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Tools and Information to Help You Manage and Grow Your Practice
Using a Sliding Fee Scale  *What to Do, What to Avoid*

*From time to time, practitioners encounter clients who are unable to afford the services they need. Many practitioners faced with this situation consider reducing their fee on a “sliding scale” basis. Doing so may carry significant legal risk if not instituted correctly.*

Following are several pointers for practitioners on what to do and what not to do.

**DO**

*Do follow your managed care contract.*

You cannot charge an insured client less (or more) than you have contractually agreed to with his or her managed care company. The vast majority of managed care contracts prohibit practitioners from waiving or reducing copayments or deductibles. If this issue is covered in your contract, you must contact the managed care company for permission to waive or reduce the copayment or deductible. Unfortunately, this interaction is likely to be a complicated and time-consuming endeavor.

**DO**

*Do create a paper trail.*

Require written documentation of need from those clients who will be paying an adjusted rate. Documentation can include pay stubs and income tax returns. One approach involves charting a payment scale based on annual household income and the number of dependents. Consider basing adjusted fees on the poverty levels of your state. For example, some psychologists offer a reduced fee to those clients whose incomes are less than a certain percentage above the poverty level. If a Medicare beneficiary cannot afford the charges for copayments or deductibles, the practitioner must ask the beneficiary to sign a waiver explaining the financial hardship. If the beneficiary fails to sign the waiver, the practitioner must document that he or she made a good-faith effort to collect the charges.
Don’t routinely waive coinsurance payments or deductibles for Medicare and Medicaid patients.

Offering to waive coinsurance payments or deductibles for Medicare or Medicaid patients can be considered fraud. In addition, the government may view frequent reduction of copayment or deductible amounts for these patients as an attempt by the practitioner to induce patients to use his or her services, which is illegal under federal law and many state laws.

The Office of the Inspector General for the U.S. Department of Health and Human Services has made clear that “non-routine, unadvertised waivers of copayments and deductibles based on individualized determinations of financial need” is an exception to this prohibition.

Therefore, it is important that practitioners who wish to waive copayments or deductibles do so only on an occasional basis and not advertise their waiver program in a way that is intended to induce people to use their services – for example, by indicating that Medicare beneficiaries are routinely entitled to a specified discount.

In some states, fraud is not just limited to those who entice Medicare and Medicaid clients but may apply more broadly. Your state psychological association likely has information about applicable state laws and regulations.

Don’t overlook the potential impact on your practice finances of routinely reducing fees for patients with insurance coverage.

When practitioners regularly discount their fees, they risk having payers reduce their payments. Most government programs and managed care companies pay practitioners based on the lesser of the practitioner’s actual charge or the payer’s fee schedule amount.

For example, if a practitioner’s charge is $120 an hour and the Medicare fee schedule amount for that service is $100, Medicare pays the practitioner 80 percent of the $100 (with the client paying the remaining $20 as copayment). If the practitioner routinely discounts his or her fee by half for non-Medicare clients, Medicare could argue that the practitioner’s usual and customary rate is $60 per service hour, not $120, and Medicare therefore should be paying the practitioner 80 percent of $60. Many managed care companies could make a similar argument, depending on how the payment provisions in the contract are worded.

Keeping in mind the general considerations outlined above, every practitioner needs to make an individual decision about the level of his or her fees, as well as discount and fee waiver policies.

Many psychologists who prefer not to institute a sliding fee scale are still concerned about helping those who need psychological services but are hard-pressed to pay. One option to consider is allowing those clients to pay their bill over time. Another option is to keep your full fee but offer a limited amount of pro-bono services in the community. You can contact local social services agencies to be placed on a referral list for clients in need.

In the event that you are unable to provide the needed services at a cost some clients can afford, provide them with several referral options from an up-to-date list of lower cost but competent providers, such as community-based mental health centers in the area.

Please note: This article does not constitute legal advice. If you need a legal opinion, you should work with an attorney in your area with appropriate experience.
Adding Value ‘Outside of the Therapy Room’

One psychologist’s focus on financial health yields a diversified practice.

Whether the economy is healthy or ailing, clients hear the same advice from their financial planners: Keep a diversified portfolio. One Hawaii psychologist has found that focusing on helping others improve their financial health has enabled him to build a diversified and thriving practice.

Brad Klontz, PsyD, has been in practice since 2000, shortly after he had invested all his money in stocks. “Unfortunately, it was just several months before the bubble burst in the technology sector,” he said, and the U.S. stock market plummeted.

