _____

Member of APPCN Yes _____ No _____

Participate in APPCN Match Program Yes _____ No _____

Number of neuropsychology resident placements each year _____

Full-Time Faculty Number _____

Number Board Certified _____ Certifying Board(s) _____

Prerequisites for Admission:

None __ Only APA/CPA-accredited doctoral program? Yes___ No___

Only APA/CPA-accredited internships Yes___ No___

Is there specialty coursework for neuropsychology residents? Please specify.

Course	Frequency
_____	_____
_____	_____
_____	_____

Please list the rounds/seminars/conferences the neuropsychology resident is required to attend:

Type	Frequency
_____	_____
_____	_____
_____	_____

Please specify other didactic training:

Type	Frequency
_____	_____
_____	_____
_____	_____

Indicate if specific training/education is available for the following:

___ Functional Neuroanatomy ___ Disorders Affecting the Nervous System

___ Neurodiagnostic Techniques ___ Neuropsychologic Interventions

Stipend ($)/annum ___

Month/Day program begins _____ _____

Length of Program _____(years)

Specific Setting ___Academic Medical ___General Hospital

___VA Hospital ___Rehab Hospital ___Psychiatric Hospital

___Outpatient or private setting ___Other (please specify)

Patient Population

Adult _____% Child_____%

Please list the primary disorder(s) in your patient population.

_____

_____

_____

_____

List the current research projects of the faculty and residents (indicate if funded).

_____

_____

_____

_____

Percent time/week in clinical service (assessment, intervention, consultation) _____

Number of Assessments/week: Full _____ Brief _____

Percent time/week in clinical research _____

Percent time/week in educational activities _____

List types of clinical experience in the program:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Identify the exit criteria for the residency:

Capable of independent practice in:

___ Assessment

___ Intervention

___Consultation

___Other (name)

___Advanced knowledge of brain-behavior relations

___Scholarly activity submitted for publication, presentation, or grant proposal

Is there an exit exam: Yes ___ No ___

Please add additional information to be included in your listing.

_____

_____

_____

_____

Public Interest Advisory Committee

Chair: Deborah Koltai Attix, Ph.D. (koltai@duke.edu)

The primary mission of the Public Interest Advisory Committee (PIAC) is to increase public awareness of Division 40 and the practice of clinical neuropsychology. Through the work of this committee, we hope that the public sector will become more informed about neuropsychology, and reciprocal communication will be enhanced.

In 2002, the PIAC announced the publication of two brochures, "Clinical Neuropsychology" and "Pediatric Neuropsychology". These brochures were designed for consumers, are easy to read, and provide a general introduction to clinical neuropsychology. Approximately 65,000 copies of each have been distributed thus far. They are intended for use in patient education, communication with referral sources, and whenever there is an opportunity to increase public awareness of neuropsychology. They are currently being translated into French and Hebrew at the request of Division 40 members.

The PIAC also has two very active mentoring programs: one involving Ethnic Minority Affairs (EMA), and one involving women in neuropsychology (WIN).

The mission of the Divison 40 Ethnic Minority Affairs Subcommittee, in part, is to promote the integration of diverse populations into the fabric of neuropsychological practice, research, teaching, and training in order to provide neuropsychologists with the knowledge and resources to better understand and serve an increasingly diverse U.S. population. Two important vehicles have been established to facilitate this mission: a mentoring program/database and a listserve for all who are interested in cross-cultural/multicultural issues in neuropsychology. Additional information about EMA, as well as listserve and database contacts, can be found in the detailed EMA description in this issue.

The mission of the Division 40 Women in Neuropsychology (WIN) Subcommittee is to actively support and mentor women in neuropsychology. The committee has established a variety of means to support this overarching goal, including:

1) Establishing a list serve with over 300 members for anyone interested in mentoring and supporting the role of women in neuropsychology. To join the list serve contact Cynthia Kubu (kubuc@ccf.org).
2) Developing a mentoring program and database designed to facilitate identification of mentors for women at all stages of their professional career. Please contact Desiree Byrd for additional information or to have your name included in the mentoring database (dab2006@columbia.edu).
3) Sponsoring a variety of activities at the APA annual meeting and INS February meeting designed to support women's professional development. Recent activities have included panel discussions on editorial responsibilities and grantsmanship.

Finally, the PIAC organizes the efforts of many Division 40 APA liaisons, monitors, and committee chairs. These individuals work closely with APA committees and boards to enhance communication and coordination of efforts between Division 40 and APA as a whole.

Current members of the PIAC:

- Deborah Koltai Attix, Ph.D. *(Chair, PIAC; Liaison, Board for the Advancement of Psychology in the Public Interest; BAPPI)*
- Cynthia Kubu, Ph.D. *(Liaison, Women in Psychology; Chair, Women in Neuropsychology Subcomittee)*
- Monica Rivera Mindt, Ph.D. (*Co-Liaison, Ethnic Minority Affairs; Co-Chair, Div40 Ethnic Minority Affairs)*
- Tony Wong, Ph.D. (*Co-Liaison, Ethnic Minority Affairs; Co-Chair, Div40 Ethnic Minority Affairs)*
- Gerard A. Gioia, Ph.D *(Liaison, Children, Youth & Families)*

- George Miller, Ph.D. *(Monitor, Lesbian, Gay & Bisexual Concerns)*
- Scott Hunter, Ph.D. *(Monitor, Office on AIDS; Monitor, Urban Initiatives)*
- Doug Johnson-Greene, Ph.D. *(Monitor, Disability Issues in Psychology)*
- Deborah Cahn-Weiner, Ph.D. *(Monitor, Committee on Aging)*
- Michele Macartney-Filgate, Ph.D. *(Chair, Ethics Subcommittee)*
- Bernice Marcopulos, Ph.D. *(Liaison, Rural Health)*
- Gordon Chelune, Ph.D.
- Jovier Evans, Ph.D.
- Elsa Shapiro, Ph.D.

Our current president, Kathy Haaland, Ph.D., recently appointed many new monitors, liaisons, and subcommittee chairs to serve on the PIAC, and at present there are no openings. However, we would like to know if members would like to be considered for future openings, and welcome ideas from the membership at any time.

Announcement

APA/IES Postdoctoral Education Research Training Fellowships Awards to match postdoctoral fellows with established mentors to pursue research training related to teaching and learning in preK - 12 settings. Two year fellow stipend: $55,000 per year. Initial deadline for fellows and mentors to qualify is January 1, 2004.

For more information, please visit: www.apa.org/ed.

The American Psychological Association has been awarded $2,070,573 by the Institute of Education Sciences to launch the APA/IES Postdoctoral Education Research Training Program. The overall objective of this fellowship program is to increase the application of cutting edge psychological science to research in education in order to address our nation's needs for high quality research on teaching, learning and achievement of K-12 students. The purpose of the proposed program is to establish a fellowship program that matches promising psychologists with established mentors for intensive research training in order to: build capacity by attracting psychological scientists to conduct research at the interface of psychology and education; develop education and training models to advance school-based scientific research; and increase the visibility of education research within the discipline of psychology. Fellowships will be awarded to individuals who are interested in pursuing research training in school-based research related to teaching and learning and who have been awarded a doctoral degree in psychology by the time of appointment. In addition, all fellows will participate in a series of joint activities that will be focused on translating research into practice, promoting professional socialization, building a community of APA/IES scholars, and developing interest in education sciences throughout the graduate education pipeline in psychology.

The Practice Advisory Committee

The Practice Advisory Committee is a standing committee that focuses on issues relevant to the clinical practice of neuropsychology.

Chair: Neil H. Pliskin
Committee Members: Jeffrey Barth, Julie Bobholtz, Elizabeth Kozora, Shana Kurth, Michael McCrea, Alice Medalia, Mark Sherer, Lisa Stanford, Alex Troster, David Williamson, James Youngjohn

There are two urgent issues that face practicing clinical neuropsychologists today, which the Practice Advisory Committee of Division 40, in conjunction with the APA Practice Directorate, has devoted significant effort:

Technician Issue

There have been an increasing number of challenges by different states (Arkansas, New York, Oregon and previously in North Carolina) to the use of testing technicians. The assumption by these groups has been that only psychologists can do their own testing. The Practice Directorate of APA has been instrumental in taking the lead on this critical practice issue on behalf of neuropsychologists, and has been working closely with state psychological associations to address these issues as they have arisen state by state. The APA's position is that the safety net that assures the protection of the consumer is ultimately the responsibility of the licensed doctoral level provider and that use of technicians for routine aspects of neuropsychological test administration does not place the public at risk. Thanks in large part to their efforts, there have been positive results in meeting these challenges both in North Carolina and, most recently, Oregon. In Oregon, an amendment to the practice act which states that, "Practice of psychology also includes delegating the administration and scoring of tests to technicians qualified by and under the direct supervision of a licensed psychologist" was passed by both the house and senate and has been signed by the governor of Oregon. The amended practice act is officially effective January 1, 2004. Challenges to the use of test technicians are still pending in Arkansas and New York, and the Practice Advisory Committee will continue to work closely with the Practice Directorate on this critical practice issue.

