Compliance Issues Arise with Mental Health Parity Implementation

Is That Insurance Company Avoiding the Parity Law?

Leading Psychology into the Telehealth World

Reimbursement for Telehealth Services

Cultivating a Role in Parenting Coordination

Bringing Psychology to the Community

Is Your Practice Client-Friendly?

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Good Practice is the recipient of a Platinum Award, the highest honor, from the Association of Marketing and Communications Professionals.
According to Ron Bachman, president and chief executive officer of Healthcare Visions, Inc., legislation has a four-step life cycle.

In the first phase, legislation gets passed. In the second, regulations fill in the details of how the new law will actually be put into practice. In the third, those covered under the law either comply — or don’t. And in the final stage, the courts settle any disputes about what the law’s language means.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, which requires private health insurance to cover mental and physical health services equally, is in the compliance phase. Most of the covered plans had to start complying with the law on January 1 this year. Are they?

For most employers, says Bachman, the answer is yes. But while the vast majority of employers have implemented parity without a hitch, some have reacted to the law by creating aggressive ways to manage mental health and substance abuse benefits.

The law’s impact

Passed in 2008, the law requires group health plans covering 51 or more employees to ensure that financial and treatment limits for mental health and substance use benefits be no more restrictive than those applied to medical and surgical benefits. In 2010, the government issued a rule giving detailed instructions about how to implement the law. (See “Implementation of the Federal Parity Law” in the Winter 2011 issue of Good Practice.)

“Regulators went a bit further than the law’s statutory requirements,” says Doug Walter, JD, counsel for legislative compliance issues.

Early reports suggest the need for vigilance even as many health plans seem to comply.
and regulatory affairs at the American Psychological Association’s (APA) Practice Directorate. In addition to requiring parity in such quantitative areas as deductibles, annual and lifetime dollar limits and the number of sessions allowed per year, the regulations also require parity in nonquantitative areas. These include differences in medical management and provider network participation.

How have employers and insurers reacted? Despite fears that the law would prompt employers to ditch mental health coverage, says Bachman, just 1.6 percent of affected employers have done so.

And while “they grumbled the whole time they were doing it,” he says, most have made changes, improved benefits and implemented the law without problems. For some, parity has meant bringing “carved out” behavioral health benefits back in-house to facilitate common deductibles and cost-sharing. As for costs, says Bachman, the impact was minimal. As one insurer told him, “It wasn’t even a blip on our radar screen.”

Assessing compliance

Nonetheless, there are some companies that aren’t complying with the law. Alan Nessman, JD, senior special counsel for legal and regulatory affairs for the Practice Directorate, fields calls from psychologists concerned that their clients’ employers or insurers are violating the law.

“The main thing we hear are questions about management of the benefit,” says Nessman. “What we’ve seen is that once the parity law took away companies’ ability to limit care to, say, 20 sessions a year, some companies appeared to panic.”

But not everything that seems to be a violation actually is, warns Nessman. He guides APA Practice Organization members to a checklist of questions to help psychologists determine whether a company is complying with the law as it relates to mental health benefits management. (See companion article on page 4.)

For one thing, some plans are not subject to the parity law. For plans that are covered, even though you might think a company’s management of mental health benefits is intrusive, it has to be more intrusive than management of medical benefits to qualify as a violation.

That can be tricky, says Nessman. “One problem is that we’re so used to dealing with the mental health side, we often don’t know what’s happening on the medical side,” he says. And it can be hard to compare restrictions — such as having to get reauthorization after 10 sessions — because of differences in the way people use care. “Most people don’t see their primary care provider 10 times per year or get surgery that often,” Nessman points out.

For quantitative limitations, the regulations say that any limit on behavioral health benefits needs to also apply to “substantially all” — generally defined as two-thirds — of medical and surgical benefits. In nonquantitative areas, limitations must be “comparable,” a standard Nessman hopes will eventually be clarified as enforcement agencies and courts take on questionable insurance company practices.

You also need to determine whether a practice represents a barrier to treatment. “Many people will call and say, ‘This is a real nuisance,’” says Nessman. “That’s unfortunate, but the real point of parity is, ‘Is this creating a barrier to patients accessing mental health care?’”

This article is based on a session called Parity in Practice: Health Plan Compliance with the Mental Health Parity Law and Challenges Ahead at the APA Practice Organization’s 2011 State Leadership Conference.

The checklist of questions in the companion article on page 4 can assist you in determining whether a company may be avoiding the requirements of the federal parity law as related to mental health benefits management. Of course, you don’t have to figure out the answers on your own. If you have questions or think you’ve uncovered a potential violation, contact the APA Practice Directorate’s Legal and Regulatory Affairs Department at 202-336-5886 or praclegal@apa.org.

“You can begin the vetting process,” says Alan Nessman, JD, the directorate’s senior special counsel for legal and regulatory affairs. “You are our eyes and ears on compliance.”
Is That Insurance Company Avoiding the Parity Law?

Asking these questions can help you assess whether an insurance company may be involved with questionable practices related to mental health benefits management.

Effective January 1, 2011, federal regulations governing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act took effect for most health plans covered under the law. Some psychologists are wondering whether some health insurance companies covering their patients are engaging in certain practices that run afoul of the new rules.

As part of a 2011 APA Practice Organization State Leadership Conference workshop panel on parity law implementation, Alan Nessman, JD, senior special counsel for legal and regulatory affairs, outlined several questions psychologists should ask in assessing whether an insurance company may be involved in questionable mental health benefit management practices — such as authorization requirements and telephone reviews — in light of the federal parity law. The list includes the following questions:

Is the health plan subject to the parity law?

A plan is not required to comply with the law if it covers 50 or fewer employees. While it is not common, plans that cover state government employees are able to opt out of the federal law. It’s also important to consider whether someone other than an employer is providing the coverage. For example, student health insurance provided by a university is not subject to the law, nor is individual coverage that a consumer obtains directly from an insurer.

Is the company applying more restrictive or intrusive practices to managing mental health benefits than it applies to managing medical benefits?

