GOOD PRACTICE

Health Care Reform Advocacy Update
Integrating Care at VA
Dealing with Discount Networks
New Practice Guidelines on Health Care Delivery Systems
Disaster Mental Health 10 Years after 9/11
Doing Well with Wellness
Putting Your Practice Assessment to Work

Tools and Information to Help You Manage and Grow Your Practice
GETTING A WEBSITE HAS NEVER BEEN SO SIMPLE.

FAST. EASY. AFFORDABLE.
TherapySites gives all the online tools you’ll ever need - for one low monthly price.

Yes! You can launch a successful online presence in just four simple steps. Our all-inclusive package includes all of these features at no extra charge!

- CREDIT CARD PROCESSING
- ONLINE APPOINTMENT REQUEST CAPABILITY
- CLIENT ORGANIZATIONAL TOOLS
- UNLIMITED DESIGN CHANGES
- EMAIL & WEBSITE HOSTING
- DOMAIN REGISTRATION
- TOLL-FREE CUSTOMER SUPPORT
- Psychology Today DIRECTORY LISTING
  See TherapySites.com for details

SPECIAL OFFER FOR OUR MEMBERS!
www.TherapySites.com/APAPO
APAPO CUSTOMERS SIGN UP AND GET TWO MONTHS FREE!
PROMO CODE: APAPO

ONLY $59 PER MO.
ALL-INCLUSIVE
NO HIDDEN CHARGES
NO CONTRACT FEES

thepysites.com
WEBSITES FOR THERAPISTS. MADE SIMPLE.
THERAPYSITES.COM | 866.597.2674

STEP 1: Select design
STEP 2: Customize
STEP 3: Preview, Edit
STEP 4: Launch Site
CONTENTS

Health Care Reform Proceeds toward an Uncertain Future .............................. 2
SIDEBAR: Basics of the Affordable Care Act ............................................ 4
SIDEBAR: Online Resources .................................................................. 5

Integrating Primary Care and Mental Health at VA ................................. 6
PRACTITIONER PROFILE: Lisa K. Kearney, PhD

Dealing with Discount Networks ............................................................ 8

New Guidelines Inform Practice in Health Care Delivery Systems ................. 10
SIDEBAR: Excerpts from the Guidelines .................................................. 11

Ten Years After 9/11: The Changing Face of Disaster Mental Health ............ 12
SIDEBAR: References and Resources ....................................................... 18

Doing Well with Wellness .................................................................... 14
PRACTITIONER PROFILE: John Weaver, PsyD
SIDEBAR: Cultivating Wellness .............................................................. 14
SIDEBAR: Resources for Psychologists .................................................. 15

SPECIAL FEATURE
Putting Your Practice Assessment to Work ............................................. 19

Good Practice is the recipient of a Platinum Award, the highest honor, from the Association of Marketing and Communications Professionals.
Even as elements of the 2010 health care reform legislation known as the Patient Protection and Affordable Care Act (ACA) are implemented, the federal law is unfolding in a landscape of growing uncertainty. This article identifies several key environmental factors in play as of September 2011, followed by a brief summary of major aspects of the law and related advocacy efforts by organized psychology.

Much of the uncertainty surrounding health care reform relates to the long timeline for implementation, combined with political dynamics and stark budget realities.

Many of the ACA’s fundamental provisions do not take effect until January 2014—for example, the creation of state-level health insurance exchanges whereby health plans will be made available to individuals and small businesses. ACA is not slated for full implementation until 2015. Even so, several insurance market reforms including the elimination of lifetime and annual visit limits, prohibitions against retroactive cancellation of insurance coverage and denying coverage for children with pre-existing conditions, and benefit appeal rights took effect in September 2010. (See the sidebar on page 4 for more about the law’s basic provisions.)

**Political and economic dynamics**

According to Doug Walter, JD, legislative and regulatory counsel for the APA Practice Organization (APAPO), much of what ultimately happens to ACA will depend on who is president in 2013. “There’s a good chance the law will be re-examined if the White House changes parties following the November 2012 election,” Walter says.

Meanwhile, the partisan bickering in Congress that preceded the law’s passage has extended to its implementation. During the first half of 2011, the newly Republican-controlled House
voted to repeal the law and then to cut off funding, though the Senate countered these actions.

Congress’s legislative focus for the foreseeable future is on deficit reduction. Under the Budget Control Act of 2011, if a bipartisan deficit reduction committee representing both chambers of Congress fails by November 2011 to identify at least $1.2 trillion in savings over the next ten years, automatic cuts to Medicare and other programs will result. Similarly, Medicare and Medicaid services could be vulnerable to substantial payment reductions if the committee identifies the requisite budget savings, according to Walter. President Obama has announced his own ten-year deficit plan with significant cuts to Medicare and Medicaid over that period.

**As of September 2011, nearly 30 states had filed or signed onto lawsuits challenging ACA, notably the constitutionality of a central tenet: the mandate requiring individuals to have health insurance coverage.**

Given the federal budget situation, another element of uncertainty involves funding for demonstration projects included in ACA. For example, psychologists are eligible to participate in a Community-based Collaborative Care Network Program and a Medicare Independence at Home demonstration project. However, according to Marilyn Richmond, JD, assistant executive director for government relations with the APA Practice Organization, “ACA demonstration project funding is unlikely when Congress is focused on cutting entitlement programs.”

Recent judicial actions also contribute to the uncertain future course of health care reform. As of September 2011, nearly 30 states had filed or signed onto lawsuits challenging ACA, notably the constitutionality of a central tenet: the mandate requiring individuals to have health insurance coverage. Six federal district courts had ruled on the issue and were evenly split on whether the individual mandate was constitutional. Three federal appeals courts had considered lower court decisions and also came to differing conclusions about constitutionality of the individual mandate. Many observers believe the disparate rulings increase the likelihood that the U.S. Supreme Court will consider the issue, perhaps in 2012.

### Key elements of reform

Despite this environment, government officials and many others at the federal and state levels are forging ahead with health care reform implementation. Following is a brief summary of key aspects of ACA and related advocacy efforts by the APA Practice Organization and APA:

#### Integrated primary health care delivery models

ACA encourages accountable care organizations (ACO) and smaller-scale patient-centered medical homes (PCMH) as two models for comprehensive, integrated patient care led by primary care providers. ACOs contract with payers to provide a broad range of services to a designated population, with the goal of reducing costs while ensuring quality care. The PCMH model of care involves an interprofessional team of providers led by a personal physician delivering continuous and coordinated care to patients. Under these models, service delivery focuses on “whole person” care that recognizes the mind-body connection and the importance of integrating physical health services with mental and behavioral health services.