Work Value

The value of our current CPT codes (96115 & 96117) continues to decline. The Practice Directorate is working with our CPT Subcommittee (Tony Puente) in an effort to split the current code into technical and professional components as a means of ultimately increasing reimbursement for our services at a reasonable rate.

The Practice Advisory Committee has also been working on these other important practice issues that have arisen over the past year:

Social Security Disability Issue

The Division 40 Practice Advisory provided input regarding the plan by the Social Security Administration to update and revise its rules for how to evaluate mental disorders in both adults and children who apply for Social Security disability benefits or Supplemental Security Income payments based on disability. After soliciting opinions from a broad range of neuropsychologists, a letter was sent to the Social Security Administration on behalf of the neuropsychologists in Division 40 making the following points: (1) emphasizing the importance of educating state disability administrators on the training, clinical utility and

expertise of clinical neuropsychologists, (2) requesting more flexibility be written into the listings with regards to the assessment tools requested, (3) suggesting that the child listings be updated to include behavior disorders and to eliminate personality disorders in children in order to be in keeping with current diagnostic standards, (4) similarly requesting that Attention-deficit/Hyperactivity Disorder be added to the Adult Listings of Impairments, (5) that consultants be provided with all relevant records obtained by the Social Security Administration, and (6) recommending that assessment of effort be included.

Idea Legislation

A resolution has recently passed in the House of Representatives that would significantly weaken the Positive changes underway for children with special needs. H.R. 1350 would weaken rights and responsibilities declared in the Individuals with Disabilities Education Act (IDEA) of 1997. In particular:

The new bill would change the current Individualized Educational Program system that requires annual review and update to a mandatory review every 3 years, significantly weakening the abilities of professionals and parents to define relevant goals and objectives for children, and to track performance.

In addition, there are modifications to the rights of young children with Behavior Disorders which would allow schools to suspend and expel children regardless of disability, if they violate school conduct codes.

Aspects of the bill that focus on "paperwork reduction" will allow states to file for waivers which in turn will allow them to "omit" certain parental notifications of rights and responsibilities under federal law.

In conjunction with representatives from the Psychological Corporation and with the strong support of the Practice Directorate, our committee contacted over 300 neuropsychologists through the American Academy of Clinical Neuropsychology and Grassroots Network urging them (and their colleagues) to contact key legislative members of Congress emphasizing the importance of psychological testing in the evaluation of LD. We provided these neuropsychologists with a sample letter and urged them to share it with all interested colleagues.

HIPAA Fact Sheet For Neuropsychologists:

In response to our Division members' requests, the PAC and Science Advisory committees recently wrote a document entitled "HIPAA Fact Sheet for Neuropsychologists". This document will serve as a general primer specific to neuropsychological issues and questions as it relates to HIPAA. It is currently being reviewed by APA, and we hope to have it published in the newsletter and on the website later this year.

Task Force On Cognitive Testing In Clinical Fmri Procedures

The PAC and Science Advisory Committee are chairing a taskforce to examine the role of clinical neuropsychology when cognitive testing is utilized in the context of clinical fMRI procedures currently being performed at many medical centers across the country. Eventually there are plans to take clinical fMRIs through the complex process of getting CMS approval for regular billing and there has already been some movement towards developing a clinical CPT code for these procedures. Our committee believes that clinical neuropsychology has an important role to play in such evaluations. In addition to billing and practice issues, there are education/training considerations for the Taskforce to address. For these reasons, we have organized a Taskforce chaired by Julie Bobholz of the Practice committee to examine this issue and generate a position statement for APA to consider.

HIPAA and Databases

As a follow up to our HIPAA fact sheet project, the PAC committee is now exploring the parameters of research utilizing archival data under HIPAA and hope to develop a new fact sheet for Div40 members later this year.

**Should you wish to contact Dr. Pliskin about this committee or practice-related issues, his email address is* npliskin@uic.edu *and his phone number is 312-996-6217.*

President's Message
Continued from page 1

- 55,000 Adult and Child Neuropsychology brochures mailed to Division 40 members for use in their practice. Soon brochures will be available on our website with authorization to download (Public Interest Advisory Committee, Deborah Koltai-Attix, chair).
- Development of the Women in Neuropsychology (WIN) Interest Group, an organization which fosters communication about women's professional issues in the field. Through the leadership of Paula Shear, past chair of WIN, WIN has developed a successful listserv of over 300 neuropsychologists, which has been a useful source of information. WIN has organized conversation hours at APA to provide information about career opportunities, such as editorial review and board certification (Cynthia Kubu, Liason to the APA Committee on Women in Psychology and chair of WIN)
- Communication with the Science Directorate to push the needs of neuropsychologists' research interests through NIH and the Department of Veterans Affairs where recent changes in research administration are negatively affecting many neuropsychologists (Mike Westerveldt did the groundwork over the past three years; Current Science Advisory Committee chair, Allan Mirsky)
- Division 40 Newsletter, which has blossomed under the leadership of editor, Joel Morgan.
- Appointment of six new Division 40 fellows: Thomas Bennett, Jacobus Donders, Connie Duncan, Jill Fischer, Lisa Rapport, and Joseph Ricker. They will all be invited to present their most recent work in a Fellows Symposium at the 2004 APA meeting in Honolulu (Fellows Committee Chair, Eileen Fennell).
- Recognition of several students for their excellent submissions for the 2003 APA Program: Paula Alhola (University of Turkoo) and Jane Booth (James Haley VA Medical Center, Tampa, Florida). Student scholarships were also provided through the generosity of The Psychological Corporation to Lisa Holme (Yale University) and Aiko Yamamoto (West Virgina University).
- An impressive program at the 2003 APA meeting with 18 hours of CE opportunities and excellent keynote addresses by Professors Brenda Milner and Donald Stuss. The program committee worked very hard under the leadership of Jennifer Manly, 2003 Program Committee chair. The 2004 Program will include an address by Dr. Edith Kaplan, who received the Benton Award (2004 Program Committee, Robert Elliott, chair), and keynote addresses by Daniel Schachter and Alex Martin.

I am very pleased that the membership recently approved an increase in dues, and I hope that you agree that the work of Division 40 is important for the field of Neuropsychology and for you as an individual neuropsychologist. The Division could not do its work without your support.

I have asked each of the committee chairs to provide you with information about the purpose of each committee, their recent accomplishments, and how you can contact the committee chair if you want to get more involved. One of my goals as President of the division is to encourage the involvement of new people in division activities. Committee membership is the best way to find out more about the organization, and to eventually take a leadership role. So, I want to encourage you to contact the committee chairs if you are interested. If there are no openings in a particular committee or you're not chosen as a member this year, we will keep your name for future openings.

We need you. Please contact the committee chairs if you have any concerns, questions, or ideas.

Thank you, and I look forward to meeting many of you over the course of this year.

Kathleen Y. Haaland, Ph.D.
Division 40 President
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Maximizing Coping and Compensation in Dementia:
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functional deficits will also help establish appropriate goals (Pramuka & McCue, 2000). For instance, is the patient not doing things on his calendar due to his forgetting to check it (memory disorder), his not being able to follow its structure (executive dysfunction), or his lack of interest (apathetic depressive disorder)? Obviously, the intervention strategy would vary considerably depending on the source of the problem, even though the intervention target is the same. The patient's **motivation** to actively participate in the therapeutic process is also considered (Koltai & Branch, 1999), with sources of diminished motivation clarified (e.g., CNS dysfunction, depression), as some are treatable while others are not. **Unique patient factors** that have the potential to influence outcome are also identified, as are social and environmental factors. Likewise, **compensatory methods and activities** already in place are considered, in order to avoid dismantling effective systems or introducing a competing routine.

Anosognosia, or the lack of awareness of deficits, is an indispensable variable to consider, as unawareness of deficit or its functional consequences logically does not promote the use of compensation (Crossen, 2000). In the dementia population, it is well understood that neuroanatomical compromises are more often the source of inaccurate self-appraisals that motivated denial. Patients with frontal systems compromises may be particularly vulnerable to poor insight (Reed et al., 1993o Stuss, 1991). It is reasonable to hypothesize that the intervention gains among anosognostic patients may be hindered due to decreased motivation resulting from a lack of appreciation for the need for effortful processing strategies. There may also be a decreased ability to acquire intervention techniques due to the executive dysfunction frequently associated with this condition. We found differential perceived gains among patients with and without insight as a result of participation in a memory and coping program, although interestingly caregivers perspectives of gain did not vary by subject insight status (Koltai et al, 2001).