Dr. Klontz became very interested in examining his own thinking around money, which led to an interest in the psychology of money and personal finance. “As I explored this area, I partnered with my father and a financial planner to develop a treatment approach for disordered money behaviors,” said Klontz. He and his partners created a five-and-a-half-day workshop to address the issue.

Now several years later, he’s sometimes involved with treating a disordered money behavior such as compulsive shopping or pathological gambling. But with a highly diversified practice, his professional activities involve much more.

A few of his varied roles include:

Consultant: Dr. Klontz trains financial planners to enhance their ability to help clients establish and maintain healthy financial behaviors – for example, active savings and spending plans, along with reasonable debt. He saw an opportunity to team up with planners who expressed frustration that they couldn’t get their clients to follow through on established financial plans. Among his other consultant activities, he is helping a client develop a Web-based interactive media experience that will teach adolescents and young adults the basics of financial health.

Researcher: Dr. Klontz has a clinical effectiveness study being published this year in the American Psychological Association (APA) journal Psychological Services that assessed participants in his workshop. Meanwhile, he is completing two other studies: one that involves developing a measure of financial health, and another that explores the relationship between specific money beliefs and financial status and behaviors.

Author/Columnist: Two years ago, Klontz co-authored a self-help book* based on his disordered money behaviors treatment program. His latest book, due out this spring, is geared for financial professionals.** It includes a “decision tree” that offers general guidance for considering whether clients may need therapy rather than financial coaching or planning. The tool is designed to help financial coaches and planners understand and respect boundaries of professional competence. His prolific writing also includes a monthly column on issues related to mental health and the psychology of money published in the Kauai Business Report. Copies of his column have also run in newspapers including Rocky Mountain News, Honolulu Advertiser and Honolulu Star Bulletin.
In exploring various niches, Klontz has found it helpful to ask potential consulting clients what they find most difficult or frustrating in their work. Chances are, he said, it will relate to human behavior. “As master change agents, psychologists are uniquely positioned to provide exceptional value to individuals and systems outside of the therapy room,” said Klontz.

He sees psychologists as highly skilled in applying their expertise to diverse professional roles. “It’s up to us to figure out how to translate our skills to other areas,” said Klontz. Doing it well, he adds, may require thought, planning and further skill development.

Dr. Klontz has actively trained himself to become more effective in his various pursuits. “When I decided to write a book, I spoke to several authors and read a dozen books on how to write books,” explained Klontz. “When I learned I had to market my book, I read a dozen books on marketing and interviewed authors who were successful at marketing.” He prepared himself for media interviews to promote his book in part by joining the public relations committee of the Hawaii Psychological Association, where he now serves as president, and attending media skills trainings.

Meanwhile, Klontz has found an anchor in the traditional practice roots he planted eight years ago. “It has helped me tremendously to remain linked to a more traditional practice,” he said. For Klontz, the link to traditional practice is the approximately 50 percent of his professional time on contract with the Hawaii Department of Education that he spends providing school-based behavioral health services to students and their families.

Klontz says this activity has provided him with a consistent income and given him the opportunity to explore different markets while expanding his skill set. “I’ve been able to develop my products and service models without putting undue financial strain on me and my family,” said Klontz.

One of the goals that Klontz helps his own clients work toward is low financial stress. There appears to be plenty of opportunity for him and other psychologists to lend a helping hand. According to the results of the APA’s 2007 “Stress in America” survey, money is a major stressor and it’s on the rise. Seventy-three percent (73) percent of those surveyed said money was a significant source of stress in their life, up from 59 percent in the 2006 survey.

According to the results of the APA’s 2007 “Stress in America” survey, money is a major stressor and it’s on the rise. Seventy-three percent of those surveyed said money was a significant source of stress in their life.

Dr. Klontz imagines that a worsening economy will heighten people’s experience of financial stress. He thinks the situation is likely to lead a growing number of people to seek help in understanding how their financial behaviors have affected their financial health, and they will want help changing.

“The possibilities and opportunities are only limited by our ability to see them,” he said.

* The Financial Wisdom of Ebenezer Scrooge: 5 Principles to Transform Your Relationship with Money (Health Communications, Inc., 2006).

Access “Practitioner Profiles” from the landing page at APApractice.org and see how more psychologists are building and diversifying their practices.
Treating Post-Traumatic Stress Disorder (PTSD) Related to Military Combat

This question-and-answer article was stimulated by the documented mental health needs of active duty military, National Guard, Reservists and veterans who have served in Operation Iraqi Freedom and in Operation Enduring Freedom in Afghanistan.

Terence M. Keane, PhD, is director of the Behavioral Science Division of the National Center for PTSD at VA Boston Healthcare System. He is also professor and vice chairman of the Division of Psychiatry at Boston University School of Medicine and professor of psychology.