The APA Practice Organization and APA are advocating for psychologists’ ability to participate in these models. APA Chief Executive Officer Norman Anderson, PhD, and Executive Director for Professional Practice Katherine C. Nordal, PhD, commended the Department of Health and Human Services (HHS) for its decision to include psychologists among the providers eligible to participate in Medicare ACOs. In a June 2011 letter, the psychology leaders provided supportive comments to HHS regarding its draft proposal to establish ACOs and implement payments to participating providers, including psychologists, through the Medicare Shared Savings Program.

Recognizing strength in numbers, APA serves on the executive committee of the Patient Centered Primary Care Collaborative (PCPCC), a massive coalition intent on fostering the move toward patient-centered medical homes. The broad range of organizations participating in the PCPCC, numbering in the hundreds, includes health care professional associations, hospitals, large employers and health information technology firms, among others. APA is the sole association of its kind on the PCPCC executive committee and helps the coalition sharpen its focus on integrating mental and behavioral health into primary care, according to Dr. Nordal.
Health Care Reform Proceeds toward an Uncertain Future

**Expanded coverage for preventive services**

The APA Practice Organization supported the inclusion of preventive services in ACA. The law requires private health insurers to cover a variety of preventive services such as screenings for depression and counseling related to obesity as well as tobacco and drug use.

While pleased that the federal government is implementing new requirements for preventive services as a result of the law, organized psychology is addressing a problem with psychologists not being included among the “primary care professionals” eligible to provide these services in Medicare. In response to related decision making by the Centers for Medicare and Medicaid Services, Dr. Nordal has formally asked the federal agency to incorporate psychologists as eligible providers for services related to obesity and smoking cessation.

**Electronic health record keeping**

ACA builds on the 2009 law known as the Health Information Technology for Economic and Clinical Health (HITECH) Act, which substantially expanded the federal government’s effort to establish a national electronic health records (EHR) system by 2014. Proponents believe that, due to administrative and other efficiencies associated with health information technology, electronic records will substantially lower health care costs. Yet these record-keeping systems are expensive to implement.

The HITECH Act included incentive payments for designated providers—only physicians, dentists, podiatrists, chiropractors and optometrists, or those defined as “physicians” for purposes of Medicare law—to adopt EHR in their practices. The APAPO has since pursued legislation to include psychologists and other excluded mental health providers eligible for the Medicare and Medicaid incentive payments. But the bill, along with companion legislation pending introduction in the House, faces an uphill climb toward passage. Any legislation that would increase federal health program costs is subject to intense scrutiny.

The APAPO’s multi-pronged legislative advocacy strategy would address the limitation in HITECH through yet another key initiative: adding psychologists to the Medicare definition of “physician.” As a result of persistent advocacy with members of Congress, including visits to

---

**BASICS OF THE AFFORDABLE CARE ACT**

The Patient Protection and Affordable Care Act (ACA) passed in March 2010 preserves the U.S. system of employer-based health insurance while mandating a number of insurance market reforms. Health coverage is expanded to an estimated 32 million more Americans, while costs are lowered over the long term (according to the Congressional Budget Office).

The law seeks to transform the U.S. health system from one that reacts to health problems as they arise to one that focuses on addressing whole-patient health through initiatives that promote primary and integrated care, improve quality and emphasize prevention.

Several additional provisions of ACA supported by the APAPO and APA are particularly significant for practicing psychologists and consumers of psychological services:

- Restoration of Medicare payments for psychotherapy services following reductions in 2007
- New opportunities for psychologists to participate in primary and integrated care such as through community-based, interprofessional health teams
- Mandatory coverage of mental health and substance use disorder services, covered at parity with physical health services, as part of the essential benefit packages offered by plans participating in state-level health insurance exchanges
- Required inclusion of mental health as “basic services” in state Medicaid plans, also covered at parity with physical health services
- Prohibition against health plans excluding psychologists or other categories of health professionals from its network.

For additional details, see the article, “What the New Health Care Reform Law Means for You,” in the Summer 2010 issue of Good Practice magazine from the APA Practice Organization.
Capitol Hill by several hundred participants during the APAPO’s 2011 State Leadership Conference, bills in both the House (H.R. 831) and Senate (S.483) that would provide for this change in Medicare definition have growing numbers of cosponsors.

Focus on state-level implementation
Under ACA, states have particularly important roles regarding Medicaid expansion, the creation of health insurance exchanges (HIE) and regulations governing insurance companies that offer products through those exchanges. Medicaid programs and HIEs, along with the Children’s Health Insurance Program, serve as the predominant mechanisms whereby ACA will expand coverage to tens of millions of uninsured individuals. ACA puts the onus on states to be innovators in creating models of care though medical home grants and other integrated care initiatives.

So the APA Practice Organization has begun collaborating with state psychological associations to generate resources and expertise that state leaders can use to position psychology for maximal participation in health care reform. In its early stages, the joint initiative will focus on a few concrete issues that psychology needs to be knowledgeable about and plugged into: Medicaid redesign, state health exchange committees, partnering with primary care associations and accountable care organizations.

“State psychological association leaders need to be involved to help ensure that emerging models of care at the state level include behavioral health and psychological services. If we aren’t at the table, it’s because we’re on the menu.” – Katherine C. Nordal, PhD

She and many other leaders at the national and state levels are working to ensure that professional psychology is well represented as ACA and state regulations related to health care reform are developed and implemented, and that psychologists are well positioned to participate fully in the evolving health care system.

ONLINE RESOURCES

apa.org/health-reform
American Psychological Association website content on health care reform

apapracticecentral.org/advocacy/reform/index.aspx
APA Practice Organization website content on health care reform

HealthCare.gov
Federal government website devoted to health care reform managed by the U.S. Department of Health and Human Services

healthreform.kff.org
Health Reform Source, The Henry J. Kaiser Family Foundation

pcpcc.net/providers-and-clinicians
Information for providers and clinicians at the Patient Centered Primary Care Collaborative website

statereforum.org
National Academy of State Health Plans website
Psychologist Lisa K. Kearney, PhD, came by her love of the military early: She was born at Fort Hood. “My dad is a Vietnam vet,” says the lifelong Texan. “I always wanted to serve in the military myself, but I didn’t think I could make it out of basic training!” Fortunately, Kearney found a different way to support her country: serving those who serve. As the National Integrated Care Coordinator for the U.S. Department of Veterans Affairs (VA) Office of Mental Health Operations, she’s working to improve veterans’ health by integrating primary care and mental health services at VA facilities across the country. “My dad and mom instilled the value of real service to country,” says Kearney, “so this is my way to give back.”