Finally, no intervention evaluation is complete without an assessment of the patient's **affective status.** Because the multiple potential effects of emotional distress on the individual and his or her functioning can aggregate in a manner that undermines treatment progress, affective dysfunction warrants attention. Depression and other sources of emotional distress are clear and prevalent sources of treatable dysfunction that should be identified and targeted throughout intervention. Any intervention effort targeting cognitive variables may well be unsuccessful if attempted in the context of emotional distress. As noted, emotional distress frequently leads to even less efficient processing, and affective symptoms tend to work against participation in cognitive techniques that require motivation and effort (e.g., apathy, anhedonia, irritability). It is useful to differentiate emotional and personality changes that are a result of, rather than in response to, the neurological changes, or those which may have existed premorbidly, as treatment of these vary (Crossen, 2000o Pramuka & McCue, 2000). Targeting depression before memory compensation minimizes inefficiency introduced by the emotional distress and increases the patient's resources that will be applied during any cognitive based intervention.

In summary, we can now answer the question "But is there anything I can do_how do I fix the problem?" with a bit more optimism than we historically have. We can recognize the work of our colleagues within neuropsychology and related disciplines that allows us to consider intervention alternatives for our geriatric dementia patients. We can support clinical practice, education and training opportunities, and funding in this area, and express guarded enthusiasm given the promising lines of evidence emerging. We can insist upon quality, evidence-based lines of research in this area, and we can take pleasure in knowing that we may be able to favorably impact the journey of those that seek our assistance.

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Dr. Koltai Attix is the recipient of the Division 40 (of the American Psychological Association) Early Career Award in Neuropsychology for 2003. *Newsletter40* is very pleased to present this paper.

Neuropsychologists Wanted For Grassroots and Advocacy Efforts:

The Division of Neuropsychology is seeking Division 40 members who would be willing to join a grassroots network of neuropsychologists in federal advocacy activities on behalf of psychology in concert with APA's Federal Advocacy Network. We would like to recruit Division 40 members to our grassroots network who have key political contacts with members of Congress and/or those who are willing to volunteer their time to quickly educate as many neuropsychologists as possible in their region about crucial legislative issues that affect our profession. If you are interested in joining this effort, please contact the Division's Federal Advocacy Coordinator, Neil Pliskin (npliskin@uic.edu).

DIVISION 40 EXECUTIVE COMMITTEE MEETING MINUTES
Thursday, August 7th, 2003, 8:00 – 11:00 am
Fairmont Royal York Hotel, Banff Hospitality Suite
Toronto, Ontario, Canada

Present: Drs. Adams, Axelrod, Bauer, Bondi, Craig, Elliott, Fischer, Heaton, Ivnik, Koltai-Attix, Koffler, Manly, Mirsky, Morgan, Nemeth, Pliskin, Puente, Ricker, Shear, van Gorp, Westerveld, Yeates

Invited Guests: Drs. Randy Phelps (APA Practice Directorate) and Pat Kobor (APA Public Policy Office); Michael Cole (ANST), Chris Loftis (ANST)

1.) The meeting was called to order by Dr. Puente at 8:08 am. He thanked the Division 40 Executive Committee (EC) and the Committee Chairs for attending this morning meeting and for all their hard work over this past year. In addition, Dr. Puente wanted to go on record that our thoughts are with Dr. Fennell in her present difficult time. Finally, Dr. Puente stated that a good deal of Division business and communication was beginning to take place via the APA listserv process, and formal bylaw changes for official Division activities and EC votes will be drafted over the coming year.

2.) Secretary's Report: The Minutes of the EC meeting held in February 2003 were reviewed and approved with minor typographic revision and amendment of the program committee report to reflect that Division 22 contributed $500 to offset expenses for the joint social hour.

3.) Treasurer's Report: Based on final income and expense figures, we had a fund balance of $204,002.79 at the end of Fiscal Year (FY) 2001, reflecting a net loss of $17,339.88 (7.8%) over FY2001. This net loss was anticipated, as Division 40 expanded its activities in the face of declining interest income. It was the basis for the dues increase proposed to the membership in May 2003. Our fund balance for FY2003 (as of the end of June 2003) was $256,159.26, consistent with our fund balance last year at the same time ($255,051.41). Thus, we have sufficient funds to cover our anticipated deficit for FY2003.

A proposal for a dues restructuring and increase from $20/year to $34/year ($29/year base dues + $5/year division publication fee) to cover expanded divisional activities was presented to the membership for a vote in May 2003; a vote was also requested for a separate ($21/year) journal fee. With a total of 810 votes cast, the dues increase passed by a margin of 513 (63.3%) to 297. (The additional journal fee was narrowly defeated (420 [51.9%] opposed vs. 390 in favor)). If approximately 3500 members pay dues (as in FY2002) and approximately 1000 dues-exempt members and affiliates pay the $5 division publication fee, we will have an estimated $124,000 in dues income for FY2004.

As of July 24, expenses for all line items were at budget or favorable to budget (based on reimbursement requests processed by the Treasurer). However, a few line items will undoubtedly be over budget by the end of the fiscal year (most notably the Secretary, Membership Committee, and Newsletter). These overruns are largely due to escalating expenses associated with the production of materials and postage, which the new Division Publication Fee will only partially offset. (Although mailing costs were figured into the budget for PIAC Brochures, expenses associated with mailing these brochures to members have been allocated to the Membership Committee, as APA Division Services invoices combine non-bulk mailing costs into a single line item.) It is recommended that the Secretary, Membership Committee Chair, and Newsletter Editor work with APA and the Division Treasurer to develop more cost-effective approaches to production of materials and postage.

Proposed FY2004 Budget: A budget of $138,400 is proposed for FY2004, representing a 9.8% increase over our FY2003 budget. There is a significant increase in the budget for the Secretary's office to accommodate increased costs associated with mailings, and modest increases in budgets for most other elected officers in part to take into account cost-shifting by APA, academic institutions, and health care organizations. Budgets for the Focus Areas are essentially level, although the budget for brochures is shifted to the Membership Committee for two reasons: 1) these are now a routinized member service; and 2) expense reporting for membership mailings and brochures is intertwined at Division Services. Finally, the Budget for the Publications Committee is increased to accommodate the escalating production and mailing costs noted earlier.

Dr. Puente thanked Dr. Fischer for her outstanding work as Treasurer, congratulated her on her re-election to a second term, and particularly highlighted her excellent drafting of the document sent to the membership for a vote on the dues increase and journal issues. The EC unanimously approved the budget without modification.

4.) Council of Representatives: Dr. Westerveld attended the Council meeting and reported in Dr. Fennell's stead that the following items of business were to be taken up by APA Council at its August meeting, and were of significant potential interest to the membership. Divisions were remanded not to provide guidelines or any other information that could be construed as a suggestion as to the practice of the profession of psychology. Any such guidelines require APA formal review and approval through Council. APA finances are leveling and they are projecting a surplus for FY2004, due in part to the dues increase and re-financing of the APA building. APA also will return to its regular scheduling of two consolidated meetings next year.

5.) Membership: Dr. Bradley N. Axelrod reported that, from January 1 until July 16 2003, 948 Division interest mailings were sent to individuals requesting that information through APA.

In addition, letters encouraging membership were sent to 1160 targeted APA Members who were in divisions compatible with interests in clinical neuropsychology. For this mailing, the cost of supplies was $315 and the cost from Member Services was $100. Of the 1160 mailings, 77 recipients joined the Division. Although the percentage of new members generated is low (6.6%), it seems to be a positive way to market the Division and increase membership.

As of July 16 2003, the Division gained 147 new Members and 220 new Affiliates (216 Students, 4 International) during the current year.

Our current numbers, both paid and unpaid for 2003, include 92 Fellows, 3690 Members, 87 Associates, and 932 Affiliates. It should be noted that some of the unpaid individuals might eventually resign through nonpayment of dues. The total number of individuals associated with Division 40 is 5071.

6.) Election Results: Dr. Allan Mirsky reported the following election results for 2003: President-Elect (2004-2005) – Dr. Robert J. Ivnik, Secretary (2003-6) – Dr. Paula K. Shear, Treasurer (2003-6) - Dr. Jill S. Fischer, Member-at-Large (2003-6) – Dr. Cheryl H. Silver.

Dr. Mirsky expressed his sincere gratitude to Drs. Gordon Chelune, Jason Brandt, Connie Duncan, and everyone who assisted in the nomination and election process. And, on behalf of the entire Division, he would like to thank all the candidates for their willingness to run for office and to serve their colleagues through Division 40 governance.

7.) Fellows: Dr. Eileen Fennell could not attend the EC meeting but relayed that four completed Fellow applications were forwarded to APA by the deadline for consideration in 2003. The newly elected Fellows for 2004 are Drs. Jacobus Donders, Jill S. Fischer, Lisa J. Rapport, and Joseph H. Ricker. Current Fellows of other Divisions, but newly elected to Division 40 Fellowship, are Drs. Connie C. Duncan and Thomas L. Bennett. On behalf of the entire EC, Dr. Puente congratulated all the new Fellows to Division 40.