For example, does the company impose authorization requirements on outpatient mental health that it does not impose on outpatient visits to physicians? Is the company conducting telephone reviews that seek considerable sensitive personal information related to mental health services that appears to be more intrusive than information the company seeks related to medical services? Such practices may be questionable.

Some important considerations:

- Compare services provided in the same setting — outpatient medical services and outpatient mental health services. For example, if you’re considering treatment limits placed on outpatient psychotherapy services, you shouldn’t compare them to limits placed on inpatient medical services.

- When focusing on an insurance company’s management of multiple sessions of psychotherapy (for example, re-authorization after 10 sessions), compare those practices to medical services such as physical therapy that similarly involve multiple sessions.
• Psychologists tend to be less aware of how a company manages medical benefits compared to mental health benefits. To fill the information void, psychologists can draw on their own experiences with obtaining medical benefits from the company, check with physicians or other medical professionals who work with the company, and talk with colleagues in practices that integrate medical and mental health services delivery.

• The determination of whether services are considered the mental health or medical side of insurance coverage is based on the diagnosis, not the profession. For example, neuropsychological assessment of stroke or brain injury patients is considered medical. So are health psychology services to help diabetes patients with medication and diet compliance, as well as assessment of patient suitability for bariatric surgery.

Is there ‘comparable’ treatment of medical and mental health services benefits management?

The federal parity law requires “non-quantitative treatment limitations” (NQTL) such as treatment authorization requirements to be managed in a “comparable” manner for mental health and medical services. Unfortunately, the parity rule does not clearly define what constitutes “comparability” and companies are interpreting the rule differently.

Insurance companies may defend their NQTL practices by asserting simply that they are comparable. In this event, you should be prepared to ask the company pointed questions related to its claim of comparability. See the following sections for additional details.

Does the policy create a barrier to patient access?

Perhaps the most crucial question is whether a mental health management practice that appears disparate creates a barrier to patients obtaining mental health care. The parity law is intended to eliminate such barriers.

For example, does an authorization requirement impedes patient access to care because patients or their psychologists have to spend hours on the phone trying to get authorization? Do telephone reviews intrude so much on the patient’s privacy that patients forego treatment or pay out-of-pocket rather than sharing sensitive personal information with a company reviewer?

Such considerations should grab the attention of the government agencies enforcing the parity law and help counter companies’ justifications for disparate management.

Another example: An insurance company requirement that a provider must obtain reauthorization every few sessions may be challenged on the grounds of creating barriers to patient care. The uncertainty created by this practice may prevent you from being able to establish a long-term treatment strategy. Further, the uncertainty may make it difficult for the patient to fully engage in the therapeutic process if he or she is concerned that the process is about to end.

What is the company’s explanation for any disparities in coverage practices?

We recommend that you ask the company to explain in writing how the seemingly questionable practice complies with the parity law. As noted previously, companies have expressed divergent views on what it means to have “comparable” practices. It is important to know what interpretation of “comparability” the company is using.

If the company’s answer is insufficient, ask for more information or clarification. For example, if the company claims that it is applying similar utilization management to a number of medical services, ask the company representative to specify what management techniques are being applied to what services.

For further information and to report or discuss specific company practices, contact the APA Practice Directorate’s Legal and Regulatory Affairs department at praclegal@apa.org or 202-336-5886.

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.
Leading Psychology into the Telehealth World

Clinical applications offer a glimpse of the future.

Imagine you could give your clients a cellphone application that would help keep them engaged in treatment between sessions. Constantly collecting data via a GPS, Bluetooth, accelerometer, and the many sensors available in modern smart phones, the phone could learn to interpret the client’s state, including how they’re feeling, and whether they are adhering to their homework assignments. The phone would soon get to know your clients almost as well as you do.

If you’ve recommended that a client avoid depression by getting together with friends, the phone could ping that person and urge her to call a friend if it senses she’s sitting at home alone on Saturday night. Or if you’re working with a patient who’s having trouble complying with a complex medical regimen, the phone could ping him with a reminder when it’s time to take medication.

Sound far-fetched? Psychologist David C. Mohr, PhD, a professor of preventive medicine at Northwestern University’s Feinberg School of Medicine, has already developed a prototype. And while the device is cutting-edge technology that won’t be commercially available for a long time, psychologists are already using phones, the Internet and other means to check in with clients, provide consultations and second opinions and even conduct therapeutic interventions with patients who aren’t right there in front of them.

“Technology gives us entirely new ways to interact with people in the environments where they live,” says Dr. Mohr.

Clinical applications

Vanessa K. Jensen, PsyD, a pediatric psychologist at the Cleveland Clinic Children’s Hospital, is one psychologist who is taking advantage of telehealth in her practice, including using electronic communications in her forensic work as well as to extend clinical/patient care.

In her clinical work, Dr. Jensen uses the phone and video to stay connected with patients and their families, and to communicate with other involved professionals even when they can’t meet.

For example, through the Cleveland Clinic, Dr. Jensen has arranged contracts with several patients to provide consultation regarding a child’s progress and programming via periodic review of school materials, progress reports and video/DVD clips of the child performing a specific task or in various situations at home or school. The audio-visual information is invaluable for helping Dr. Jensen better understand the child’s problematic behaviors and then provide specific recommendations to those working with the child on a day-to-day basis. With distances as great as several hundred miles separating them within the state, it would have been time-consuming and expensive for Dr. Jensen to observe the child’s behavior in person.

Dr. Jensen provides such telehealth services on a fee-for-service basis, asking clients (in this case, typically parents) to sign a consultation agreement with the hospital and billing them by the hour. She does the same when providing telehealth services in her forensic work, where she reviews records, videos and other materials and then uses videoconferencing, Skype or other telehealth methods to share her opinions with attorneys.

Now Dr. Jensen is poised to start providing telehealth consultation services to individuals who aren’t already her patients or forensic clients, via Cleveland Clinic’s online service, “MyConsult.”
Designed to provide second opinions on more than a thousand life-threatening or life-altering conditions, MyConsult has been providing “second-opinion” consultations for a wide array of physical disorders (for example, heart disease, cancer and gastrointestinal disease) and is now establishing consultations for certain behavioral health diagnoses and treatment plans on a pilot basis.