Integrating physical and psychological care

VA’s push toward integration began with two realizations. First, primary care practitioners often did not adequately address depression, anxiety, alcohol misuse and other behavioral health problems until the conditions became too severe to overlook. And psychologists weren’t fully utilized to help patients with medical conditions make the behavioral changes that could improve their health.

The plight of veterans returning from the wars in Afghanistan and Iraq also contributed to a desire to integrate services. “We noticed continuing stigma around seeking mental health services,” says Kearney. “We wanted to decrease stigma and increase access to care.”

To make that happen, VA launched the National Primary Care-Mental Health Integration Program in 2007. For VA, integration has two key components. One is co-located, collaborative care, which means placing psychologists and other mental health professionals within primary care clinics. That allows for instant, just-down-the-hall access to consultations or even brief therapy for patients with mental health or chronic physical health problems.

The second component is care management. To help ensure that patients follow through on their physicians’ recommendations, care managers—typically mental health nurses but also psychologists and social workers—provide health education and use motivational interviewing to help patients identify and achieve health-related goals by following algorithmically based, researched models of care by telephone.

In addition to providing direct service within primary care clinics, psychologists are leading efforts to integrate services in their facilities, supervising care managers and training primary care providers how to do brief interventions for pain, depression and other conditions.

As a result, the program helps ensure that psychologists and other specialty mental health professionals are available for those who really need their help. “Before this program, all the folks—even those who had minor problems like stress related to finals—were being sent to specialty mental health,” explains Kearney. This new model allowed for less severe problems to be managed in less intensive settings, while utilizing more intensive services for patients needing those care modalities.

Primary care-mental health integration is working well and Kearney believes it could serve as a model for other large health-care systems. “We’ve seen improvements in screening of disorders within primary care settings and more access than ever before,” says Kearney.

And while the national evaluation is still ongoing, past studies of various components of the initiative show just how effective integration can be. In one study, for example, remission rates for veterans with depression and alcohol problems more than doubled when patients received disease management by phone rather than usual care.
Preparing for integration

Kearney spends her days evaluating programs and helping other facilities put integration into practice by providing consultation, training and technical assistance to facilities around the country.

But even before she began the job last November, Kearney had firsthand experience of integration’s effectiveness. She points to one experience as a success story during her tenure as Chief of the Psychology Service at the South Texas Veterans Health Care System in San Antonio. Working together with Dr. Vicki Hannigan, Associate Chief of Staff for Ambulatory Care, and Dr. Tera Moore, Clinical Pharmacist, Kearney called together pharmacists, primary care physicians, diabetes educators, dieticians and psychologists, who created an intervention in which a veteran who was successfully managing his diabetes called vets who weren’t doing as well and encouraged their participation in an interdisciplinary group medical appointment with individualized stepped follow-up care for diabetes management.

The result? Improvements in blood sugar levels as well as blood pressure, cholesterol levels and other indicators. “That just shows when we all come together as a team across different disciplines and play to our strengths, patients and providers both benefit,” says Kearney.

Of course, she adds, psychologists may not always receive training in interdisciplinary settings.

In addition to having to learn about chronic health conditions, interdisciplinary work and large health systems, she says, psychologists in integrated settings must be prepared for what she calls a “culture shift.”

“Psychologists are used to 50-minute, don’t-interrupt-me sessions off in specialty care,” she points out. “You’ve got to get used to your door always being knocked on. You always have to be available.” In addition to constant communication with colleagues in primary care and other disciplines, psychologists must also adapt to a much faster pace. In contrast to the six or seven patients a day seen in specialty mental health, primary care psychologists can see as many as 12 or 15. Knowing how to do quick functional assessments and provide brief therapy interventions is key, says Kearney. “You have to love the adrenaline rush!” she says.

Kearney herself came from what she calls a “traditional” counseling psychology program at the University of Texas at Austin, where she earned her doctorate in 2004. She came to the South Texas VA as an intern in 2003 and, she says, “fell in love with working with veterans.”

Leadership opportunities

Kearney hopes other psychologists and students will also fall in love with the VA—the nation’s largest employers of psychologists.

Over the past several years, mental health staffing overall—and psychologist staffing in particular—has expanded significantly to meet the needs of veterans. Opportunities abound, she says, noting that psychologists serve as chiefs of psychology, directors of training, researchers and administrators within VA.

Psychologists are also leaders within the organization, says Kearney, who is secretary of the Association of VA Psychologist Leaders. For example, Antonette Zeiss, PhD, recently became the first psychologist and first woman to be appointed to the top mental health position at VA, and Mary Schohn, PhD, is currently acting director for mental health operations. Another psychologist, Lisa M. Thomas, PhD, became chief of staff at the Veterans Health Administration in July. “We’re very inspired and delighted to see psychologists—and also women—in those roles,” says Kearney.

Kearney enjoys what she does. “I love integrated care, so I’m in my dream job right now,” she says.

Even though she never made it to basic training, Kearney’s parents—who live in San Antonio along with her husband and two young sons—are proud of the way she’s fulfilling her early dreams.

“The mission of the VA is so wonderful,” says Kearney. “It is to serve those who have sacrificed so much for us.”
Dealing with Discount Networks

A step-by-step guide for psychologists

Consider the following hypothetical scenario:
Several years ago, you signed a contract with the Looks Promising Network. You thought the network would be a good source for referrals, but it never contacted you or sent you a single patient.

Now you have a contract with a health insurer known as Big Insurer. It has been paying you a certain amount for a particular psychological service, but the payment rate recently dropped by a substantial percentage. You contact Big Insurer for an explanation of the decrease, and you are told that your rate has been discounted because you are on the provider list for Discount Network.

You have never heard of Discount Network.

You learn that Discount Network purchased the Looks Promising Network and acquired its contracts. Discount Network approached Big Insurer with a list of providers—including you—who are available at their discount rate. Big Insurer relied on your old contract with Looks Promising to lower your payment rate.

Now that Big Insurer is paying you less, what do you do? Review the following steps for addressing this predicament building on the hypothetical example.

STEP 1—Determine if your provider contract with Big Insurer allows it to pay less than the contracted rate.