8.) Program: Dr. Jennifer Manly submitted the following Program Committee report:

Overview: Allocation of the Division 40 programming hours was described in detail in the 1/03 Program Committee report, and no substantive changes have been made to the program since the previous report was submitted.

SARS-Related Cancellations: To date, three poster presenters have notified the Program Chair that they will not attend the meeting in Toronto due to SARS. The Program Chair of the 2003 NAN Conference, Frank Webbe, and Steve Moelter, the NAN Poster Program Chair, have offered those who cancelled the opportunity to present their work in Dallas in the fall. The only other presenter to cancel was Edith Kaplan, who was scheduled to deliver the Benton Lecture.

Committee: The committee this year consisted of 21 members, and efforts were made to maintain and increase the diversity of the committee. The committee for 2002-2003 includes Drs. Jennifer Manly, (Chair), Robert Elliott, (Co-Chair), Lisa Barnes Young, Cynthia Cimino, Glenn Curtiss, Jacques Donders, Kimberly Espy, Rosemary Fama, Philip Fastenau, Tanis Ferman, Pamela Keenan, Greg Lee, Cheryl Luis, Lisa Ravdin, Sean Rourke, Maria Schultheis, Andrew Swihart, Daniel Tranel, David Tulsky, Anna Weber Byars, and Tony Wong. Thank you to everyone for the excellent job and the responsiveness to the rapid turnaround time necessary for review of the large number of submissions this year. Special thanks to Bob Elliott as co-chair of the committee.

Division 40 Hospitality Suite: For the first time this year we have arranged for all committee meetings (except the EC meeting) to occur in a Division 40 Hospitality Suite at the Royal York Hotel. The suite will also be the location for the ANST Launch Party and a reception for Division 40 Committee Members.

Social Hour: The Division 40 Social Hour is being held jointly with Division 22. The social hour is being sponsored this year by Psychological Assessment Resources, with a donation of $1000. Division 22 has indicated that they will contribute $500 to the costs of the social hour. This year will include a formal recognition of Past Presidents of the Division.

Blue Ribbon Papers: The Division 40 Blue Ribbon award winners were reported in the January Program Committee Report.

Other Awards and Special Sessions: The recipients of the following awards were announced after the January report was submitted. The recipient of the Early Career Award in Neuropsychology is Deborah Koltai Attix, Ph.D.. For the third year there will be a new Fellow session in which the new Division 40 Fellows from the prior year will be recognized and one of them, Dr. Paula Shear, will present.

Program Committee 2003 Membership: The 2003 Program Committee will be chaired by Dr. Robert Elliott. The incoming co-chair is Dr. Kimberly Espy. Eight new committee members will be appointed with three-year terms beginning in 2003, to replace those who are rotating off of the committee this year, and two existing members whose three-year terms ended this year will be re-appointed.

Budget: The majority of the Program Committee costs will be not incurred until the Convention. The expected cost of LCD projectors for platform presentations will most likely be $900, substantially less than budgeted, since APA has arranged for most of our sessions to take place in rooms with projectors.

The Program Committee has had the following expenses as of 7/21/2003: (a) $500.00 for assistant to Jennifer Manly, (b) 395.50 for the Program Committee breakfast at INS, (c) 405.00 for the INS email list ($1295.50 Total).

On behalf of the entire EC, Dr. Puente thanked Drs. Manly and Elliott for the excellent program and for their extraordinary work over the past year. Dr. Puente particularly thanked Dr. Manly for her efforts in nearly doubling the number of submissions to the program this year through her grassroots and email initiatives.

9.) Publications and Communications Committee (PACC): Dr. Russell M. Bauer reported on the activities of PACC outlined below.

Division 40/APA Publications Bulk Purchase Agreement for Neuropsychology: At APA in August 2002, the EC voted to approve the bulk purchase agreement making

Neuropsychology the official journal of Division 40, and the agreement was signed and forwarded to APA after the INS EC Meeting in Honolulu. The signed agreement stipulated that the agreement would go forward if the resulting $21 dues increase was ratified by the membership. The vote of the membership was 390 in favor, 420 opposed, meaning that the proposed increase was not ratified. These results were quite different than those seen in 2001 when the membership was polled about the issue of making Neuropsychology the official journal of the Division. There has been some discussion of ways the EC could come to better understand the nature and reasons behind the membership vote. Discussion ensued regarding further exploring and clarifying the journal question with APA, and Dr. Puente charged Drs. Ivnik, Mirsky, Bauer, and himself to continue talks with Gary VanDenBos over the next year.

Division 40 Archives: Dr. Nemeth's term as Division 40 Archivist ends with this Executive Committee Meeting. On behalf of all affiliated with Division 40, the EC thanked Dr. Nemeth for her outstanding service to the Division.

During last year's APA meeting, the committee discussed two proposals regarding the ongoing logging of archives at the LSU site, and at that time Dr. Bauer recommended that we adopt a proposal that would require the submission of both paper and electronic records to LSU so that the ongoing business of the division could be posted to the web while it was simultaneously stored in secure conditions. In her report for the EC at that time, Dr. Nemeth had indicated that it was her understanding that the Division's records were the property of LSU. This came as a surprise to most of the members of the EC, and Dr. Bauer was charged with clarifying this issue by discussing it with individuals who executed the original contract on the part of the Division

As Dr. Nemeth's term as Division 40 Archivist ends soon, we will need to appoint a successor. Dr. Nemeth believes that a Louisiana neuropsychologist might best serve in this position due to the physical location of the archives at LSU. The procedure whereby a successor to Dr. Nemeth will be selected will be discussed at the meeting. Dr. Nemeth was present at the EC as an observer, and will be available to provide additional details regarding the status of the Archive. Dr. Bauer presented a motion that the EC adopt the previous recommendation to archive documents electronically (at a cost of $2,000 per year). The motion was unanimously passed. Dr. Bauer was charged with furthering explorations with APA regarding its archiving capabilities.

Newsletter: The June 2003 issue of the Division 40 Newsletter (Vol. 21, No. 2) is now available for download at the Division 40 Website. The 40-page issue is devoted largely to the topic of Forensic Neuropsychology. Feature articles include "Competency to Stand Trial" by Robert L. Denney, Psy.D., ABPN, ABPP/F; "Mental Retardation and Capital Offenses: Case History", by Jerid M. Fisher, Ph.D., ABPN and Laura Samson, Ph.D.; "Things I Didn't Learn in School: A Look at Forensic work", by W. John Baker, Ph.D.; and "Testamentary Competence: Antemortem and Postmortem Neuropsychological Analysis", by M. Frank Greiffenstein, Ph.D., ABPP/Cn. The issue also contains the full Division 40 and Division 22 APA programs and an obituary of Ted Blau, Ph.D., by Rod Vanderploeg, Ph.D. Dr. Puente thanked Dr. Morgan for his excellent work and stewardship of the Newsletter.

Website: Several changes and updates have been made to the Division 40 Website, and many more are planned for the coming months. Some highlights of already existent changes:

1) Many files of interest to members and potential members have been converted to .pdf format for direct download. Examples include the application form and newsletters.

2) The Division 40 APA Program was posted to the website in advance of APA so visitors to the site could download it directly and bring it to the convention.

In the coming months, additional updates will bring more of the EC's activities to website visitors and will make available additional resources to the membership. Additional aesthetic/design changes will be made to make the website more attractive. As one example of expanded content, Dr. Bauer and colleagues plan to create pages for each of the EC's standing committees so that material of the committee's choosing can be posted there. On-line resources, including .pdf's of the brochures and other documents, will be substantially expanded. A simplified "site map" of Dr. Bauer's plans to modify the structure of the website was presented.

Within the next year, Dr. Bauer and the website team plan to turn over control of the training program portion of the site to the training directors themselves through the use of searchable forms. The training directors can enter information pertaining to their training program and it will obviously be in their best interests to keep the listings current and accurate. Training directors will have access to their own program only through the use of passwords. The use of forms will enable the training program portion of the site to take on true database stature so that we can have flexible data about pre- and post-doctoral training programs in clinical neuropsychology.

On behalf of the entire EC, Dr. Puente thanked Dr. Bauer for his excellent work on the website upgrades and updates.

10.) Committee on Interorganizational Relations (CIOR): Dr. Joseph Ricker submitted the following committee reports:

American Speech-Language Hearing Association / APA Division 40 Committee on Interprofessional Relations (Dr. Robin Hanks, Chair):

Membership: During the year, there have been a number of new members added to the committee (3 new ASHA members and 3 new APA members).

Frequency of Meetings: In an effort to be more productive in between our usual 6-month in-person meetings, the committee has initiated telephone conference calls at 3-month intervals. The first of these conference calls was in June and was very successful. Committee members had made significant progress on their projects and the agenda was set for the next in-person meeting on October 25th at 3:00 pm at the annual conference of the American Congress of Rehabilitation Medicine.