The author of more than 200 publications and editor of nine volumes on Post-Traumatic Stress Disorder (PTSD), Dr. Keane also has developed many of the most widely used measures of psychological trauma and PTSD. He is recognized internationally as a leading authority on PTSD and trauma.

Randy Phelps, PhD, is deputy executive director of the American Psychological Association (APA) Practice Directorate and has worked for many years on veterans issues.

Dr. Phelps: Where do individuals who have returned from combat get treated for their mental health needs?

Dr. Keane: The Department of Veterans Affairs (VA) operates an integrated health care system that provides services to men and women who were injured during their military service or who developed a disease/disorder during the time of their service. Additional eligibility is conferred on those whose annual income is below a certain level and who do not have alternative sources of health care available to them. Elderly veterans over the age of 65 can also receive care at VA. Further, an act of Congress created time-limited eligibility for National Guard members and Reservists to use VA services.

Approximately one-third of eligible veterans who served during the current conflicts in Iraq and Afghanistan have been to a VA setting for some type of care. Of course, combat-related PTSD is the most common psychological problem. But veterans also present with depression, substance abuse, chronic pain, traumatic brain injury (TBI) and other anxiety disorders.

The vast majority of veterans and their family members receive their mental health care from the private sector. For this reason, it’s important for mental health practitioners of all types to assess for veteran status. Making this determination may provide important information for case formulation and treatment planning.

Dr. Phelps: What is important for psychologists to know about the demographics of returning service members?

Dr. Keane: Several key demographic features of the current military force are important to appreciate. First, it is a decidedly diverse, multicultural military. More than 40 percent of active duty military personnel is a racial or ethnic minority. This figure represents greater diversity than in the U.S. population at large.
Second, women constitute more than 10 percent of the military serving in Afghanistan and Iraq, and they perform a wide range of professional roles and combat roles. This situation is different than Vietnam, for example, when women were disproportionately represented in nursing and administrative positions and served in the war zone in far lower percentages of the total military force.

Third, there is a bifurcated distribution of age among service members. Some members serving in their first enlistment might be in their late teens or early twenties. Others are Reservists and National Guard members who might be in their later thirties or forties. Accordingly, their backgrounds and issues are very different and reflect their age, vocational and family structures.

Dr. Phelps: How do family members – spouses, children, parents and others – factor into treatment for returning service members?

Dr. Keane: Veterans themselves are the ones deemed eligible for VA care. The VA’s statutory authority to treat family members is limited.

Family members are treated to the extent to which they are directly involved in the veteran’s care. For example, if a veteran develops depression or PTSD as a consequence of his or her service, the veteran’s spouse could be actively involved in a marital treatment program for these conditions. If a veteran is injured by an improvised explosive device (IED) and his/her cognitive processes are compromised, the parents could be involved in a psychoeducational rehabilitative program in conjunction with the veteran. This treatment would be fully provided by VA to the veteran and his or her family members.

Dr. Phelps: How generalizable are skills in treating trauma to treating people exposed to combat? How likely is

“My experience is that veterans can be extraordinarily open in describing the devastation of war but may be reluctant to express details of events in which they might have had an active role.”

— Terence M. Keane, PhD
someone with a practice focused generally on trauma, such as helping victims of abuse, to be well skilled in meeting the needs of returning service personnel?

Dr. Keane: I’d like to think that the specific skills and conceptual models for understanding and treating one type of trauma are directly generalizable to another form of trauma exposure.

Yet, specific contextual factors are important to consider if one is to succeed in navigating the transition from working with one group of trauma-exposed people to another group. In the instance of combat trauma, it is critical to understand general military contextual variables and the specific details associated with the war itself, and to have an appreciation of the stressors and pressures under which the individual served. Even understanding the political climate in Afghanistan or Iraq during the time of service may communicate to your patient important things about your competence. Learning about the contextual factors associated with a particular type of trauma exposure would, in my view, be far easier and quicker to master than the acquisition of new therapy skills.

The principles for treating trauma survivors are far better understood today than 30 years ago when we first started to treat combatants. Importantly, the models and techniques that guide psychological assessment and psychological treatment of PTSD now possess reliability and validity data that transcend the various types of trauma to which people are exposed. These same principles appear to be effective across racial, ethnic and cultural boundaries.

Dr. Phelps: What is important for practitioners to know about the combat-related experience that today’s returning soldiers may bring to treatment that’s different from other trauma-related life experiences?

Dr. Keane: Fundamentally, trauma is about exposure to life-and-death situations. Trauma may also be secondary to exposure to events that challenge one’s personal integrity or may inculcate shame or humiliation. For combatants, their experience in a war zone may transcend all of these experiences and exposure to these experiences often happens multiple times over the period of service.