Review the payment provisions in your provider contract with Big Insurer. See if there is any applicable language that allows Big Insurer to pay you less than the reimbursement rate in Big Insurer’s contract. One example would be if Big Insurer’s contract states that the insurer will pay you a rate indicated in the contract unless you have agreed to a lower rate with another network with which Big Insurer has a contractual relationship. If you do not see such a provision, ask your company representative what in the provider contract allows the provider to discount the rate. If the representative fails to identify an applicable provision, you can argue that Big Insurer is breaching its provider contract with you by paying less than the agreed-upon rate.

STEP 2—Verify the existence of the contract used to discount your rate.

Your contract (called the “Original Contract”) with Looks Promising is another key document. Assuming that Big Insurer is able to discount your rate based on Step 1, Big Insurer must then rely on the Original Contract to argue that you have agreed to this lower rate. Thus, it is important to verify that the Original Contract in fact exists.

You may wonder which of the two contracts takes precedence. Your provider contract with Big Insurer takes precedence because it controls your relationship with Big Insurer, the company that is contractually obligated to reimburse you for seeing patients insured by Big Insurer. As noted above, Big Insurer’s contract with you should indicate whether you are entitled to the reimbursement rate stated in that contract; or if there is a provision allowing Big Insurer to pay you a lower rate, based on contracts you have signed with other networks. If Big Insurer’s provider contract allows the provider to discount the rate. If the representative fails to identify an applicable provision, you can argue that Big Insurer is breaching its provider contract with you by paying less than the agreed-upon rate.
contract does give it the right to pay a lower rate, then the Original Contract is arguably irrelevant.

If you do not recall signing a contract with Looks Promising or cannot find your copy of it, ask Discount Network to provide you with a copy of that contract. Also ask Discount Network to state in writing that it has purchased Looks Promising Network and/or the rights to its provider contracts.

If Discount Network does not provide you with a copy of your Original Contract, you can argue that it has failed to establish that you agreed to be part of the Discount Network. In addition, if you do not have a copy of your Original Contract you will be unable to answer the questions in Step 3 regarding the validity of this contract.

**STEP 3**—Review your Original Contract

Following are several key provisions to review in the Original Contract:

**Reimbursement Rate.** Does this contract state the reimbursement rate that is now being used as your discount rate? If not, does it allow the company (Looks Promising or its successor, Discount Network) to change the reimbursement rate without notifying you? Most regular provider contracts require that the company provide you with written notice a specified amount of time before changing the reimbursement rate. In most discount network situations, the psychologist has not heard anything from the discount network prior to discovering that his/her rate has been discounted. In that circumstance, the psychologist obviously would not have received the required notice of the rate being lowered.

**Definition of the network.** Does the contract state what network you signed up with? Does it give Looks Promising the right to rent or lease that network to other companies? If not, you can argue that the contract applies only to referrals from Looks Promising or its successor, and thus it doesn’t allow for discounting your rate for referrals from Big Insurer.

**Term and Termination.** Look at this provision to see if there is an argument that the contract is no longer in effect and/or if you decide to terminate the contract (see Step 5).

Many provider contracts renew automatically each year if neither side terminates. Many contracts can be terminated by the psychologist with 90 days’ written notice, but some have longer termination periods.

**STEP 4**—Make your arguments

Now that you have gathered your information in the first three steps, it is time to start your advocacy. You may want to start with a phone call if the company is responsive to telephone inquiries and you have a good relationship with a representative at Big Insurer. But be ready to escalate to concise, written communications (and beyond that) if the phone calls are not effective.

When communicating by e-mail or postal mail, write to both the main insurance company, Big Insurer, and the discount network company (Discount Network in this example) because both are responsible for discounting your rate.

Make the following arguments, if applicable:

- Big Insurer’s provider contract does not allow it to pay you less than the rate provided in Big Insurer’s contract.

- The Original Contract (with Looks Promising) is not valid if you never received any referrals under it. The argument is that Looks Promising’s part of the bargain was that it would send you referrals. (Your part of the bargain was to provide services to the referred patient at the agreed-upon rate.) No reasonable person would accept a contract to join a network that provided no referrals, where the only effect was that years later his/her business from other sources would be discounted. Even if the Original Contract does not specifically state that Looks Promising will give you referrals, you would argue that this is implied from the nature of the contract or from its marketing materials.

- The Original Contract, even if valid, does not allow the
Psychologists practice in an increasingly diverse range of health care delivery systems. In February 2011, the American Psychological Association (APA) adopted Guidelines for Psychological Practice in Health Care Delivery Systems to help practitioners and others conceptualize the roles and responsibilities of psychologists in a variety of practice settings.


Good Practice interviewed Mary Ann McCabe, PhD, 2010 chair of the Committee on Professional Practice and Standards, which developed the guidelines. Dr. McCabe addressed the following questions about the content and uses of the health care delivery system guidelines.

**Q:** To what practice settings do these guidelines pertain?

**A:** The 2011 guidelines build upon earlier APA guidelines and practice documents focused on psychology practice in hospitals. Over the last few decades, psychologists have assumed more diverse roles in mental, behavioral and physical health care, and the systems in which psychologists practice have evolved. These new guidelines pertain to the full range of health care delivery systems, including integrated primary care facilities, tertiary care hospitals, rehabilitation centers, nursing homes, outpatient surgery centers and mental health/substance abuse treatment centers.

**Q:** How are changes in the U.S. health services delivery system reflected in the new guidelines?

**A:** Practice guidelines are intended to facilitate the continued, systematic development of the profession. The health care arena is changing more rapidly than ever before, and psychologists are positioned to assume an ever greater role in advancing health, mental/behavioral health and health care systems. The new APA guidelines are sufficiently broad to cover the full range of activities and settings in which psychologists are practicing currently, and yet also accommodate the many changes in health care, both anticipated and unanticipated, before these guidelines expire in 2021. The focus on both preventive care and integrated care in the Patient Protection and Affordable Care Act of 2010 is reflected in these guidelines, as is the anticipated rapid growth in the use of technology and electronic health records.

**Q:** How do the guidelines support psychologists’ involvement in integrated, team-oriented care?

**A:** Integrated care is built upon the recognition that mental/behavioral health is key to both maintaining physical health and treating medical conditions effectively. The guidelines emphasize that psychologists are not only experts in mental and behavioral health; they also have special expertise in communication, behavior, patient decision making, human interaction and systems that will be useful in the design and operation of integrated care or the health care home. This same expertise will be critical to interprofessional training for the future health workforce.

**Q:** Do these guidelines acknowledge that many practitioners continue to provide diagnostic, assessment and treatment services in traditional settings?