Presentations: A presentation titled "Evaluating and Treating Communication and Cognitive Disorders: Approaches to Referral and Collaboration for Speech-Language Pathology and Clinical Neuropsychology" authored by Diane Paul-Brown and Joseph Ricker, has been accepted for the annual conference of the American Congress of Rehabilitation Medicine, which will meet October 23-26, 2003 in Tucson, Arizona.

Publications: A summary of the manuscript "Evaluating and Treating Communication and Cognitive Disorders: Approaches to Referral and Collaboration for Speech-Language Pathology and Clinical Neuropsychology" submitted as a committee document to the *Archives of Physical Medicine and Rehabilitation* has been prepared by Diane Paul-Brown and Joseph Ricker for resubmission to this journal.

Current Projects: Public Relations Articles to ASHA and Division 40 Newsletters: Robin Hanks is preparing an article for the Division 40 newsletter describing the purpose and goals of this committee, as well as a synopsis of the manuscript noted above. Diane Paul-Brown has prepared a similar document for the ASHA newsletter and is following up on this initial submission.

Interdivisional Healthcare Committee Representative (Cheryl Silver, Ph.D.):

The APA Interdivisional Healthcare Committee (IHC) met on February 22, 2003. The committee devoted time to the following key issues in this session. Prior to the IHC meeting, Geoff Reed distributed four chapters from the manual for the International Classification of Functioning, Disability, and Health (ICF). Committee members were to read and critique the chapters from the viewpoint of a practicing clinician who would be using the manual. A discussion was initiated during the session, but Geoff also revisited the question of whether or not further effort on the part of APA should go into this extremely time-consuming project. Pros and cons were discussed thoroughly, including the important fact that APA would have an agreement with WHO to be the sole publisher of the manual in English-speaking countries if the project were to go to fruition. Conversely, if clinicians do not see a need for the system, there would be no market. The conclusion was that Geoff would propose to hold a training conference in Washington with division representatives to continue refining the existing chapters, but APA resources would not be directed at this time toward the construction of more chapters.

Dr. Randy Phelps gave an update on the implementation of the Health and Behavior codes. He stated that Medicare is responding positively in most places except Florida. The next step is to promote the correct use of the codes by other insurance carriers.

Dr. Phelps also updated the committee on the Complementary and Alternative Medicine initiative, stating that the work has been deferred by the Science Directorate because of insufficient staff at this time.

A telephone conference took place with Dr. Ivan Miller (Div 42) concerning the Interdivisional Task Force on Managed Care and Health Policy. Their group is proposing that the APA health divisions and practice divisions form an integrated task force to promote the idea of psychology as a healthcare profession that has significant impact on the reduction of disease and mortality. The IHC discussed this issue at the previous meeting held during the 2002 APA convention, but because a number of IHC members could not be present, it was revisited. In the present session, Dr. Miller proposed to develop an alternative service delivery model for the way in which psychology would fit into a future healthcare system. This effort would include various papers written for consumers, the press, and professional groups. When the phone call concluded, a lengthy discussion centered around what part, if any, the IHC would be willing to play. A white paper on basic psychological principles in healthcare was discussed, but no specific plans were generated. The committee agreed that the task force issue is really beyond the scope of the IHC, but our divisions might be interested in knowing about the proposed idea.

Marie DiCowden informed the committee about the need for initiating a National Coverage Analysis for cognitive retraining because claims are not being paid in Florida. The IHC agreed to generate a letter to the Practice Directorate to request that this be initiated.

11.) Committee on APA Relations: As the newly appointed Chair of this committee, Dr. Paul Craig attended the EC meeting and stated that he welcomes opportunities to shepard issues regarding Division 40 to APA.

12.) Science Advisory Committee (SAC): Dr. Michael Westerveld submitted the following report of the SAC activities of the past year:

Membership: Many committee members will be completing their terms, including the Chair. The members whose terms do NOT expire are listed below, followed by those members who are rotating off the committee.

Greg Lee, Ph.D. Awards Committee Chair (2003-2006); Eileen Martin, Ph.D. (2001-2004); Joseph Tracy, Ph.D. (2001-2004); Mark Aloia, Ph.D. (2001-2004); Jacobus Donders, Ph.D. (2002-2005); Bonny Forrest, JD, Ph.D. (2003-2006)

Dr. Westerveld also took the opportunity to thank the following members for their contribution to the committee: Richard Kaplan, Ph.D.; Kimberly Stoddard, Ph.D.; Ronald Cohen, Ph.D.

Also, Dr. Westerveld recognized Dr. Diane Howieson's contribution as Chair of the Awards committee.

The SAC selected the award winners with the assistance of the Program committee. The winners this year are: (a) Paula Alhola, Dept of Physiology, University of Turku, Sleep Research Finland, and (b) Jane E Booth, MA, James A. Haley VA Medical Center, Tampa, FL.

The Psychological Corporation generously contributed $2000.00 to fund two Student Scholarships. Preliminary indications are that they will continue to fund these awards for the foreseeable future. The awardees this year are: (a) Lisa Holme, Psy.D., Dept of Neurosurgery, Neuropsychology Service, School of Medicine, Yale University, New Haven, CT, and (b) Aiko Yamamoto, MA, Dept of Behavioral Medicine and Psychiatry, West Virginia University, WV.

The committee is recommending changes to the award process. Although the Awards committee, the SAC, and the

Program awards (e.g., the Blue Ribbon awards) are consolidated under the SAC for budgetary purposes, there is no centralized process for other aspects of the awards such as printing certificates, notification of winners, distributing the award checks and certificates, etc. Since all of the awards fall under the SAC budget, it makes sense to consolidate the other aspects of the award as well. It is recommended that the Awards committee assume responsibility for production of certificates and other aspects of the awards in the future.

Dr. Bonny Forrest worked with Dr. Pliskin to develop the Division 40 HIPAA Fact sheet for Neuropsychologists, which has been made available to the EC for review and comment.

Also, the SAC will have representation on other initiatives that cross practice/science domains, such as study of the role for Neuropsychology in emerging technologies like fMRI.

Finally, Dr. Westerveld thanked the committee for the opportunity to serve Division 40 as Chair of the Science Advisory Committee for the past three years. On behalf of the entire EC, Dr. Puente thanked Dr. Westerveld for his excellent service to the Division.

13.) Practice Advisory Committee (PAC): Dr. Neil Pliskin reported that the following individuals have been added to the Practice Advisory Committee: Drs. Julie Bobholz, Liza Kozora, Mark Sherer, Lisa Stanford and Jeff Barth. Returning members include: Drs. Shana Kurth, Alice Medalia, DJ Williamson, and James Youngjohn. Committee members who have rotated off: Drs. Tammy Scott and Julia Grenier-Ramos.

Dr. Pliskin next reported that there have been significant concerns recently raised by licensing boards in Arkansas, North Carolina, New York and Oregon regarding the use of testing technicians. The assumption by these groups has been that only psychologists can do testing. Drs. Puente and Pliskin wrote a letter to Dr. Newman in the Practice Directorate expressing concern about this issue and outlining Division 40's position. On June 25, 2003, we received a response from Billie J. Hinnefeld, JD, PhD, the Senior Director of Legal and Regulatory Affairs for APA assuring us that this issue was of great importance to APA and that they will continue to "rely on the expertise of our members to maximize our ability to support the state associations on this issue". Dr. Pliskin followed up with a phone call to Dr. Hinnefeld and restated Division 40's willingness to support APA in their efforts.

At the request of Dr. Puente, The Division 40 Practice Advisory was asked to provide input regarding the plan by the Social Security Administration to update and revise its rules for evaluating mental disorders in both adults and children who apply for Social Security disability benefits or Supplemental Security Income payments based on disability. The SSA requested interested people and organizations to send them comments and suggestions for revising the rules they use to evaluate mental disorders. In addition to comments about its rules, SSA was also interested in any ideas about how to improve their programs for people who have mental disorders.

The PAC solicited feedback from a broad and representative group of neuropsychologists through the NPSYCH, AACN, Grassroots and Ped-NPSY listserves. Additionally, Dr. Leslie Rosenstein of the National Academy of Neuropsychology PAIO office also contributed substantially to this effort. A letter was drafted, revised by the EC, co-signed by Dr. Eric Zillmer, President of NAN, and Dr. Puente, and was sent to the Social Security Administration.

Dr. Pliskin informed the EC that a resolution has recently passed in the House of Representatives that will significantly weaken the positive changes underway for children with special needs. H.R. 1350 would weaken rights and responsibilities declared in the Individuals with Disabilities Education Act (IDEA) of 1997. In particular:

— The new bill would change the current Individualized Educational Program system that requires annual review and update to a mandatory review every 3 years, significantly weakening the abilities of professionals and parents to define relevant goals and objectives for children, and to track performance.