Combat is not exposure to a uniform, single traumatic event. Rather, it often involves multiple types of life-and-death experiences associated with strong and wide-ranging emotional reactions in the context of a malevolent living environment that is estranged from the usual forms of family and social support. As a result, it’s vital to conduct a comprehensive assessment of exposures both in the war zone and prior to service in the war zone.

My experience is that veterans can be extraordinarily open in describing the devastation of war but may be reluctant to express details of events in which they might have had an active role. Patience is needed to understand the precise role of the individual in certain war events, their immediate reactions to those events and the long-term impact of this participation. Combatants are often actively and passively involved in acts of violence; understanding the boundary conditions of war is pivotal in making progress in the psychological treatment of war veterans regardless of their rank at the time of service.
**Dr. Phelps:** What specific treatments show the greatest promise for successful treatment of combat-related PTSD?

**Dr. Keane:** The general principles that guide treatment of PTSD are derived from several different models of care. First, the development of a strong therapeutic alliance is pivotal for all future work. It may determine the extent to which particular patients might even share with you the details of their military experiences. Conflict about one’s participation in combat is a function of what one does in the war zone and what happens to that person in the war zone. The complex emotions that emerge can be fear, anxiety, dread, horror, shame, guilt and disgust – the strongest and most aversive of human emotions.

Treatment of these emotional responses initially involves a quieting of the strong emotions often employing relaxation or meditational strategies, accompanied by psychoeducational efforts to inform the patient of the psychological, physiological and interpersonal consequences of trauma exposure. Reframing the experiences using cognitive restructuring models that focus upon realistic appraisals of the situation and the circumstances found in a war zone by combatants also is an important component of psychological care. Finally, emotional processing of the details associated with difficult combat events is also demonstrably effective in helping patients to overcome their reactions. Emotional processing can take many forms, including prolonged exposure therapy, systematic desensitization, eye movement desensitization and reprocessing (EMDR) and other approaches that focus directly upon the emotional reactions precipitated by the traumatic events per se.

**Dr. Phelps:** Psychologists are trained to pay attention to countertransference. But are there potential blind spots for certain practitioners, such as those unfamiliar with military service or opposed to war, that they should be mindful of in working with returning service members?

**Dr. Keane:** The therapeutic alliance can be a challenge in any setting and with any type of patient, but there are some key features that will determine whether veteran patients will return for continuing care. Listening attentively to the description of service, while asking informed questions about location, duties and training, can communicate to the veteran an understanding of their experience in important ways.

Most people who join the military do so for the honor and defense of their country. Their belief system is such that they respect those who join the military and they consider the work of the military among the most worthwhile things possible. Challenging this belief or even demonstrating a political position on the value and merits of a particular war may inadvertently damage the therapeutic alliance in ways that aren’t remediable.

For many war veterans, even those in their eighties today, the work they did for their country in the military was among the most rewarding life experiences they’ve had. Supporting this belief is important to moving to the next stage of treatment.

**Dr. Phelps:** What is the Department of Veterans Affairs doing to help psychologists – both VA psychologists and non-VA psychologists – become better informed?

**Dr. Keane:** The National Center for PTSD has an award-winning Web site, www.ncptsd.va.gov, with a special emphasis on combat-related PTSD. The PILOTS (Published International Literature on Traumatic Stress) literature search engine, one of the most widely used facets of the Web site, contains both published and unpublished works on the topic of trauma, including chapters in books from across the world. PILOTS can be accessed directly from www.ncptsd.va.gov.

At the moment there are two initiatives within VA to bring effective treatments to all corners of the VA mental health system. Several treatments appear to help veterans and others to overcome symptoms of PTSD: Exposure Therapy, Cognitive Therapy, Anxiety Management (for example, Stress Inoculation, Stress Management) Treatments, EMDR, combinations of the above treatments and psychopharmacological treatment using serotonin-acting medications. These treatments are identified and described in the most recent edition (in press; Guilford Press) of the International Society for Traumatic Stress Studies (ISTSS) Best Practice Guidelines for PTSD.

Further, several colleagues and I are involved in a project that will disseminate evidence-based approaches to the assessment of PTSD nationwide. We have developed a Best Practice Guideline for PTSD assessment. Following a recommendation from the Institute of Medicine, the VA will disseminate these best practices to bring uniformity to the process of evaluating veterans seeking compensation for psychological war injuries.
With more than 1.6 million troops deployed to serve in the Middle East since September 11, 2001, psychologists around the country are spearheading volunteer efforts to help service members and their families deal with psychological issues related to deployment.