**A:** Psychologists’ expertise in diagnosis, assessment and psychological treatment is the foundation for both the endurance and the evolution of the profession. The guidelines were specifically constructed to include psychologists’ continuing roles in these core services no matter how they interface with health care delivery systems.

For example, some psychologists are employed by a health care organization. Others work primarily in independent...
practice but have privileges at a local hospital or provide contracted services to a health care facility. Many others either need to seek hospital privileges for continuity when one of their patients moves into a health care delivery system or refer patients to hospitals or other facilities for inpatient or intensive outpatient treatment. Therefore, most practicing psychologists can benefit from a deeper understanding of how these systems work.

Q: How can the APA guidelines help interested practitioners explore potential new opportunities for providing professional services?

A: The guidelines can assist psychologists in conceptualizing new roles for themselves in a range of health settings. For example, practitioners with appropriate training can provide services in such diverse areas as health promotion/disease prevention, integrated care, screening for mental health conditions, behavioral medicine, care of patients with chronic medical conditions, rehabilitation and end-of-life care. The guidelines assist psychologists in maintaining a distinct professional identity while working seamlessly in collaboration with other professions. In addition, the guidelines were written in such a way that psychologists can use them to educate other health care providers, administrators in health care delivery systems and the public to understand the unique training and skills of psychologists and how they complement those of other health care professionals.

Q: How do these guidelines encourage psychologists to cultivate leadership roles?

A: The guidelines acknowledge that health care delivery systems can be complex and often highly structured organizations. Therefore, they advise psychologists about issues that are likely to require their advocacy—for example, confidentiality, health records, budgets and clinical privileges. And the guidelines clearly indicate that psychologists’ background and expertise often prepare them to assume leadership roles in programs, departments, committees and administration of health care settings. These roles might include oversight of service delivery and access, quality improvement and risk management, credentialing and privileges, and institutional policies and procedures—pertaining not only to psychology but to the full range of health professions.

On collaboration with other disciplines: [Psychologists’] training and expertise are well-suited for collaboration with other disciplines, such as:

- Enhancing communication with patients
- Observing behavior change in relation to symptom/disease progression, medication and other interventions
- Attending to problems with continuity of care
- Facilitating decision-making
- Problem-solving to maximize adherence to treatment regimens
- Adjusting practices as needed for patients with developmental, behavioral or psychiatric conditions
- Attending to gender, age, culture, spirituality, socioeconomic status and other factors related to health beliefs and behavior
- Attending to life span developmental issues and aging
- Involving family or other support systems in order to maximize treatment outcome
- Ensuring quality-of-life considerations in treatment decision making, including end-of-life care
- Negotiating differences of opinion among patients, families or health care providers

(From Guideline 6)

On psychologists’ wide-ranging roles: In health care delivery systems, psychologists are called to take on wide-ranging roles within their areas of expertise. These include but are not limited to:

- Providing psychological assessment
- Developing and implementing prevention programs
- Consulting
- Leading and participating in multidisciplinary treatment planning
- Conducting psychotherapeutic or counseling intervention
- Taking a leadership role in admission, diagnosis, treatment, consultation order and discharge decision making
- Training and professional development for both psychologists and professionals from other disciplines
- Engaging in scientific research
- Serving in health care delivery system management and administration roles

(From Guideline 9)
The Changing Face of Disaster Mental Health

Field evolves in the ten years after 9/11

Before the tragic events of 9/11, disaster mental health focused mostly on emergency response: gearing up volunteers to deploy quickly to disaster sites. Psychologists talking with survivors over a cup of coffee or handing out meals might have seemed indistinguishable from non-licensed volunteers.

Today, there have been significant advances in disaster training and preparedness, along with greater emphasis on longer-term recovery. The distinct contributions of psychologists and other mental health professionals are clearly recognized, and their efforts are an integral part of disaster services.

The American Psychological Association’s Disaster Response Network (DRN) has partnered with the American Red Cross (see photo below) since 1991 to assist disaster survivors and relief workers. The collaboration has evolved along with the field of disaster response.

Among the fundamental changes in disaster mental health over the past 10 years:

Advancing Psychological Research

Large-scale disasters have enabled researchers to look at human reactions in greater detail than before. Researchers have found that people by and large are resilient and able to bounce back from tragedy (Bonanno et al., 2010). Survivors frequently experience stress in the immediate aftermath of a disaster. But within a few months, they have begun to manage feelings of distress. Many survivors recover on their own or with support from friends and family and minimal or no professional assistance.

Research shows that a small percentage of the population will have a harder time bouncing back, perhaps as a result of greater exposure to trauma or because they have a harder time coping in general (Bonanno et al., 2010). According to the research, when these individuals are offered support and encouraged to actively address their distress, they are more likely to have better outcomes than those who disengage from coping and become more isolated (Silver et al., 2002).

Developing Psychological First Aid and Promoting Resilience

Greater recognition of the importance of resilience and ways people can build their resilience has fostered Psychological First Aid, which involves providing basic care, comfort and support to people who are experiencing disaster-related stress. Basic elements include: being kind, calm and compassionate; actively listening; providing accurate and timely information; giving realistic assurances; and helping people make connections to social supports and resources.

These small but significant forms of assistance can help people manage in the early aftermath of a disaster, and
anyone can offer the assistance. Many organizations including the American Red Cross (ARC) now teach Psychological First Aid to all disaster volunteers. ARC’s Psychological First Aid training, which incorporates several components of APA’s “Road to Resilience” brochure (available online at www.apa.org/helpcenter/road-resilience.aspx), also includes tips for making referrals to disaster mental health professionals for additional assistance.

**Improving Disaster Mental Health Assistance**

The overarching goal of disaster mental health response is to make resources available so that individuals who may be at risk for difficulty with coping can receive support to actively employ their coping skills, connect with social supports and obtain information that facilitates healthy psychological responses.

The past decade has witnessed considerable research related to identifying how mental health professionals can best support disaster survivors. The research has resulted in greater clarity about disaster mental health triage and interventions.

A 2002 consensus report published by the National Institute for Mental Health titled “Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence” included input from leading disaster experts as well as a comprehensive research literature review. This report, supported by later research (Hobfoll et al., 2007), paved the way for current thinking regarding early disaster mental health intervention.