— In addition, there are modifications to the rights of young children with Behavior Disorders that would allow schools to suspend and expel children regardless of disability, if they violate school conduct codes.

— Aspects of the bill that focus on "paperwork reduction" will allow states to file for waivers which in turn will allow them to "omit" certain parental notifications of rights and responsibilities under federal law.

Dr. Pliskin stated that its specific relevance to neuropsychology is such that this resolution will seriously limit or eliminate intellectual and cognitive assessment as part of the special education process. As part of the re-authorization of IDEA, there have been debates regarding the utility of the IQ-Achievement discrepancy model for making eligibility determinations under the learning disability category. Some influences in the federal government have suggested that because IQ-Achievement discrepancies are problematic that all IQ testing and cognitive assessment, more generally, has no place in special education. In place of testing, there would be early screening for reading problems and intervention. A diagnosis of learning disability is made when a child does not benefit from intervention and no testing is needed to refine the diagnosis or to identify the underlying information processing deficits that are interfering with the child's progress.

In conjunction with representatives from the Psychological Corporation and with the permission of the APA Practice Directorate, the PAC committee contacted over 300 neuropsychologists through the AACN and Grassroots Network urging them (and their colleagues) to contact key legislative members of Congress emphasizing the importance of psychological testing in the evaluation of LD.

Dr. Pliskin further reported that the PAC committee recently submitted a draft document for EC review entitled HIPAA Fact Sheet for Neuropsychologists. This project represents the efforts of several Division 40 committees. It was written by Dr. Lisa Stanford of/with the PAC committee and research relevant sections/edits were written by Dr. Bonny Forrest (also JD) of the Science Advisory Committee. The entire document was reviewed and edited extensively by Division 40 members Drs. Joe Comaty and Cary Rostow, the former being the HIPAA liaison officer for the state of

Louisiana and a clear expert on the topic. This document is not intended to replace the need for the online course provided by the Practice Directorate, but rather will serve as a general primer specific to neuropsychological issues and questions, and indeed directs the reader to the PD course for state-specific and more detailed information. Dr. Pliskin moved that the document be approved by the EC (and the APA attorneys) so that the Public Interest Advisory Committee can offer it to our membership. The motion was seconded and the EC voted unanimously to have it forwarded immediately to APA for final approval for eventual uploading to the Division website for dissemination to the membership.

Dr. Pliskin reported that the PAC and Science Advisory Committee are planning on moving forward with a plan to examine the role of *clinical* neuropsychology when cognitive testing is utilized in the context of *clinical* functional MRI procedures currently being performed at many medical centers across the country. Eventually there are plans to take clinical fMRIs through the complex process of getting CMS approval for regular billing and there has already been some movement towards developing a clinical CPT code for these procedures. If CMS approves commercial insurance usually follows. We believe that neuropsychology has an important role to play and needs to stake its claim to this turf among other disciplines that will do the same. For these reasons, we are organizing a taskforce to examine this issue and generate a "practice parameter" for the EC to consider. In addition to billing and practice issues, there are education/training considerations for the taskforce to address. Dr. Julie Bobholz of our committee has already agreed to chair this taskforce and Drs. Steve Rao, Robert Bilder and John Sweeney have agreed to serve on the taskforce thus far.

Reports From Pac Subcommittees:

CAPP: (From Drs. Ted Peck and Jennifer Morgan)

A Randy Phelps met with Ted Peck (Div 40 CAPP Observer), Dr. Jennifer M. Morgan (Division 40 CAPP Observer/Alternate), and Dr. Dawn Schlegel (NAN CAPP Observer) to provide an update regarding an APA Action Alert on surveying the testing and assessment CPT codes. As we know, last year APA along with the societies representing pediatricians, neurologists, and social workers conducted a survey of CNS Assessment/Test CPT Codes in hopes of remedying the problem of professional work value. The societies originally planned to jointly present the data to the AMA's Resource Based Relative Value Update Committee (the RUC) and to request that the RUC recommended work values for these codes. Unfortunately due to scheduling problems, only representatives from APA and NASW were available to discuss the survey data when the issue arose at the January RUC meeting. Under the rules of the RUC, its members could not hear the request without the participation of a physician group. After much discussion, the RUC directed APA to bring four of the codes before the non-physician RUC, known as HCPAC. APA, along with NASW and ASHA will now seek to obtain work value for 96100, 96105,97115, and 96117 from the HCPA. The American Academy of Pediatricians will bring the two developmental codes (96110 and 96111) back before the RUC. Unfortunately, the survey data obtained last year cannot be used. Therefore, APA's Government Relations Office is requesting NAN and Division 40's assistance in APA's efforts to find psychologists/neuropsychologists who provide these services and would be willing to repeat (or complete) the survey. The next HCPAC meeting is in September; therefore, completed surveys must be completed by mid July. For additional information, contact Diane Pedulla of the Government Relations office at 202-336-5889.

B Drs. Dawn Schlegel (NAN CAPP Observer), Jennifer M. Morgan (Division 40 CAPP Observer/Alternate), and Ted Peck (Division 40 CAPP Observer) met with Russ Newman to discuss Virginia State Supreme Court Ruling John v. IM, a landmark ruling that denies clinical psychologists/neuropsychologists court permission to offer statements in court relating to CNS and related medical disorders such as TBI (e.g. cannot say whether or not there is brain damage/dysfunction). Russ Newman expressed interest and offered to look into having the APA enter an Amicus Brief in support of clinical psychology/neuropsychology when there is an appropriate case that goes up for appeal.

CPT Subcommittee (from Dr. Antonio Puente)

Efforts are still being devoted to obtain RVUs for the testing codes, and towards that end the CPT code survey is being repeated. It will be extremely important that psychologists with experience in providing services under CPT codes 96100, 96105, 96115 and 96117 participate in a survey of these codes in order to demonstrate to the American Medical Association's Relative Value Update Committee (RUC) that the codes deserve professional work values. By taking part in the survey psychologists will be assisting in obtaining work values and increasing reimbursement for their services. The survey has been sent out.

Business of Practice Network: Dr. Wilma Rosen reported that she would no longer be serving as the BOPN representative. According to Dr. Rosen, the way the BOPN is configured now (virtually all state representatives) and it's goals, which are the individual state healthy practice awards to companies and then a national award (which is in the works), neuropsychology has no particular role to play. The criteria for evaluating companies does not include material that would be particularly relevant to neuropsychology, such as how do they support returning workers who might have had some compromise in brain function or does their EAP provide for LD evaluations for children. Dr. Rosen proposed this at the meeting two years ago, but most of these state representatives didn't consider that useful. She recommends that Division 40 no longer have a representative to BOPN.

14.) Public Interest Advisory Committee (PIAC): Dr. Deborah Koltai Attix outlined the activities of the PIAC, and also specifically reported on activities of the subcommittees,

liaisons, and monitors for the past six month.

PIAC General Activities

PIAC continues to focus efforts on development of a PIAC area on our Division website. We look forward to working with the new Webmaster to make substantial progress with our plans over the next six months. A number of issues related to the brochures need attention. The brochures continue to be received with great enthusiasm. To date, roughly 65K of each have been distributed. Translations of the brochure are currently underway. We have asked that the brochures be made available on the web in a PDF format. On behalf of Division 40, we sent a response to Draft 10d of the *Guidelines for Psychological Practice with Older Adults*. The Interdivisional Task Force on Practice in Clinical Geropsychology received our comments, and incorporated most of our feedback. We distributed these changes to our Representatives on Council so that they would know what concerns Division 40 raised and how they were attended to, so that we could be consistent when this issue came to vote at Council. Overall, this was a very successful undertaking. The PIAC Chair receives regular correspondence from the Practice Directorate on the Public Education Campaign. We will continue to monitor the program for areas of interest to Division 40. The chair continues to serve in the role of liaison to the Board for the Advancement of Psychology in the Public Interest (BAPPI).

Liaison, Committee on Ethnic Minority Affairs (CEMA; Dr. Jovier D. Evans)

The Division 40 CEMA co-sponsored a mentoring activity with WIN at INS 2003 on grants and research productivity. The Steering committee met at INS 2003, drafted a mission statement, and organized planning work for the next APA meeting in Toronto. They specifically discussed ways to bring more senior members into the group, publicize its existence, and make links with similar minded organizations. CEMA members are now working on an article with the NAN diversity committee to be published in a special issue of Applied Neuropsychology edited by Dr. Ruben Echemendia. The steering committee will meet at APA 2003 to discuss mentoring program and conversation hour at APA. The CEMA submitted an abstract for a conversation hour to the Division 40 program committee for the APA meeting in Toronto. The mentoring activity has been scheduled for August 7th at 6pm.