The process will begin when an individual logs in, pays the fee, fills out questionnaires and submits videos, test results or any other relevant materials. A nurse or other coordinator organizes all of the data and schedules time for the clinician to review the materials for the formal “consultation.” The clinician then uses voice-activated dictation to work through a template to produce a written report that concurs with the previous diagnosis or provides alternative recommendations.

“I might agree with the previous diagnosis if it makes sense given the available data and say that basically, the outlined treatment plan looks good,” says Dr. Jensen. “I might say I agree with the autism diagnosis, but also see possible schizophrenia or other co-morbid diagnoses and suggest further assessment or alternate treatment possibilities. Or I may question the overall diagnosis and recommend another course of action entirely.” All direct interaction with the patient is through MyConsult’s team of nurses, not the individual practitioners.

“The person doesn’t ever become your patient,” says Dr. Jensen, who is working on the specific background questionnaires and required data set for the autism module. “As a professional, you are not making a diagnosis; you are instead reviewing someone else’s work and providing an expert opinion about next steps, typically in a very specialized area where there are limited resources across the country.”

**What the research says**

Other psychologists are going even farther and administering psychotherapy by videoconference or the Internet. But how well do such “telemental health” interventions work? According to Mohr, the research has found that such strategies are effective, safe and acceptable to both patients and practitioners.

Take telephone-administered therapy, for instance. Dr. Mohr’s 15 years of research on this approach has found that it has good, strong effects, and may increase access and reduce dropout.

Other researchers have examined videoconferencing, which large systems like the Veterans Health Administration use to provide services across large geographic areas. That research has demonstrated that videoconferencing is just as effective as face-to-face therapy, says Dr. Mohr, adding that there may be specific situations where videoconferencing is particularly useful as compared to the telephone. “With the treatment of hoarders, for example, it would be useful to see the environment,” he points out.

There has also been one large clinical trial using secure instant messaging to provide cognitive behavioral therapy, with significantly better results than those achieved by general practitioners treating depression.

“This research shows that effective therapy can be delivered by a variety of media,” says Dr. Mohr. Plus, in a meta-analysis, he and his colleagues found that attrition rates for telephone-administered therapy were just 7.4 percent compared to the 30 percent or more often experienced in clinical trials. “When you call people up,” says Dr. Mohr, “they tend to answer the phone.”

In a trial Dr. Mohr is just finishing, he found that while 37 percent of patients preferred to receive cognitive-behavioral therapy face to face, 27 percent preferred the telephone and 36 percent had no preference. Practitioners often find phone therapy acceptable, too, despite some concerns about whether psychotherapy loses something when you’re not able to see the patient. “We haven’t found any evidence of poorer therapeutic alliance,” says Dr. Mohr.

Internet-based interventions are another effective option. These interventions typically include the provision of standardized instructional information and interactive tools to support therapy homework. While provision of a website

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**MORE ON TELEHEALTH**

Psychologists interested in telehealth service delivery must be aware of legal and regulatory issues such as the types of services that constitute “telehealth” in a particular state and providing services across state lines. For additional information, see “Telehealth: Legal Basics for Psychologists” in the Summer 2010 issue of *Good Practice* magazine from the APA Practice Organization.
Reimbursement for Telehealth Services

Here’s how Medicare, Medicaid and private payers now handle payment.

Under Medicare, telemedicine reimbursement is on par with reimbursement for the same service when provided face-to-face.

Yet a number of limitations apply, including:

- Technology is limited to real-time, interactive audio-video telecommunications, not “store-and-forward” technology such as email (other than federal demonstration projects in Alaska and Hawaii).
- Eligibility for reimbursement is limited to services provided to a Medicare beneficiary located at an eligible site in specified geographic areas – either a “rural health professional shortage area” or a county outside a Metropolitan Statistical Area.
- CMS limits the sites where a Medicare beneficiary may be located when receiving telehealth services. Eligible sites include a provider’s office, hospitals, skilled nursing facilities, rural health clinics and federally qualified health clinics. Additional information is available online at the Medicare Learning Network® (cms.gov/MLNMattersArticles) and the CMS telehealth fact sheet (bit.ly/CMSfactsheet).
- CMS requires that claims submitted for telehealth reimbursement use the GT modifier along with the appropriate billing code.

Medicaid

CMS has not formally defined telemedicine for the Medicaid program. Because the federal government does not mandate reimbursement for telehealth under Medicaid, states have the option to reimburse for Medicaid services furnished through telehealth.

It’s up to each state to specify what telemedicine/telehealth services, if any, are eligible for Medicaid reimbursement.
For states that do offer telehealth reimbursement under Medicaid, relevant issues affecting reimbursement include:

- Does psychotherapy fall under the state’s Medicaid covered services (or is it an optional service)?
- Are psychologists included in the state’s Medicaid list of qualifying providers?
- Are there specific requirements that providers must follow when submitting claims for services furnished using telehealth?

As many as 35 states allow for at least some reimbursement for telehealth services. Medicaid reimbursement for telehealth services by psychologists is available in 13 states: Alaska, Arizona, California, Colorado, Hawaii, Kansas, Maine, Michigan, Nebraska, North Carolina, Oklahoma, Utah and Virginia. Coverage and billing requirements vary by state.

Private payers

To date, 12 states have enacted legislation requiring private sector insurance companies to pay for telehealth services. The states are: California, Colorado, Georgia, Hawaii, Kentucky, Louisiana, Maine, New Hampshire, Oklahoma, Oregon, Texas and Virginia.

While all of these states mandate coverage, not all require reimbursement rates on par with rates for face-to-face services.

A 2007 Michigan State University survey indicated that 130 private payers were reimbursing for telehealth services. Based on survey results, Blue Cross/Blue Shield has been identified as a leading payer for these services. While private payer reimbursement varies by insurer and state, there is a growing trend toward reimbursement for telehealth services, especially among the larger health care insurance companies.

Important Caution: Check with any applicable payers to find out their reimbursement policies before providing and billing for telehealth services. For example, a payer may cover “telemedicine” services that do not include the psychological services you may be interested in delivering via telehealth.