Red Cross training (American Red Cross, 2011) supports triage and behavioral health surveillance using the PsySTART™ risk factors measure. Created by psychologist Merritt (Chip) Schreiber, PhD, this measure facilitates individual triage by identifying those survivors at heightened risk for experiencing post-disaster stress reactions, with the goal of quickly connecting these individuals to disaster mental health services. PsySTART™ can also aggregate data from various disaster mental health volunteers and help depict where the greater numbers of survivors with risk factors are located. This capability in turn enables organizations coordinating relief efforts to allocate volunteers to locations where they are needed most. PsySTART™ has taken some of the guesswork out of identifying survivors who might benefit from disaster mental health support.

**INTERESTED IN DISASTER RESPONSE?**

The APA Disaster Response Network (DRN) consists of licensed psychologists with training in disaster response who offer volunteer assistance to relief workers and survivors in the aftermath of disasters. For more information about the DRN, visit www.apa.org/practice/programs/drn/index.aspx.

Interventions focus on mitigating psychological complications of disaster. The interventions can be psycho-educational in nature and can help survivors experiencing a number of challenges to manage difficult circumstances. They are inherently brief and are not psychotherapy. For example, a family member may be grieving the death of a loved one either prior to or as a result of the disaster. Psychologists and other mental health professionals who are familiar with grief and loss can help people struggling with intense emotions. Disaster mental health interventions can also include referrals to community resources for longer-term care.

**Incorporating Cultural Awareness**

APA’s Disaster Response Network (DRN) regularly includes cultural awareness in its training sessions to better prepare psychologist volunteers to work with diverse populations. For example, the federal government has changed its disaster sheltering procedures so persons with disabilities are being accommodated in general population shelters rather than in separate facilities. Disaster response volunteers are learning how to engage in outreach to individuals with disabilities.

In 2008, APA produced the *Guide to Cultural Awareness for Public Education Campaign and Disaster Response Network Members* as a handy pocket-size reference that responders could take to disaster sites to prepare themselves for working with diverse populations. A PDF version of the guide is available online at http://www.apapracticecentral.org/update/2008/12-17/cultural-awareness.pdf.

**Expanding the Focus Beyond Short-Term Response**

Psychologists often engage in long-term community outreach throughout the post-disaster recovery period.
After John Weaver, PsyD, of Waukesha, WI, earned his doctorate from the Wisconsin School of Professional Psychology, his plan was simply to open a private psychology practice. But within three years of setting up practice at the Stress Management and Mental Health Clinics, Weaver was also providing consultation to businesses. He positioned himself for the new venture by joining three colleagues to create an email newsletter for the business community about psychology. Over the next four years, the group built up a list of about 700 subscribers.

Today Weaver no longer writes for the newsletter, but he continues business consulting through his company, Psychology for Business, which provides clinical services through a private practice and works in the wellness field through his Healthy Thinking Initiative. “I’m hired by businesses as part of their health and wellness training,” Weaver says. “The Healthy Thinking Initiative comes in to teach mindfulness, optimism and resilience.” (See sidebar at right for more on this work.)

Weaver also speaks and develops training manuals on the issues he promotes. This way, he says, businesses can benefit from his expertise without his needing to be present. “It creates extra revenue and extends the work that I do to more people,” Weaver says.

A wide-open field

In the last few years, more and more of his work has been in the burgeoning field of health promotion and wellness, or as Weaver calls it, “how to help people achieve psychological wealth. From a psychological point of view, health and wellness is a wide-open field,” he says.

Weaver found his way to the wellness community in 2005. Attending a Society of Human Resources Management meeting in an effort to learn more about the business community, he sat in on a session called “Presenting Lifestyle Programs to Executives.” The speaker offered statistics on the high cost of depression to business, but didn’t delve deeper. Weaver spoke up, asking why he didn’t detail solutions. “The speaker said, ‘That’s because nobody knows how to do it.’ And I thought, ‘That’s something I could figure out.’”

The National Wellness Conference takes place in Weaver’s state of Wisconsin every year, and when he became interested in the issue of depression in the workplace he decided to submit a workshop proposal. “On the Prevention of Depression: The Missing Piece of Wellness” was accepted for presentation during the 2006 conference. He later converted it into a book of the same name, published in 2009.

His was the only offering on psychological wellness, and the

CULTIVATING WELLNESS

As director of the Healthy Thinking Initiative (www.preventingdepression.com), John Weaver, PsyD, focuses on helping employees cultivate three primary skills for achieving and maintaining psychological wellness.

The first is mindfulness. “Psychological research demonstrates that those who are mindful have a great deal of resistance to depression, make better choices in life, resist anxiety and make better decisions,” says Weaver.

The second is optimism. Weaver calls optimism attributing the good outcomes in one’s life to personal effort. “Optimism is one of those critical skills that can help people see what’s going right and how you can apply it in life,” he says.

Finally, he works with clients to develop resilience. “When you learn resilience you develop what I call the Vitamin Cs of Emotional Health: You act on your commitments, you accept and work on challenges in your life and you know what is in your control.”
large room he was given was filled to capacity. “I got a lot of positive responses and the leader of the institute stopped me to say, ‘I’m so glad you came. We need more of this here.’ From that point on, I’ve been presenting every year.”

Weaver is scheduled to present at 20 conferences this year, and he encourages his colleagues to explore the field. “The wellness community is hungering for good involvement from psychology,” he says. “The community knows that psychologists have a great deal to offer—people ask me why more aren’t involved.”

**Joining the wellness community**

For those looking to get a foot in the door of the field, Weaver recommends attending wellness conferences. *(For more resources on networking with the health and wellness community, see the sidebar at right.)*

Weaver says it’s a good idea to go and take some time and listen to what questions are coming up. “Attending just to listen gives psychologists a real opportunity to sit back and think about what it is they know something about and look at how they can begin to contribute,” Weaver observes. “You don’t have to know everything, but we have a discipline, a way of thinking about things that really helps to clarify these questions.”

Next, take the time to create your own presentation proposal. Weaver says that’s the hardest step, but “it’s critical for psychologists in the workplace and health and wellness field. Our contributions have to be oriented toward helping people live a higher quality of life.”

Weaver took the time to sit down and write out his work in an easily explained format. “I spent hundreds of unpaid hours in order to be paid really well,” he says.

The wellness community is a small one, according to Weaver, and he found that once psychologists are part of the community others will approach them for their expertise. “Many are looking for psychologists to help them with dimensions of their programs. They may have the exercise and nutritional [components], but they are looking for assistance with social relationships, resilience and emotional health.”

Rather than developing comprehensive wellness programs, Weaver builds on programs that already exist. “That way I can work with well-developed programs and add in the psychology expertise,” Weaver says. “We can collaborate.”