Monitor, APA Committee on Aging (CONA; Dr. Bernice Marcopulos)

Dr. Marcopulos continues to actively monitor APA's Committee on Aging (CONA). A detailed report will be available for the next meeting. The most central item of relevance to Division 40 involves the Guidelines now going to Council (see General PIAC activities).

The final version of the Medicare LMRP Toolkit was reviewed and approved and put on the web. The URL is www.apa.org/pi/aging/lmrp/toolkit.pdf. The American Bar Association Commission on Law and Aging are discussing working together to provide information regarding the competency assessment of older adults, including capacity for financial management. They acknowledged that information and guidelines would be helpful to attorneys, judges and local Social Security Offices involved in determining capacity for financial management. The work of Dr. Daniel Marson was cited as important to this endeavor, as well as Drs. Michael Smyer and Barry Edelstein. To quote from the CONA meeting minutes: "CONA and the ABA Commission on Law and Aging decided they would explore a possible joint venture – a symposium of invited psychology and law representatives to: (1) promote an understanding of the key issues and "state of the field" from each perspective (2) create the opportunity to discern the gaps of knowledge in our respective fields (3) develop recommendations in areas of research, training, and practice and (4) generate ideas for products and strategies to share existing knowledge."

Liaison, Rural Health (CRH; Dr. Richard Salamone)

Dr. Salamone reported that Dr. Morgan Sammons is the current Chairperson of the APA CRH. Business materials from the Committee on Rural Health Spring 2003 Meeting outline the following priorities: Integration of psychology ("behavioral health") into primary health care; increasing more specific and relevant training for practitioners destined for rural environments; prescription privileges; the utilization of telehealth in rural psychology; also, APA maintains a website resource for rural practitioners (or those interested) at http://www.apa.org/rural/about.html. There was a recent featured series of articles in the APA Monitor of June 2003 on *The Rural Psychologist*.

Liaison, Children, Youth and Families (CYF; Dr. Gerry Gioia)

Dr. Gioia continues to monitor the Individuals with Disabilities Education (IDEA) reauthorization process in collaboration with School Psychology colleagues in terms of (1) its potential impact on pediatric neuropsychology service and (2) opportunities for pediatric neuropsychology to contribute to the process. This action is being considered at the state levels at present. Division 40 may have an interest in taking a more active role in the definition of the Act and its potential impact on our practice. There has been considerable discussion related to common/conflicting practice issues have been developing between areas of Pediatric Neuropsychology and School Psychology (Div. 16/ NASP). This may be an issue in which Division 40 wants to become more actively engaged to better define training, the boundaries of practice, as well as areas of mutual collaboration. The ultimate goal would be a stronger alliance with our school colleagues in serving children and families.

Monitor, Committee on Disability Issues in Psychology (CDIP; Dr. Doug Johnson-Greene)

Johnson-Greene reported that a current agenda of CDIP is to broaden its collaborative relationships. CDIP discussed the need to "infuse issues related to disability" into other areas of APA, particularly divisions. Division 40 may want to explore how they can be supportive of CDIP's efforts and should

consider sending a letter from the EC and/or President to this effect.

Another CDIP agenda involves a Resource Guide for Students with Disabilities. The target date for publication of the guide was the 2003 annual convention, but several factors have caused significant delays resulting in the need for a condensed version. Another CDIP focus involves Barriers to Training: Testing and Assessment. The Committee proposed two courses of action: 1) draft correspondence to the Association of Test Publishers requesting that they appoint a person to serve as a point of contact for persons with disabilities requesting alternative formats of test instruments, and to collect data whenever the test instrument is an alternative format, and 2) that the committee initiate contact with test Central, the newest department of the American Printing House for the blind.

Ethics Subcommittee (Dr. Michele Macartney-Filgate)

Dr. Macartney-Filgate reported that a panel discussion for APA on 'Release of Test Data to Non-psychologists' has been organized. The subcommittee has been working on a response to an enquiry/complaint from a member, including working out the appropriate manner of response.

There are plans for future papers. The subcommittee will be meeting at APA. This will be the first meeting in two years. Dr. Puente advised Dr. Koltai-Attix to charge Dr. Macartney-Filgate with establishing a consultative role to the APA Ethics Committee for issues related to neuropsychology.

Committee on Women in Psychology (CWP; Dr. Paula Shear)

Dr. Shear reviewed e-mail notices from CWP and forwarded several notices to appropriate members of the Division 40 EC with information about positions that CWP was trying fill with women and minorities, in order to solicit possible Division 40 nominations. Messages that were relevant to members of our Division were also posted to the WIN listserv (see below).

The Steering Committee for the Women in Neuropsychology (WIN) Interest Group met during the 2003 INS meeting to plan for the next six months and to review progress on our current primary goals: 1) increase the number of Fellow applications from women in Division 40, 2) facilitate the election of women to Division 40 offices, 3) continue development of our mentoring program for women, and 4) provide activities at APA and INS that are oriented to the special needs and interests of women in the field. The current Steering Committee members are Drs. Desiree Byrd (student representative), Jill Fischer, Eileen Martin, Cynthia Kubu, Pamela Keenan, and Paula Shear. Dr. Keenan will be rotating off the committee following the APA Convention, and Dr. Shear will be stepping down as Liaison to the CWP and Chair of WIN. She will remain on the Steering Committee for one year to facilitate the transition in leadership.

WIN disseminated information to women about offices coming open within the Division, and provided listserv members with the names of individuals interested in being nominated for office. We are pleased that 3 women were elected to office on the recent ballot. We also provided information to women seeking to apply for Fellow status in the division.

WIN continues to offer a listserv, which is provided by APA at no cost to the Division. The listserv currently has 315 members. This list has been used primarily as a forum for group discussion of WIN activities, correspondence about questions and concerns that individuals have raised about professional development, dissemination of information from CWP and other sources about requests for nominations, and position and funding opportunities. Interested individuals may join the listserv by sending e-mail to listserv@lists.apa.org. The subject line should be blank. The message should read SUBSCRIBE DIV40WIN First Last [substitute your own first and last names]. WIN activities have also been publicized in the Division's mailings and the newsletter.

Dr. Shear continues to receive regular referrals from APA of individuals who are seeking advice about career development in neuropsychology. These requests are managed either through input from the listserv or contacts with colleagues who have volunteered to serve as mentors.

WIN sponsored a panel discussion at the INS Convention that focused on grant activities. Thank you to Dr. Eileen Martin for coordinating this conversation hour. At the APA Convention, we will have a discussion focused on ways to become involved with editorial activities and also strategies to increase women's representation on editorial boards. Based on the WIN group activities over the past several years, Dr. Shear has recently given several invited talks about designing mentoring programs for women in academics and ways to increase women's representation in leadership positions. Dr. Shear will be attending the CWP Network meeting at the APA Convention.

APA Office on AIDS (Dr. Scott Hunter, Monitor)

Dr. Hunter reported that AIDS experts are sought for the APA committee. Specifically, APA's Ad Hoc Committee on Psychology and AIDS (COPA) is seeking nominations for one new member to serve from Jan. 1 through Dec. 31, 2006. COPA is an ad hoc committee that reports to APA's Board of Directors and guides APA's response to the HIV/AIDS epidemic. Members are required to attend at least one committee meeting each year in Washington, D.C., with expenses reimbursed by APA, and to participate in monthly conference calls. Between meetings, members are expected to devote a substantial portion of time to COPA projects, provide consultation to APA's Office on AIDS staff and participate in advocacy activities as needed. Candidates should have expertise on HIV/AIDS issues as a researcher, practitioner, educator or policy advocate. COPA seeks to involve a diverse group of psychologists—including persons of color and individuals with HIV—and is interested in candidates employed in traditional university settings. The committee also encourages candidates with expertise in HIV/AIDS public policy, international HIV/AIDS issues and technology transfer or replication of effective HIV-related interventions to apply. The nomination deadline is Sept. 1. Nomination materials should include the nominee's

qualifications, a letter from the nominee indicating willingness to serve on COPA, and a curriculum vitae. Self-nominations are encouraged. Send nomination materials to Robert Beverly, Office on AIDS, at the APA address.

There will be a APA Conference presentation of relevance to Division 40: Impact of HIV on the Brain and Behavior. This is a sponsored event of The Committee on Psychology and AIDS at the Toronto APA Convention. Thursday, August 22, 2:00pm-5:50 pm.

APA Committee on Urban Initiatives (CUI; Dr. Scott Hunter, Monitor)

Dr. Hunter continues to monitor the Committee on Urban Initiatives (CUI). However, CUI is undergoing retooling. This was noted in the last issue of the American Psychologist. Dr. Hunter will provide further information as it is provided to him.

15.) Education Advisory Committee (EAC): Dr. Sandra Koffler provided a report of the activities of the EAC. The EAC continues to address issues regarding education and training in clinical neuropsychology.