For example, 1,000 licensed mental health professionals who volunteer nationally with Give an Hour provide free and confidential treatment for anxiety, depression, substance abuse, post-traumatic stress disorder, sexual health and intimacy concerns, and loss and grieving to veterans. “Our goal is to provide easy access to skilled professionals for all of the people affected by the war,” says Barbara Romberg, PhD, the organization’s founder. “The healthier the support system for the returning troops, the lower the risk of severe or prolonged dysfunction within these military families.”

SOFAR is starting chapters in New York and Michigan. “Our ultimate goals are to build resilience and to prevent intergenerational transmission of trauma,” says Darwin.

State, provincial and territorial psychological associations are also aiding volunteer efforts. For example, the “Support Our Family in Arms” task force, or SOFA, by the Colorado Psychological Association, has coordinated its efforts with both Give an Hour and SOFAR. According to Chairman Edward Cable, PsyD, SOFA provides a wide range of pro-bono psychological services to National Guard members and Reservists and their families.

Dr. Cable finds that volunteering time and talent confers many benefits. “Not only is it a way to repay our veterans for the sacrifices that they have made physically and mentally,” he says, “It is an opportunity to educate the public about the services that psychologists provide and to make them aware that we are compassionate professionals.”

For more information:
Give an Hour: www.giveanhour.org
SOFAR: www.sofarusa.org
SOFA: Contact Dr. Cable at drednc@comcast.net
Psychologists who work with combat trauma survivors, including those who served in Iraq and Afghanistan, need to be aware of factors that may put them at risk of professional stress and impairment. Meanwhile, they should remain mindful of self-care.

The Need to Self-Monitor

Psychologists’ reactions to client stories of interpersonal violence can trigger feelings that range from numbness to rage, helplessness to excessive control, and over-identification to distancing and detachment. Some practitioners may cope with their feelings through maladaptive behaviors such as excessive alcohol consumption or overeating. Psychologists need to continually self-monitor their emotional and behavioral responses to working with trauma clients, paying particular attention to the following factors.

Therapists working with trauma survivors commonly experience a sense of over-identification with the client (Stamm, 1999). For example, a practitioner may feel anger toward the government after service members share harrowing experiences related to military combat. Over-identification with a client may be especially problematic for psychologists with prior military service and for those with a personal history of trauma. The result may be a blurring of boundaries between clients’ clinical issues and the psychologist’s own experiences.

Over-identification may interfere with a practitioner’s ability to remain objective and detached from the client’s problems and therapeutic needs. In such cases, a psychologist may unconsciously seek to meet his or her own personal needs through advice giving, self-disclosure and perhaps intentional contact with the client outside of therapy sessions. Therapists who over-identify often report ruminating about the client during the week and express strong feelings of concern or anger on behalf of the client (Figley, 2002).

Some practitioners can become caught up in the sensation-alistic aspects of the trauma work and push clients to recount details of their trauma past the point of healthy processing. This experience typically causes the client to feel unduly distressed and overwhelmed. Instead of effectively processing the event(s), the result may be client re-traumatization.

On the other hand, some practitioners may feel so distressed by the traumatic stories that they unconsciously distance themselves from their clients due to their own feelings of helplessness, avoidance, denial, guilt or shame. This distress may appear in therapy sessions as victim blaming or resistance to work on traumatic material. In these situations, therapists may even avoid seeking consultation with other therapists or supervisors about their trauma patients, further complicating the therapy and the psychologist’s own reactions.

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Self-Care Considerations

If these reactions occur frequently, the therapist may become burned out or develop “compassion fatigue” (Figley, 2003) from working with clients who have experienced traumatic life events. When a psychologist begins to notice any of these reactions, or other behaviors that may be interfering with therapeutic work — for example, forgetting or canceling appointments, loss of empathy, cynicism, rescue fantasies, feelings of helplessness, rage, disgust or grief — he or she could seek consultation from another mental health professional experienced in working with trauma. If consultation is not available, or if the disruptions are more severe, the therapist might consider seeking therapy to examine his or her reactions to the client and to address any personal problem(s), such as past history of trauma, that may be impairing the therapist’s effectiveness.

Talking about personal reactions to hearing trauma clients’ stories will help the practitioner to assimilate his or her experience from both an emotional and cognitive standpoint. Psychologists need to be able to feel their natural emotions related to hearing about traumatic experiences without having those reactions disrupt the course of therapy. Further, practitioners need to be able to examine their thoughts for any cognitive distortions such as over-generalization that may be triggered by the trauma-related information — for example, thinking that the world is an unsafe place.