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The process of parenting coordination is designed to help parents or guardians involved in high-conflict custody disputes implement and comply with parenting plans, make timely decisions consistent with children’s developmental and psychological needs, and reduce the amount of damaging conflict between caretaking adults to which children are exposed.

The American Psychological Association (APA) Practice Directorate has been involved for the past several years with developing parenting coordination as an emerging practice area for psychologists. The association appointed a task force in 2008 to draft parenting coordination guidelines. APA’s Council of Representatives approved the proposed guidelines as policy in February 2011.

Good Practice interviewed Helen T. Brantley, PhD, chair of the guidelines development task force, about the content and uses of the guidelines and how psychologists can prepare themselves to practice as parenting coordinators. See the sidebar on the following page for information on where to find the guidelines online.

How is parenting coordination different from other interventions such as couples counseling?

Parenting Coordination is a non-adversarial dispute resolution process for high-conflict divorcing parents or guardians which is either ordered by the court or agreed upon by parents. It is a complex, hybrid role. A parenting coordinator’s (PC) work includes: helping parents comply with court orders, reducing conflict between parents, providing parent education and protecting the best interest of the child.

In many states, if mediation through the parenting coordination process does not work, decision-making by the PC is permitted. The process generally is not confidential.

Parenting coordination is distinct from couples counseling, family therapy, or therapy either for the parents or children. Therapy, formal evaluations and diagnoses are specifically excluded from the practice of parenting coordination.

Why is parenting coordination often preferable to judicial interventions?

The process of parenting coordination provides an alternative forum for parents to resolve differences other than in an adversarial legal setting. It continues for a specified period of time, thereby enabling the PC to reassess needs of the children and parents under changing circumstances. The PC can make decisions in the best interests of the child in a timely way so the parents and child need not wait for the frequent delays characteristic of court hearings.

PCs are trained in child development, family dynamics, domestic violence and conflict resolution, as well as relevant legal terminology and procedures. By contrast, some judges are not well trained in understanding children’s needs, which may result in less advantageous decisions for the children.

Many problems brought to the PC require relatively immediate resolution or are minor adjustments to the custody order, for example, regarding place or time of transition between parents. These decisions may take inordinate time in the court’s schedule, and PC intervention allows the court to be used more efficiently.

Why should practicing psychologists consider providing PC services?

Practicing psychologists are especially qualified to provide PC services by virtue of their knowledge of child development, separation and divorce research, and human interaction. Psychologists generally value non-adversarial resolution to conflict. Many psychologists are adept at negotiating difficult situations with families and understand the problems of working with individuals who have personality and mental disorders. In addition, some psychologists have found it helpful for expanding their practice to incorporate parenting coordination.
How are the new guidelines useful for a practitioner who works with children and high-conflict divorcing families regardless of the clinician’s interest in practicing as a PC?

Even if choosing not to provide PC services, practitioners will learn from the guidelines what kinds of services the PC may supply in their cases involving children and high-conflict parents. Additionally, they will learn how and when to recommend clients for PC services. For example, cases involving intimate partner violence and child abuse may not be appropriate for PC intervention.

As reflected in the new guidelines, what breadth of training and specialized knowledge is appropriate for practice as a parenting coordinator?

PCs require specialized knowledge to understand the limits and complexity of the PC role, to analyze disputes, and to mediate and arbitrate issues between the parents and render decisions. Further, PCs should know and apply research about high-conflict dynamics, intimate partner violence, child abuse and child development. Understanding and appreciating children’s vulnerabilities and resiliencies are very important.

The PC also needs to understand legal terminology, the laws or rules that apply specifically to PC practice, and other relevant laws regarding child custody and ex parte communications in his or her jurisdiction. States with statutes governing PC practice may specify training requirements in terms of number of hours, content and mediation training. PCs need to know what training their state or jurisdiction requires.

Because of the difficulty and complexity of the situations presented to PCs, ongoing education and peer consultation are strongly recommended.

What kinds of issues or dilemmas can the guidelines help practitioners address?

The APA guidelines address crucial issues such as cultural diversity, gender issues and ethical concerns including dilemmas of dual roles and sequential roles with a family. For example, a psychologist who has been a child custody evaluator or a therapist for a family generally would not assume the role of PC for his or her clients.

In February 2011, the American Psychological Association (APA) Council of Representatives adopted as APA policy the following guidelines related to the practice of psychology:

• **Guidelines for the Practice of Parenting Coordination.** See the question-and-answer article about these new guidelines on page 10.

• **Guidelines for Psychological Practice in Health Care Delivery Systems.** Building on earlier APA guidelines focused on hospital settings, the 2011 guidelines are intended to assist psychologists with understanding and conceptualizing roles and responsibilities in diverse health care delivery systems.

• **Guidelines for Psychological Evaluations in Child Protection Matters.** These guidelines, a revision of 1999 APA guidelines with the same name, are intended to promote proficiency in using psychological expertise when psychologists conduct evaluations in child protection matters.

These three APA guidelines for practitioners and others are found on **Practice Central** at [apapracticecentral.org/ce/guidelines/index.aspx](http://apapracticecentral.org/ce/guidelines/index.aspx).

Further, the guidelines address distinct requirements for the PC regarding confidentiality, court orders and payment sources. As one example, PCs do not bill insurance companies for their services.

The guidelines also provide record-keeping guidance for psychologists. While important for all psychological services, record keeping acquires special significance in PC work, which may be liable to scrutiny of the court through subpoena. Because most parenting coordination is not confidential and may result in decisions affecting children and parents, record keeping that will facilitate dispute resolution and meet requirements of the courts and families is necessary.

Another area of complexity addressed by the guidelines is the interdisciplinary nature of the PC role. The PC has access to and interacts with many other professionals including attorneys, teachers, physicians and day-care providers. The ability to collaborate with a variety of other professionals is vital.
Psychologists make up only 16 percent of the behavioral health workforce in the U.S. What are the chances that a person needing practitioners' skills and training will find his or her way to a psychologist's office?