The EAC took under advisement the question of support for the proposed NAN Presidential Commission on the Houston Conference. The mission for the Commission was to review the outcome of the conference with respect to education and training in Clinical Neuropsychology. It was the recommendation of the EAC that the Board not support or endorse the Commission. The reasons for so recommending include: (a) no acceptable rationale was provided by the Commission for the review. The outcome of the Houston conference was not to be considered, "a work in progress" and therefore in need of review, (b) the EAC found no support for the opinion of the Commission organizers that little had been accomplished since the Houston conference, (c) the agenda for the Commission was vague, lacking specific goals or direction and open to unfocused, unproductive discussion and (d) it is too soon to review the substantive effects of the Houston Conference due to the long lead-time for full implementation.

A seemingly more productive approach was considered by the EAC, that being how to keep the guidelines current with the rapid changes that occur in our field. This may be a topic for future deliberations of the EAC.

The Questionnaires to be sent to the doctoral internship and post-doctoral site directors have gone through their first phase of development. Comments from the board, committee chairs and other interested Division members are solicited and welcomed.

The EAC proposed a workshop on accreditation to be held at the 2004 INS meeting in Baltimore. Dr. Keith Yeates has taken the lead in arranging this workshop. The goal for the workshop is to provide assistance in the preparation of a self-study of a residency program, and for directors to become familiar with the steps in preparing an application and preparing for the site visit. Dr. Celine Rey-Casserly has been working with Dr. Yeates regarding APA participation, and several directors of APA accredited sites have offered to join in presenting the workshop.

The second Educational Leadership Conference will take place on Friday, September 5 through Monday, September 8, 2003. A representative from Division 40 will be there. The purpose of the conference is to build an infrastructure related to education in psychology and psychology in education. Issues to be addressed include accountability, assessment and advocacy, with workshops in each of these areas. There will be opportunities to meet with legislators and staff on Capital Hill to promote education initiatives.

16.) The APA Science Directorate representatives met briefly with the EC. Patricia Kobor (from the APA Public Policy Office) provided the EC with an overview of APA's science advocacy initiatives, possible re-organization and merger of NIDA and NIAAA, and construction of a newsletter produced by the Directorate entitled "SPIN: Science Policy Insider News." She encouraged anyone with questions to contact her at pkobor@apa.org.

17.) The EC was visited by Dr. Randy Phelps of the APA Practice Directorate. He provided updates on the Directorate's current activities. In particular, he discussed the Directorates initiatives to move to electronic formats in disseminating information via a web portal (www.apapractice.org). Also, he discussed that the Office of CMS (Medicare/Medicaid) is exploring conducting a study of cost savings from the pairing of behavioral medicine treatment with cardiovascular treatment. In addition, the Practice Directorate continues its activities on the legal and regulatory fronts. Dr. Puente thanked Dr. Phelps for the Practice Directorate's excellent responsivity to the Division's needs and concerns.

18.) Given Dr. Paula Shear's election to Secretary of Division 40, she will not be in a position to complete the final year of her 3-year term as Member-At-Large. Thus, Dr. Puente moved to nominate Dr. Jennifer Manly to serve the final year of this term as Dr. Shear's replacement as Member-At-Large. The motion was seconded and the EC unanimously endorsed placing Dr. Manly's nomination up for a vote to the general membership at the upcoming Division 40 Business meeting for final ratification.

19.) The EC will next meet in February 2004 in conjunction with the annual meeting of the International Neuropsychological Society to be held in Baltimore, Maryland.

Given the late hour, the meeting was adjourned at 11:18 am.

Respectfully submitted,

Mark W. Bondi, Ph.D.
Secretary, Division 40

P&C Item 1
Report of the Archivist
August, 2003

It has been my pleasure to serve as APA Division 40's first Archivist and to guide the development of the Archival Repository at the Louisiana State University Libraries. I wish to personally thank Linas Bieliauskas, Ph.D., and Stanley Berent, Ph.D., for their vision and active leadership in this endeavor. Dr. Ann Marcotte also deserves special recognition for her meticulous record keeping during her two consecutive terms as Secretary. At LSU, Glen McMullan, Elaine Smyth, and Tara Zachary must be acknowledged for their tireless efforts to provide Division 40 with a state-of-the-art Archival Repository.

The past three years have brought with them many changes in the way that Division 40 communicates. Advances in scanning, emailing, and digitizing have strongly influenced the contributions to the Archival Repository. For example, less information has been sent directly to the Archivist this year than in each of the past five years. Another influence has been the restructuring of Division 40's Executive Committee (E.C.) that positioned the Archivist to report to The Publications and Communications Committee rather than to have direct access to the E.C.

In summary, six years ago the Division 40 Archives were placed as a permanent part of the LSU Libraries Special Collections. They will be held there in perpetuity for all APA and Division 40 members to access. The Archival Repository will remain as a sign of Division 40's independence, leadership, foresight, and wisdom. I thank all Division 40 E.C. members for allowing me the privilege of serving in this pioneering role. I have asked Tara Zachary, LSU's Assistant Curator for Manuscripts, to provide an additional report to you under separate cover.

Lastly, I request that the E.C. continue to provide adequate funding (i.e. a minimum of $400/year sent directly to LSU) for the maintenance of our Archival Repository.

Please know that I am willing to be available to the next Archivist to facilitate a smooth transition.

Most Sincerely,
Darlyne G. Nemeth, Ph.D.
Division 40 Archivist

CC: Russell Bauer, Ph.D.
Tara Zachary

July 21, 2003

Dear Dr. Mark Bondi

Per Dr. Darlene Nemeth's request, I am writing to report the status of the APA Division 40 Archival Records held and maintained at the LSU Special Collections.

1. Dr. Nemeth has notified me that she will have a group of materials sent to me this week.

2. The LSU Libraries received payment for fiscal year 2001-2002 in March 2003 (late billing by the Libraries).

3. The last transfer of materials was made on November 1, 2001, by Dr. Nemeth. These materials, along with the ca. 100 items received on February 21, 2001, have not been interfiled into appropriate series nor added to the online finding aid, pending notification by the Division's leadership as to if they desire to fund scanning and mounting the documents on the web. In December 2001, the Libraries provided a proposal detailing the cost of continuing to provide this service. In February 2003, Treasurer Dr. Jill Fischer indicated this proposal was still under consideration by the Executive Committee.

4. The records continue to be housed in archival boxes and maintained under the appropriate environmental and security conditions. The finding aid and scanned documents are available and searchable at http://www.lib.lsu.edu/special/findaid/a4745.html.

I hope this report meets your needs. If you have any questions or concerns, please contact me at 225-388-6546 or by email at tzachar@lsu.edu.

Sincerely,

Tara Z. Laver
Assistant Curator for Manuscripts
Special Collections, LSU Libraries

Status of
Committee Chair, Monitor and Liason Appointments
Division 40 Clinical Neuropsychology
As of 07.18.03

The following is a final list of appointments. I have solicited inputs from the respective Chairs as well as the EC. Unless I hear (backchannel would be acceptable) by Monday, I will contact all names listed below that have already not been appointed. Thanks for your input and interest.

Appointed

Program Co-Chair- Robert Elliott
CAPP Observers- Ted Peck & Neil Pliskin
Minority- Monica Rivera & Tony Wong
International Relations- Alfredo Ardila
APA Relations- Paul Craig
Ethics- Michele McCartney-Filgate

Suggested Appointments

WCP- Cynthia Kubo
Aging- Deborah Cahn-Weiner
Gay, Lesbian, and Bisexual- Randy Muller
Inter-organizational Relations- Joe Ricker
ASHA/Division 40- Robin Hanks
APA Inter-organizational Health Care- Cheryl Silver
Public Interest- Deborah Koltai-Attix
Membership- Bradley Axelrod
Training Programs- Robert McCaffrey
Science Advisory- Allan Mirsky
Education Advisory- Rus Bauer
Awards- Gregory Lee
COESP- Expired (Heaton)
Federal Advocacy Coordinator- Honor (?)
Publications- Cecil Reynolds, Robert Heaton, Rus Bauer
(1 more transitional year)
Archivist- TBD
Webmaster- Rus Bauer

Committee to be "Sunsetted"

Incident to

Additional Appointment per Kathy Haaland

Jennifer Manly to complete Paula Shear's term (2003-2004) as Member-at-Large

Newsletter 40 is the official publication of Division 40. The Editor is Joel E. Morgan. The Associate Editor is Nancy Chiaravalloti. Dr. Morgan's address is UMDNJ-New Jersey Medical School, 12 Main Street, Suite 2, Madison, NJ 07940. Email: joelmor@comcast.net. Dr. Chiaravalloti's address is: Neuropsychology Laboratory, Kessler Medical Research Rehabilitation and Education Corporation, 1199 Pleasant Valley Way, West Orange, NJ 07052. Email: nchiaravalloti@kmrrec.org.
Division 40's Website is: www.div40.org.
Webmaster is Dr. Lloyd Cripe.

Newsletter