Psychologists also should consider seeking consultation or personal therapy if working with clients is affecting their personal life in the following ways: disconnecting from friends and family; feeling numb; becoming more irritated or angry over little things; or being unable to leave work behind at the end of the day. Practitioners with little or no military experience of their own may wish to seek consultation from individuals who understand the military culture. Doing so enables the psychologist to be educated about the reality of the war experience and may improve his or her ability to relate to the client in a therapeutic manner.

Practitioners may find it helpful to take several steps to reduce the risk of impaired behavior:

- obtain adequate training in working with trauma survivors;
- maintain ongoing collaborative consultation with other mental health practitioners; and
- re-examine personal reactions to traumatic stimuli continually.

Additional Resources

The following references may provide helpful readings on this topic:


This article was prepared by the APA Advisory Committee on Colleague Assistance.

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**NPI Alert**

Practitioners are required to begin using their National Provider Identifier number (NPI) by May 23, 2008. Beyond having their insurance claims rejected, practitioners who fail to use their NPI as of this date also risk enforcement action. Additional information is available in the February 14, 2008 issue (Vol. 5, No. 2) of the PracticeUpdate e-newsletter found at APApractice.org.
Great sites, great features, great value.

Choose your design. Multiple options to fit your style.

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To see sample sites and learn more, visit APAPractice.org.
Checklist for Closing Your Practice

Whether you are relocating, making a career change, taking a new position, or winding down and retiring, closing a practice brings with it a variety of clinical, ethical, legal and business obligations. Advance planning can help make the process smooth and minimize the likelihood of unforeseen difficulties.

The items listed below serve as a basic checklist of actions and considerations.

**Getting Started**

- Talk to your accountant and attorney about your plans.1
- Contact your psychology licensing board regarding compliance with state-specific ethical, legal and professional obligations. If you are a member of your state, provincial or territorial psychological association (SPTA), contact the SPTA as well for this information.
- Start a list of tasks. Begin with this list and add/delete items to fit your practice.
- Set a time frame that balances your needs with those of your clients and staff.
- Stop taking new cases or referrals that would require services beyond the time when you intend to close your practice.
- Contact the APA Practice Organization and the APA Ethics Office with other questions as they arise.

**Clients and Their Records**

- Inform your current clients, being sure to leave adequate time for termination or referral. Your attorney may be helpful for advising you when to notify your clients and what to include (and not include) in a written notice.
- Talk to the psychologists to whom you will refer clients who need ongoing treatment. Find out about their availability, insurance accepted, location, office hours and areas of expertise.
- Ensure continuity of care by providing referrals for clients who require ongoing services and helping them with the transition.
- After obtaining informed consent from your clients, transfer a copy of their records to the new practitioners.
- Inform other health care professionals with whom you collaborate and keep them up-to-date on the status of closing your practice.
- Attempt to notify your past clients. There are a number of approaches you might take, including sending a letter and/or placing a notice in the local papers of the area you serve, on your Web site and in other community forums. Be sure to include information about how to contact you or access client records.
- Make arrangements for secure storage of client records for an adequate amount of time. Record keeping requirements vary by state, so check with your SPTA and/or licensing board to ensure you will be in compliance. Also see Guidelines 7 (“Retention of Records”) and 13 (“Disposition of Records”) in APA Record Keeping Guidelines (2007) available at www.apa.org/practice/recordkeeping.pdf. If control of your client records will be handled by another psychologist, be sure to obtain adequate patient consent to transfer the records to the other psychologist.
● After securely storing the records you are required to maintain, clear any electronic protected health information off computers, PDAs, and cell phones. See information about the Health Insurance Portability and Accountability Act (HIPAA) Security Rule for requirements regarding record storage and destruction. Also see APA Record Keeping Guideline 13 on “Disposition of Records.”

● Create or update your professional will.

**Finances**

● Talk to your attorney and accountant to determine whether selling your practice is a viable and worthwhile option. Also be aware of ethical issues related to selling your practice, and seek appropriate consultation as necessary.

● If selling your practice, decide whether to work with a broker to help you navigate this potentially complicated process that requires a sophisticated understanding of local and state laws, business valuation, marketing strategy, tax implications and contracts.

● Collect any accounts receivable.

● Pay off any outstanding debts.

● Work with your accountant to organize your financial records (for example, financial reports, tax documentation, contracts).

● Talk to your accountant and/or tax professional about the tax implications of closing or selling your practice and strategies to reduce your tax liabilities.

● Once all of your finances have been reconciled, close bank accounts associated with your practice.  