The odds aren't just low, according to Angela Londoño-McConnell, PhD, of Athens, Georgia. They are dire, especially when psychologists shut themselves away in their practices. “The survival of psychology as a viable profession will depend on how the public, policy makers and other professions get to know us,” says Londoño-McConnell. And the only way for psychologists to do so is to get out of their offices. “Community outreach has to be a part of your professional identity,” she says. “It must be intentional, and it needs to be a priority.”

“Community outreach has to be a part of your professional identity. It must be intentional, and it needs to be a priority.”

Informing, empowering and motivating

As an undergraduate student at Florida State University, Londoño-McConnell served as a peer educator and later as a health promotion advisor and consultant while obtaining her master’s degree in counseling at the University of Central Florida. She chose to pursue a counseling psychology doctorate from the University of Memphis because of what she terms the degree’s “historical emphasis on prevention.”

Londoño-McConnell says she’s always felt passionate about “informing, empowering and motivating,” and that “[psychologists] can be empowered and motivated to make informed choices only when we have access to accurate and relevant information.” She points to these three tenets as being at the core of the work psychologists do, whether through psychotherapy, advocacy or public education. After all, “research-driven information is practical only if those who can benefit from it can access it.”

The more she reaches out to her community, the more it reaches back. “I’ve become a recognized expert and resource,” Londoño-McConnell says, bringing a diverse caseload of therapy clients and consulting opportunities to AK Counseling and Consulting, Inc., the practice she runs with co-founder J. Kip Matthews, PhD.

Fluent in Spanish and English, Londoño-McConnell for years has taken to the airwaves to educate the Spanish-speaking public on psychological issues. From 2006-2007, as the host of the first Spanish-language TV talk show in northeast Georgia, she offered community resources to viewers, including information on gang membership prevention and help with recognizing depression. As the host from 2007-2008 of the weekly health segment Agenda Hispana on Georgia Public Radio, she discussed such topics as effective discipline for children at different ages, domestic violence and PTSD. In recent interviews on CNN en Español, she has discussed APA’s Stress in America survey findings, how to minimize holiday stress and why children lie, among other issues.

While media work might not be for everyone, Londoño-McConnell recommends that all fellow psychologists take part in community forums. She served on a panel at a local middle school for a talk on the importance of parental involvement in students’ education. Through Goodwill Industries and their career resource center, she participated in a vocational fair for members of the community.

In outreach to the business community, Londoño-McConnell has assisted local businesses with creating guidelines for their day-to-day operations to address
concerns about high staff turnover. She also helped a local organization identify key characteristics of successful employees to enhance their hiring practices. In addition, Londoño-McConnell provides professional development trainings for administrators and their staff on stress management and wellness, personalities at work, benefits and perils of social media, and diversity initiatives.

She credits her involvement in these activities with helping her “learn what is happening in my community. This information, in turn, can help me to better understand what my clients are facing day-to-day, which informs and enhances my practice.”

And the more one is involved in the community, Londoño-McConnell says, “the more people will know about who you are and your clinical areas of specialization. It is inevitable that the public will see you as an expert and as a resource if you are visible and active in community outreach. For instance, after appearing on CNN, a media company contacted me to take part in short videos on specific health issues to be played in doctors’ waiting rooms.”

Londoño-McConnell suggests that her peers get involved in organizations and institutions in their community. She serves on advisory boards including the Latin American and Caribbean Studies Institute at the University of Georgia, the Community Connections Latino/a Advisory Board, and el Banco de la Oportunidad Executive Committee. Londoño-McConnell points out that one doesn’t need to speak Spanish to be an asset to the Spanish-speaking community. The boards on which she serves also have local non-Spanish-speaking lawyers and medical doctors who advocate for the needs of Latinos/as and who welcome someone plugged into the mental health community.

Nearly two decades of work on college campuses has given Londoño-McConnell an appreciation for the developmental challenges that college students encounter. These days, as universities recognize the benefit of reaching out to traditionally underserved populations, she speaks to high school, transfer and first-year students, as well as their parents, on how to help high school students make a successful transition to college. Londoño-McConnell assists Latino/a and first-generation college students with addressing the various barriers to academic success that they may face. She’s also often asked by universities to assist with recruitment and retention efforts of diverse students, faculty and staff.

Londoño-McConnell found that staging a health fair provided valuable face time with local lawmakers. In her role as APA Public Education Coordinator for Georgia, Londoño-McConnell chaired the committee that brought the first Mind/Body Health Fair to the state capitol. The fair was geared toward educating legislators about the role that psychologists play in the lives of Georgians. The 12 exhibits from the Georgia Psychological Association included statistics about state residents related to aging, depression and workplace issues, along with American Psychological Association Help Center (apa.org/helpcenter) literature explaining how these areas affect people and how psychology can help.

“Legislators stopped by the exhibits, read the material, and were really surprised. For instance, they said to me, ‘I never knew how depression affects the elderly.’ Now other SPTAs [state, provincial and territorial psychological associations] are taking psychology to their capitol building, advocating not just for the profession of psychology but, more importantly, for those we serve.”

In addition to her public education work, Londoño-McConnell provides consultation services to for-profit and not-for-profit organizations and employee assistance programs on issues of staff diversification, team building, creating healthy work environments and leadership development.

“I find getting out into the community energizing. But even more so, I find that [community outreach] makes me a better psychologist.”

When asked whether she ever thinks about slowing down or scaling back, Londoño-McConnell says, “I find getting out into the community energizing. But even more so, I find that [community outreach] makes me a better psychologist.

“As a psychologist, I have the responsibility to be aware of what is happening in the world outside of my practice. If I want to reach people—and I do—I don’t have to just wait for them to come to me. I can also go to them.”
Is Your Practice Client-Friendly?

These pointers can help you gain a competitive advantage.

In an increasingly competitive health care marketplace, creating a “client-friendly” practice can help you stand out from the crowd. This article describes simple business practices that can give you an advantage while enhancing the relationships you have with your clients.

Appropriate environment

Create an office environment consistent with the professional image you want to convey.

- Office space should be appropriate for the services provided — for example, large enough for family or group therapy. If you do assessments, it is important to have space that is quiet and devoid of distractions, along with a smooth writing surface for clients. If you treat children, provide an assortment of quiet, washable toys in your waiting area.