It was at a wellness conference three years ago that Weaver connected with SC Johnson, Inc., opening up yet another revenue path. A representative of new product development at the company approached Weaver for assistance developing a product line for women. “It’s meant to support practices that help [women] live healthy and balanced lives,” Weaver says. The line’s website includes short meditations and forums on living a balanced life.

“Many people have learned how much we have to offer and are seeking out the advice and expertise of psychologists who are tuned in [to health and wellness],” Weaver says. “There’s great potential for psychologists to have a huge impact on the well-being of our nation and the world.”

---

**RESOURCES FOR PSYCHOLOGISTS**

Resources for psychologists interested in entering the health and wellness field:

**Conferences**
- Weaver and the head of APA’s Psychologically Healthy Workplace Program, David Ballard, PsyD, MBA, will be presenting at the [Art and Science of Health Promotion Conference](http://healthpromotionconference.com) April 11-15, 2012 in San Diego, CA. Proposals are due by July 1, 2012.

**Social Media**

The scores of wellness groups on LinkedIn include the Psychologically Healthy Workplace Network, CoHealth Workplace Wellness Community and Workplace Experience. Weaver advises searching “wellness” or “health promotion” on Twitter, and following people so they follow you back. Weaver is on Twitter at @bizpsych. The Psychologically Healthy Workplace Program is @PHWP_online.

**Go Local**

Weaver notes that local organic food stores, health clubs and local human resources associations tend to have activities and resources to connect people to local wellness groups. In addition, local hospitals and outpatient healthcare facilities are increasingly offering wellness programming.
discounted rate—for example, the rate originally stated was higher and you never received the contractually required notice that the rate would be changed.

• The Original Contract applies only to patients referred to you under that contract (by Looks Promising or Discount Network); the contract does not state that it will apply if the network is made available to other companies.

5

STEP 5 (optional)—Give notice to terminate the Discount Contract

You may wish to terminate the Original Contract without conceding its validity. The point of not conceding the validity of the Original Contract is to keep either company from arguing that your request to terminate the Original Contract is a tacit admission that it exists and/or is valid. Termination is not recommended if you are receiving referrals directly from Discount Network and the value of those referrals is greater than the amount of money you are losing by having referrals from Big Insurer discounted.

The benefit of termination is that it should bring a clear end to the discount. Big Insurer and Discount Network may dispute your arguments about the validity of the discount or the Original Contract. They may make arguments about how the contract terms should be interpreted. But the companies have no legitimate argument for continuing to discount your rate after you have properly terminated the Original Contract.

Follow these steps if you decide to terminate the Original Contract:

• Give Discount Network written notice with the specified time period in the Original Contract. For example, you could use language like this:
  – “This email/letter will serve as my 90-day notice of termination as specified in the contract. However, I do not concede that this is a valid contract for the reasons stated above.”

• If you do not have a copy of the Original Contract, say that you are terminating at the earliest possible date permissible under the contract.

• Send your termination notice by e-mail or certified mail so the company cannot delay termination by claiming it never received your notice.

• Send a copy of your termination notice to Big Insurer.

6

STEP 6—Getting Help

If you are having trouble deciphering the key terms in your contracts or resolving the dispute with the insurer and/or the discount network, contact the APA Practice office of legal and regulatory affairs at praclegal@apa.org or 202-336-5886.

You may also wish to retain a lawyer in your state who is knowledgeable about contract law, and ideally about provider or health care contracts. Such a lawyer would be able to cite cases from your state on the relevant contract law issues. A letter from a private lawyer is a signal to the company that you mean business and are prepared to take legal action if necessary.

Please note: Legal issues are complex and require expertise that cannot be provided by any single article. The information in this article should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.

This content is adapted from an article in the August 2, 2011, issue of the APA Practice Organization’s PracticeUpdate e-newsletter.
Practice Central provides information and resources for practicing psychologists in a variety of settings, at all stages of their career.

- Information to help build, manage, market and diversify your psychology practice
- Guidance and updates on legislative and legal issues for practitioners
- How to use billing codes and other practical pointers on reimbursement
- Continuing Education (CE) courses and other professional development resources
- And much more

New resources are being added regularly, so please visit often!

apapracticecentral.org
to share psycho-educational information about how individuals affected by disaster can take proactive steps to fortify and rebuild their lives as needed. For example, North Dakota DRN psychologists involved with the Red River Resilience Project have helped survivors of multiple floods over the years to restore and maintain hope. And psychologists who are active in the River of Hope Project continue to work with New Orleans communities and families to rebuild in the aftermath of Hurricane Katrina in 2005.

Managing Volunteer Expectations

Psychologists are better informed than ever before about what they can expect as disaster responders, and they learn ways to take care of their own stress reactions. Training is intent on deglamorizing disaster relief work by emphasizing hardship living conditions, long workdays often spent on foot and no guarantees that the volunteer will even see the disaster site. Volunteers are assigned where needed, which might mean teaching Psychological First Aid in the basement of staff headquarters nowhere near the destruction. Shaping realistic expectations about disaster service work can go a long way toward helping volunteers succeed. The Red Cross national headquarters training also encourages volunteers to think about self-care. Trainees are encouraged to prioritize their work and set limits, with the goal of promoting mind/body health.

In recognition of the 10th anniversary of 9/11, this article from the Disaster Response Network (DRN) reflects APA’s collaboration with the American Red Cross.

---

REFERENCES AND RESOURCES


American Red Cross. (2011). Foundations of disaster mental health training. Washington, DC: Author. To learn more about Red Cross training, contact your local Red Cross chapter (www.redcross.org) or email APA’s DRN program: drn@apa.org.


---

Help consumers find you.

The Psychologist Locator
A benefit of your Practice Assessment
Create or update your listing at apapracticecentral.org
This summary features advocacy activities by the American Psychological Association Practice Organization (the APA Practice Organization, or APAPO) to advance and protect the professional interests of practicing psychologists. **APAPO initiatives are made possible by Practice Assessment payments from members** that provide vital resources for sustaining the organization’s advocacy work.

The APA Practice Organization Committee for the Advancement of Professional Practice (CAPP) and APAPO collaborate closely with state, provincial and territorial psychological associations (SPTAs). The national organization provides financial, consultative and other support for numerous advocacy efforts at the state level.

**CAPP grants totaling nearly $5.8 million** have been given to SPTAs for legislative initiatives, organizational development and additional uses since APAPO began in 2001. These grants are funded by Practice Assessment payments from APA Practice Organization members.