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Checklist for Closing Your Practice  continued from page 15

Business Issues

- Discuss business, legal, financial and ownership issues with your partners. If selling or transferring your ownership to your partner(s), be sure to work closely with your attorney to protect all parties involved.

- Inform your office staff far in advance.

- Notify all of your referral sources.

- Inform other professional contacts and relevant entities, including the licensing board in your jurisdiction, professional organizations, insurance panels and other parties with which you contract, your billing and answering services and other practice consultants.

- Talk to your attorney and accountant about the business aspects of closing a practice with your particular legal structure — for example, corporation, limited liability company (LLC) or sole proprietorship.

- If you rent office space, give notice to terminate your lease in the manner and time frame that your leasing contract requires. If you own, take steps to sell or rent your office.

- Sell, donate or dispose of office equipment, such as photocopiers, fax machines and furniture. Remember that if any of this equipment contains electronic patient records, that information must be deleted in line with HIPAA Security Rule requirements. Also see APA Record Keeping Guideline 13 on “Disposition of Records.”

- Use up any remaining office inventory.

- Contact the issuers of any business licenses and permits you hold.

- Cancel any utilities (for example, electric, gas, water, phone, internet) you pay for your office.

- Submit a change of address form with the post office. Depending upon your privacy concerns and where you want your professional mail delivered, you may want to consider obtaining a post office box for a period of time to make sure you do not miss any important correspondence.

- Cancel or forward any publications or subscriptions you receive at your office.

- Forward your office telephone number or keep your answering service for a period of time. Place an outgoing message informing callers of your closure and giving instructions for contacting you or accessing their records.

Take Care of Yourself

- With all of the issues to contend with and while focusing on the needs of your clients, it is easy to forget how closing a practice affects you as a psychologist. Be sure to acknowledge and address your own emotional issues related to closing your practice and to take the time to focus on self-care. Additional information about self-care for psychologists is available in the “Professional Development” section online at APAPractice.org.

- Talk to your accountant or financial planner to ensure you are taking the steps to address your personal financial needs following your practice’s closing.

- Call your professional liability insurance carrier. Make sure you are covered for complaints filed after you close your practice. If your current policy does not cover this type of complaint, find out about purchasing a “tail” to your policy.

- Review or create a retirement plan to ensure a sound financial future and enjoy the next chapter of your life, wherever it may take you.

1 The information in this document is for informational purposes only and does not constitute legal advice. Every practice is unique and will have specific issues that need to be addressed. Psychologists thinking about closing a practice should talk to an attorney, accountant and other practice consultants, as appropriate.

2 Information about the HIPAA Security Rule is available online in the “HIPAA Compliance” section at APAPractice.org.
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— Rabbi Harold Kushner,
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Primed for Hospital Practice

Psychologist-friendly environment helps a practitioner thrive

“I don’t pass out when I see blood,” says John D. Robinson, EdD, MPH, ABPP, a professor of psychiatry and surgery at Howard University College of Medicine and Hospital in Washington, DC.

And that’s lucky, because Dr. Robinson is all over Howard University’s hospital. One day, he could be in the operating room with a patient about to undergo surgery. The next he could be working with a patient on how to better adhere to a medical regimen. And the next he could be meeting with physicians on the hospital’s transplant team to review transplant cases. “I’m all over the place,” he says.

Dr. Robinson’s full integration into the workings of his hospital is the result of three things: a change in DC’s hospital practice law, inclusive bylaws at his hospital and his own efforts to gain influence (see Pointers for Gaining Influence in Hospitals on page 19).

Interested in following in his footsteps? According to Dr. Robinson, the first step practitioners should take is to examine state laws regarding hospital practice. Also review the hospital’s bylaws to see whether psychologists qualify as medical or professional staff with full voting privileges. And don’t be fooled by people who claim that the Joint Commission (formerly known as the Joint Commission on the Accreditation of Healthcare Organizations) says that psychologists can’t practice in hospitals, says Dr. Robinson. “The commission’s rules are actually very permissive,” he says.

According to Robinson, the integration of psychologists into DC hospitals began in the early 1980s when leaders of the DC Psychological Association (DCPA) noticed a problem: The city’s 1938 hospital law was keeping psychologists from being able to practice in hospitals. DCPA’s legislative chair began the battle to revise the law by enlisting the help of an unusual ally: a city council member with a pregnant constituent upset because a hospital wouldn’t allow her midwife to deliver her baby there.

Getting other professionals involved in changing a hospital practice law is key, emphasizes Dr. Robinson. “Having a broad coalition makes it look less self-serving for psychologists,” he says. The DC coalition included nurse anesthetists, podiatrists, nurse midwives, optometrists, psychologists and others who wanted hospital privileges.