- Have adequate seating and comfortable chairs in the waiting area. Use colors, lighting, music and décor to create a soothing aesthetic.

- To address safety concerns, make sure the entrance and any parking area are safe and well-lighted, and that security measures in the building are appropriate for your location and clientele.

Good accessibility

Remove barriers to your professional services by making your office easily accessible.

- Having adequate parking available and/or good access to public transportation helps clients get to your office for the services they need.

- Be sure your office is accessible to clients with disabilities, including those who use wheelchairs.

- Become familiar with Title III of the Americans with Disabilities Act (ADA), which includes requirements for removing barriers in existing facilities as well as Standards for Accessible Design. (See the sidebar on the following page regarding newly issued guidance on ADA.)

- If you are in an institutional setting and your office is part of a larger campus (for example in a hospital or university), be sure there is clear signage and that your location and contact information is included in directories and other institutional resources. Similarly, be sure that operators or automated phone systems accurately connect callers with your direct line and that web links to your office are functional and up to date.

Scheduling that makes sense

Use a well-organized scheduling system, providing office hours that are convenient for your clientele and feasible for you.

- Making yourself available to clients during early morning, evening or weekend hours can set you apart from your competitors. It may help your clients attend regularly while still fulfilling their other obligations.

- Set a manageable and realistic schedule. Allow yourself enough time during the day to return phone calls and e-mails promptly, complete paperwork, respond to e-mail and provide for some “down time” to replenish yourself and avoid burnout.

- If crises arise frequently, leave room in your schedule to accommodate these demands, implement a reliable on-call process for handling emergencies or have backup support from other colleagues.

Professional staff

Good communication and listening skills are not just for psychologists. A well-trained, knowledgeable staff can greatly enhance your clients’ experience.
• The first point of contact for a new client often will be a telephone call to your office. Train your staff to answer the phone, take messages, schedule appointments and respond to client questions and concerns professionally and courteously.

• In institutional settings, for initial appointments and/or when scheduling is irregular, it can serve as a helpful reminder to clients and help protect against schedule disruptions to have staff confirm appointments by phone or email. This is especially important in high-volume settings and when working with populations that tend to have frequent no-shows.

Privacy and confidentiality
Conveying a clear message that your practice takes privacy issues seriously will put clients at ease and help lay the foundation for a trusting therapeutic relationship.

• Certain obligations arise from legislation and statutes that apply to psychologists. For example, among the processes and procedures mandated by the Health Insurance Portability and Accountability Act (HIPAA), covered practices are required to disseminate a notice of privacy practices. The APA Practice Organization (APAPO) has developed a compliance product called HIPAA for Psychologists available online at apapracticecentral.org/ce/courses/1370022.aspx. It includes a privacy notice and other forms required by the HIPAA Privacy Rule. Section B of the APAPO publication, The Privacy Rule: A Primer for Psychologists (online at apapracticecentral.org/business/hipaa/2009-privacy.pdf) helps psychologists determine if they need to comply with this HIPAA rule.

• Take steps to prevent accidental breaches of privacy in the office. You can keep confidential conversations from being overheard by soundproofing your office, using “white noise” machines outside the door and having music playing softly in the waiting area.

• Avoid engaging in private conversations in common areas such as hallways or the waiting area.

• Be sure that client records and other confidential documents are secure and not left where others might see them.

• Personal information from appointment books, sign-in sheets and computer screens at the reception desk should not be visible to others. If you are required to comply with HIPAA and you transmit or store patient information electronically, then you will need to comply with the HIPAA Security Rule (information found at apapracticecentral.org/business/hipaa/index.aspx), which requires you to consider various aspects of how you handle, transmit and store electronic health information and document the steps you have taken to protect it.

Helpful information
Making informational and educational materials available to your clients can help facilitate treatment.

• Create a “new client packet” with basic information about your practice, a short biographical statement and copies of your promotional materials. Include information about policies such as payment, scheduling, cancellation and no-shows, communication via email, social media and other

NEW FEDERAL GUIDANCE ON THE AMERICANS WITH DISABILITIES ACT

On March 16, 2011, the U.S. Department of Justice (DoJ) issued new guidance under the Americans with Disabilities Act (ADA), which is designed to make facilities open to, and services provided to, the public reasonably accessible to people with disabilities. The ADA applies to psychologists’ practices.

The new guidance from DoJ is found in ADA Update: A Primer for Small Business (online at 1.usa.gov/ADAprimer). This information reflects revisions to the ADA regulations that will go into full effect by March 15, 2012.

Some provisions of the new guidance pertain to making offices physically accessible; these provisions would apply primarily to psychologists who own their office space. Other provisions would apply to all practices, such as the requirements to have ADA policies and procedures, or to accept text telephone (TTY) calls from people with speech and hearing disabilities.

In 2008, the APA Practice Organization (APAPO) provided guidance on a common ADA issue affecting psychologists: Providing an Interpreter for the Deaf under the ADA (online at apapracticecentral.org/business/legal/professional/secure/interpreter-deaf.aspx).

APAPO will share further information on the revised ADA regulations in an upcoming edition of our Practice Update e-newsletter (online at apapracticecentral.org/update/index.aspx).
Since 2007, Medicare has offered incentive payments to eligible professionals, including psychologists, who report data on designated outpatient service measures as part of a program known as the Physician Quality Reporting System (PQRS, formerly the Physician Quality Reporting Initiative). New mental health measures have been added as the program has evolved, and more changes are on the way.

The most fundamental change: As a result of the Patient Protection and Affordable Care Act of 2010, the program is slated to switch from a voluntary initiative to a mandatory reporting program in 2015.

Eligible professionals who fail to participate will face a penalty of 1.5 percent in 2015 and 2.0 percent in 2016. Meanwhile, the incentive payments of 1.0 percent for 2011 are decreasing to 0.5 percent for 2012 through 2014.

For 2011, the Centers for Medicare and Medicaid Services (CMS) reduced the reporting requirement for individual measures from 80 percent to 50 percent of applicable cases. In prior years, program participants were required to report on 80 percent of cases.