Additional examples of putting Practice Assessment monies to productive use thus far in 2011 include:

- **Affirming the doctoral standard for independent psychology practice.** CAPP awarded the Texas Psychological Association (TPA) an emergency grant of $10,000 and APAPO collaborated with TPA on legal issues and strategy as the state psychological association joined a legal battle to protect the doctoral standard for independent psychology practice. This initiative culminated in an August 2011 affirmation by the Austin District Court that the Texas State Board of Examiners of Psychologists had statutory authority to require that “psychological associates” trained at the masters level be supervised by licensed psychologists trained at the doctoral level.

- **Challenging rate cuts by health insurers.** APAPO worked with the Florida Psychological Association (FPA) in August 2011 to prepare a letter to the Florida Office of Insurance Regulation (FLOIR) immediately after FPA learned that Blue Cross Blue Shield of Florida (BCBS FL) and its new behavioral health subcontractor were planning a 30- to 60-percent reduction in psychologists’ reimbursement rates. The reductions were part of a new provider contract that psychologists seemingly were asked to sign within 15 days. FLOIR responded to the letter within one week, assuring FPA that psychologists will have more time to decide about the new provider contract and that the state regulatory agency is working with the health insurers to correct certain problematic language in the contract. APAPO and FPA will continue to address the crucial issues raised with FLOIR regarding the adequacy of reimbursement rates and the impact on patient access to mental health services. Unfortunately, the problem has spread quickly beyond Florida. APAPO is collaborating with the Kansas and Michigan Psychological Associations and is poised to work with additional SPTAs as similar issues arise in other states.

- **Supporting litigation against abusive managed care practices.** In July 2011, APAPO collaborated with the New Jersey Psychological Association (NJPA) and its outside counsel on re-filing a lawsuit by NJPA and two patients against Horizon BCBS and Magellan. The lawsuit alleges that the companies violated state privacy law and the HIPAA Privacy Rule in managing mental health care for the state employee plan. An emergency CAPP grant was provided to support this litigation.

- **Advocating for professional psychology as the Affordable Care Act is implemented.** This advocacy includes providing comments in support of the Medicare Decisions Accountability Act of 2011 (H.R. 452), a bill to repeal the Medicare Independent Payment Advisory Board (IPAB). In a June 2011 comment letter, APAPO supported repealing the board, which would be tasked with making Medicare cost-cutting recommendations beginning in 2014. (See article on page 2.)

- **Challenging mental health care authorization requirements that may violate the federal health insurance parity law.** In May 2011, Blue Cross Blue Shield of Illinois (BCBS-IL) reiterated to the Illinois Psychological Association (IPA) that it will not try to re-institute authorization requirements governing outpatient therapy that had been slated to take effect in January. APAPO has worked closely with IPA since 2010 to challenge authorization requirements newly
proposed by the company. APAPO helped IPA prepare a letter to BCBS-IL objecting to implementation. Late in December 2010, BCBS-IL made its initial announcement that the company was withdrawing the authorization requirements.

• **Confronting AMA assaults on non-physician scope of practice.** In May 2011, Dr. Katherine C. Nordal and other selected representatives of the Coalition for Patients’ Rights (CPR) met with the American Medical Association (AMA) chief executive officer, president of the AMA Board of Trustees and the association’s general counsel staff. CPR consists of more than 35 organizations, including APAPO, representing a variety of licensed non-physician health care professionals. The meeting focused on advocacy packets disseminated by AMA that erroneously outlined the education, training and credentials of various non-physician disciplines, including psychology. The packets were made available in states where organized medicine opposes attempts by non-physician organizations to broaden their scope of practice. CPR members provided numerous examples of inaccuracies in the modules and requested that AMA withdraw them. The high-level AMA representatives indicated that the modules would be considered for revisions.

• **Convening the 28th annual State Leadership Conference.** In March 2011, the annual APAPO State Leadership Conference attracted nearly 500 psychology leaders to Washington, DC, to participate in workshops, symposia and networking opportunities. On the final day of the conference, attendees met with more than 300 members of Congress and staff to address advocacy issues of importance to practicing psychologists and consumers of psychological services.

• **Gaining introduction of federal legislation to include psychologists in the Medicare definition of “physician.”** In late February and early March 2011, key allies of professional psychology in the Senate and House introduced legislation to include psychologists in the Medicare definition of “physician.” This is an important step toward ensuring that psychologists are able to provide Medicare mental health services free of unnecessary physician supervision requirements that hinder patient access. Visits to congressional offices by APAPO Practice Organization 2011 State Leadership Conference attendees, and subsequent grassroots emails and calls, resulted in several dozen cosponsors being added to the bills.

• **Achieving restoration payments for Medicare psychotherapy services.** In February 2011, following months of delays, the Centers for Medicare and Medicaid Services (CMS) announced that psychologists would soon begin to receive retroactive restoration payments for Medicare psychotherapy services provided between January 1 and July 1, 2010. The restoration payments were one aspect of many Medicare payment changes included in the Affordable Care Act (ACA) of March 2010. The ACA provision followed the December 31, 2009 expiration of an earlier five percent payment restoration for psychotherapy services. The APA Practice Organization successfully advocated for reinstatement of the psychotherapy monies for all of 2010, retroactive to January. A later law extended the additional five percent Medicare psychotherapy payments through 2011.

• **Advocating for psychologists’ eligibility for electronic health records incentive payments.** The APA Practice Organization gained bipartisan support for House and Senate legislation that would extend eligibility for electronic health record incentive payments to mental, behavioral and substance use health professionals. As federal rules to implement the Health Information Technology for Economic and Clinical Health (HITECH) Act take effect, the APAPO is advocating for full inclusion of psychologists under the law’s incentive programs. Sen. Sheldon Whitehouse (D-RI) introduced legislation on March 10, 2011 to allow mental health practitioners and facilities to seek reimbursement for purchasing electronic health record-keeping systems (EHRs). Introduction of a companion bill by Rep. Tim Murphy (R-PA) was pending as of September 2011.

“For less than $12 a month, a psychologist who pays the APAPO Practice Assessment can rest assured that a team of highly skilled professionals is working every day to advocate for the profession’s interests and address threats and obstacles to psychology practice.”

– Katherine C. Nordal, PhD, Executive Director, APA Practice Organization
In this issue—

• Health Care Reform Advocacy Update
• Integrating Care at VA
• Dealing with Discount Networks
• New Practice Guidelines on Health Care Delivery Systems
• Disaster Mental Health 10 Years after 9/11
• Doing Well with Wellness
• Putting Your Practice Assessment to Work