Equally important is to get the support of those who already do have privileges. In DC’s case, for example, anesthesiologists endorsed nurse anesthetists. Orthopedists endorsed podiatrists. And pediatricians, internists, family practitioners and other non-psychiatrist physicians endorsed psychologists. Patients themselves also make good allies. Robinson adds that having a political action committee, a good lobbyist and lots of fundraising parties also is important.

The result of the coalition’s hard work was the 1984 Hospital Privilege Law, a revision of the earlier law that gave psychologists and others hospital privileges.

As for hospital bylaws, Howard University Hospital has what Dr. Robinson calls “one of the best medical staff bylaws I’ve ever seen.” The hospital’s definition of “medical staff” includes psychologists. It allows psychologists and other licensed health care practitioners to exercise their independent judgment; vote and hold office; and admit, treat, and discharge patients as a member of the hospital’s medical staff. “That gives you control and authority,” says Dr. Robinson, noting that psychologists don’t have to work under a physician’s supervision.
John D. Robinson, EdD, MPH, ABPP, professor of psychiatry and surgery at Howard University College of Medicine and Hospital, offers these tips to his fellow psychologists:

**Learn the rules.**
Psychologists often want other practitioners to act like psychologists, says Dr. Robinson. “Don’t try to change the culture - understand the culture,” he says. That means abiding by rules even if you don’t agree with them, such as the unspoken hierarchy that makes residents, interns and junior faculty step aside to let senior faculty get on the elevator first.

**Blend in.**
“Some psychologists don’t want to wear a white coat,” says Robinson. “They don’t want to be seen as a [medical] doctor and have to treat a heart attack.” That’s a mistake, he says. Robinson encourages his fellow psychologists to dress like everyone else and do whatever else it takes not to stand out from the rest of the medical staff.

**Make yourself known.**
Get to know people and talk to them, urges Robinson. If there’s a medical staff meeting, don’t ask for permission to attend – just go. “I go to a lot of meetings I don’t have to so that people know who I am,” he says. “That way they see that I’m part of the hospital, not isolated in the psychiatric unit.”

**Focus on your clinical role.**
Robinson recommends that psychologists identify themselves as clinicians, since they’re part of the medical staff. He also urges them to underline that identity by using clinical language. “And learn other people’s clinical language,” he adds.

**Serve on committees.**
One of the most important committees is the credentialing committee, which determines who can practice at a hospital. “If you’re on it, everyone on the medical staff will know who you are because they want you to be on their side,” says Dr. Robinson. Other important committees in his hospital include the admissions committee for the medical school and departmental promotions and tenure committees.

**Getting other professionals involved in changing a hospital practice law is key, emphasizes Dr. Robinson. “Having a broad coalition makes it look less self-serving for psychologists.” The DC coalition included nurse anesthetists, podiatrists, nurse midwives, optometrists, psychologists and others who wanted hospital privileges.**

Of course, the bylaws also note that psychologists and other nonphysician practitioners must seek consultations when necessary. Physicians must also perform the history and physical examination of patients upon admittance and discharge. And if patients need medication, Dr. Robinson has a psychiatrist manage them pharmacologically.

Dr. Robinson’s only regret? That there aren’t more psychologists in hospitals. Physicians “see us as something that enhances what they do,” he says. “If I could clone myself, I could satisfy a lot of other department heads.”

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**RESOURCES**

**1. PracticeUpdate e-newsletter**  
New in 2008: login not required

**2. Managed Care Reimbursement Toolkit**

**3. Why practitioners must use their NPI by May 23, 2008**

**4. HIPAA resources for psychologists**

**5. APA-approved guidelines**

**6. Medicare payment updates**

**7. Practice management and marketing resources**

**8. Mind/Body Health Toolkit materials**

**9. Self-care pointers**

**10. Breaking legislative news of interest to psychologists**
Online Resources at Your Fingertips

Check out the following online resources for practitioners and consumers of psychological services:

APApractice.org (below, upper left) has grown to include hundreds of practical articles, tools and other resources for practitioners. The award-winning PracticeUpdate e-newsletter located at this site (center left) regularly delivers timely information to practitioners. There have been more than two million visits to apahelpcenter.org (upper right) APA’s Help Center for consumers, since its relaunch in 2005. This Web site offers materials that psychologists can use in their work with clients, schools, health care facilities and in other practice settings. The APA Practice Directorate recently unveiled a Spanish-language site, centrodeapoyoAPA.org (lower right), that mirrors the content on the APA Help Center.

Among the resources available at phwa.org for employers and psychologists who work with them are the Good Company e-newsletter (lower left), a searchable database of research abstracts and regular podcasts.