Additional details about PQRS include:

- There is no application or enrollment for the PQRS. Providers can begin reporting on applicable cases at any time by adding codes to the CMS-1500 claims forms they submit for Medicare Part B reimbursement. In order to participate, psychologists must have a National Provider Identifier (NPI) number and be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS). The PECOS system and registration instructions can be accessed through the Medicare Enrollment site at pecos.cms.hhs.gov/pecos/login.do. (See the sidebar, “More resources for psychologists,” on the following page.)

- PQRS is not a pay-for-performance program at this time. Health care professionals are eligible to earn bonus payments through 2014 just for reporting on the program measures, regardless of treatment outcomes.

- When the program began in 2007, there was only one measure related to mental health services. In 2011, psychologists have ten measures available for reporting as identified in the sidebar, “PQRS measures for 2011,” on the following page. Participants are encouraged to report on at least three measures, though reporting on one to two measures is allowed.

- Participants who successfully report on applicable cases receive bonus payments for all their Medicare claims, not just the claims that include measures reported by the participant.

- All claims for a calendar year must be filed before CMS provides the bonus payments. The deadline for submitting prior year claims is two months from the end of the calendar year. Bonus payments for 2011, for example, will be made mid-year in 2012.

- CMS now allows a six-month reporting period in addition to the option of reporting for the entire calendar year. So for 2011, psychologists can choose to report on services from January through December, or only on those services provided from July through December.

- Providers can begin reporting on applicable cases at any time during the year. But keep in mind that successful program participation requires reporting on at least 50 percent of applicable cases. Failure to start early in the time period could prevent a participant from reaching this threshold.
**PQRS MEASURES FOR 2011**

Psychologists are eligible to report on ten mental health preventive care and screening measures for the 2011 reporting period:

**Major depressive disorder (MDD): antidepressant medication during acute phase for patients with MDD (#9)**
Indicates the percentage of patients aged 18 years and older diagnosed with a new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase. This measure is to be reported for each occurrence of MDD during the reporting period.

**Major depressive disorder: diagnostic evaluation (#106)**
Indicates the percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified. This measure is to be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder seen during the reporting period, including episodes of MDD that began prior to the reporting period.

**Major depressive disorder: suicide risk assessment (#107)**
Indicates the percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period. This measure is to be reported at each visit for a new diagnosis or recurrent episode of MDD, for patients seen individually during the reporting period.

**Body mass index (#128)**
Indicates the percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documents in the medical record and if the most recent BMI is outside parameters, a follow-up plan is documented. The measure may be reported when a BMI calculation has been performed by another health care provider and is documented in the medical record.

**Documentation and verification of current medications in the medical record (#130)**
Indicates the percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative is documented by the provider. This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure.

**Pain assessment prior to initiation of patient treatment (#131)**
Indicates the percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each qualifying visit prior to initiation of therapy AND documentation of a follow-up plan. This measure is to be reported for each qualifying visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure.

**Screening for clinical depression (#134)**
Indicates the percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure.

**Unhealthy alcohol use (#173)**
Indicates the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method within 24 months. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 18 years and older were screened for unhealthy alcohol use during the reporting period. There is no diagnosis associated with this measure.

**Elder maltreatment screen and follow-up plan (#181)**
Indicates the percentage of patients aged 65 years and older with documentation of a screen for elder maltreatment AND documented follow-up plan. This measure is to be reported for each initial patient evaluation during the reporting period. When reporting CPT codes 96116, 97803, and G0270 the measure is to be reported each time the code is submitted. The not eligible code can be used to report if it is not an initial evaluation with screening for elder maltreatment.

**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (#226)**
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. This measure is to be reported once per reporting period.

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**MORE RESOURCES FOR PSYCHOLOGISTS**

- Enrolling or verifying enrollment with the Provider Enrollment, Chain and Ownership System (PECOS): [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do)
- CMS overview of PQRS: [cms.hhs.gov/pqri](http://cms.hhs.gov/pqri)
Leading Psychology into the Telehealth World  continued from page 7

alone is often only minimally effective, support via periodic brief phone calls and/or email can produce outcomes that approach the effectiveness of face-to-face therapy for many clients, says Dr. Mohr. In addition, Internet treatments have the advantages of standardized presentation of materials, geographic coverage, convenience, and 24/7 availability, with minimal cost.

In a study of primary care patients, Dr. Mohr found that almost half would consider Internet-based treatment. And meta-analyses suggest it can be quite effective, says Dr. Mohr. For anxiety, for example, Internet interventions were on par with face-to-face interventions although they appear to be somewhat less effective for depression.

Now Dr. Mohr is developing an approach that takes advantage of the strengths of both telephone- and Internet-based interventions. The moodManager is an Internet intervention that uses learning modules to teach cognitive-behavioral skills, offers online tools to help with such tasks as scheduling positive activities and tracking patients’ thoughts and supplements the online work with brief phone calls from a “telecoach.” Ongoing research has found that using the program can result in significant reductions in depression.

“We may be able to use these interventions in stepped-care models, where we begin treating people with the Internet, leaving patients who do not respond and who have more severe problems to be treated by more cost- and time-intensive, face-to-face treatments,” says Dr. Mohr.

These telehealth strategies can help overcome the barriers that keep people from getting the psychological care they need, emphasizes Dr. Mohr, whether it’s cost, logistical difficulties, time constraints or stigma. They can also help psychology meet the demand for mental health services.

“There’s no way we as a field can manage the public health burden of mental illness,” says Dr. Mohr, noting that almost nine percent of Americans experience mood disorders each year and 18 percent have anxiety disorders. “Using the Internet and mobile technologies is one way of overcoming that problem.”

This article is based on a session called Leading Psychology into the Telehealth World: How Does It Work? at the APA Practice Organization’s 2011 State Leadership Conference.

Is Your Practice Client-friendly?  continued from page 15

electronic means and after-hours and emergency contact. The article, “Put it in writing: Your office policies and procedures,” online at Practice Central (apapracticecentral.org/business/management/tips/secure/procedures.aspx) provides helpful guidance.

- Broaden the range of resources you offer your clients by providing a variety of educational materials. Stock your waiting area with brochures, relevant articles, magazines and consumer fact sheets. Visit apapracticecentral.org/outreach/index.aspx to find “FYI” fact sheets for clients and consumers on depression, anxiety, eating disorders and the federal mental health parity law.

- Consider having a television and media player playing a selection of health-related videos in your waiting area.

- Also think about setting up a “lending library” of books and other materials that your clients can check out. Similarly, consider posting relevant articles, videos and links to other helpful resources on your practice website, providing clients with 24/7 access to materials that can support and enhance the work you do with them during in-person sessions.

**Client satisfaction**

In addition to clinical outcomes, it is important to assess client satisfaction. A systematic focus on this area will demonstrate your commitment to providing quality services to your clients.

- Survey your clients regularly using objective measures. A good client satisfaction survey should address topics including overall level of satisfaction with your practice and services, experience interacting with staff, convenience of available appointment times, facility cleanliness and feedback about the value and usability of the resources you include on your website.

- Use the resulting data to identify areas in need of development and make regular improvements as indicated. Survey results are helpful for fine-tuning your office policies and procedures to make them more consistent with client preferences. Let clients know you are listening by addressing concerns they raise and by implementing realistic suggestions.
Building Your Resilience

*Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress – such as family and relationship problems, serious health problems, or workplace and financial stressors. Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that anyone can learn and develop.*

*Developing your resilience is a personal journey. An approach to building resilience that works well for one person might not work for another. People use varying strategies. Some variation may reflect cultural differences. For example, an individual’s culture might have an impact on whether and how he or she connects with others and communicates feelings.*

*The following pointers may be helpful to consider in developing your own strategy for building resilience.*

**Make connections.** Good relationships with close family members, friends or others are important. Accepting help and support from those who care about you and will listen to you strengthens resilience. Some people find that being active in civic groups, faith-based organizations or other local groups provides social support and can help with reclaiming hope. Assisting others in their time of need can also benefit the helper.

**Avoid seeing crises as insurmountable problems.** You can’t change the fact that highly stressful events happen, but you can change how you interpret and respond to these events. Try looking beyond the present to how future circumstances may be a little better. Note any subtle ways in which you might already feel somewhat better as you deal with difficult situations.

**Accept that change is a part of living.** Certain goals may no longer be attainable as a result of adverse situations. Accepting circumstances that cannot be changed can help you focus on circumstances that you can alter.

**Move toward your goals.** Think about possible solutions to the problems you are facing and decide what realistic goals you want to achieve. Do something regularly – even if it seems like a small accomplishment – that enables you to move forward. Focus away from tasks that seem unachievable. Instead, ask yourself, “What’s one thing I know I can accomplish today that helps me move in the direction I want to go?”

Many people find it helpful to track their progress by making a record of any accomplishment that moves them toward their goals. It is important to spend a moment reflecting on the fact that you are taking action and achieving what you believe you need to do.

**Take decisive actions.** Act on adverse situations as much as you can. Take decisive actions, rather than detaching from problems and stresses and wishing they would just go away. Being active instead of passive helps people more effectively manage adversity.

**Find positive ways to reduce stress and negative feelings.** Following a stressful event, many people feel they need to turn away from the negative thoughts and feelings they are experiencing. Positive distractions such as exercising, going to a movie or reading a book can help renew you so you can re-focus on meeting challenges in your life. Avoid numbing your unpleasant feelings with alcohol or drugs.

**Look for opportunities for self-discovery.** People often learn something about themselves and may find that they have grown in some respect as a result of their struggle with loss. Many people who have experienced tragedies and hardship have reported better relationships, greater sense of strength even while feeling vulnerable, increased sense of self-worth, a more developed spirituality and heightened appreciation for life.

**Nurture a positive view of yourself.** Developing confidence in your ability to solve problems and trusting your instincts helps build resilience.
Keep things in perspective. Even when facing very painful events, try to consider the stressful situation in a broader context and keep a long-term perspective. Avoid blowing the event out of proportion. Strong emotional reactions to adversity are normal and typically lessen over time.

Maintain a hopeful outlook. An optimistic outlook enables you to expect that good things will happen in your life. Try visualizing what you want, rather than worrying about what you fear.

Take care of yourself. Pay attention to your own needs and feelings. Engage in activities that you enjoy and find relaxing and that contribute to good health, including regular exercise and healthy eating. Taking care of yourself helps keep your mind and body primed to deal with situations that require resilience.

Additional ways of strengthening resilience may be helpful. For example, some people write about their deepest thoughts and feelings related to trauma or other stressful events in their life. Meditation and spiritual practices help some people build connections and restore hope. The key to developing an effective personal strategy is to identify ways of building your resilience that are likely to work well for you.

Where to look for help. Getting help when you need it is crucial to building your resilience. Many people turn to family members, friends and others who care about them for the support and encouragement they need.

Self-help and community support groups can aid people struggling with hardships, such as the death of a loved one. By sharing information, ideas and emotions, group participants can assist one another and find comfort in knowing that they are not alone in experiencing difficulty. For many people, using their own resources and getting help from others may be sufficient for building resilience. At times, however, an individual might get stuck or have difficulty making progress on the road to resilience.

A licensed mental health professional such as a psychologist can assist people in developing an appropriate strategy for moving forward. It is important to get professional help if you feel like you are unable to function or perform basic activities of daily living as a result of a traumatic or otherwise stressful life experience.

Different people tend to be comfortable with different styles of interaction. A person should feel at ease and have a good rapport when working with a mental health professional or participating in a support group.

This fact sheet is adapted largely from “The Road to Resilience,” available on the Psychology Help Center, located online at apa.org/helpcenter. The American Psychological Association Practice Directorate gratefully acknowledges the assistance of Rick Allen, PhD; Lillian Comas-Diaz, PhD; Suniya S. Luthar, PhD; Salvatore R. Maddi, PhD; H. Katherine (Kit) O’Neill, PhD; Karen W. Saakvitne, PhD; and Richard Glenn Tedeschi, PhD, in developing this material.

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In this issue—

• Compliance Issues Arise with Mental Health Parity Implementation
• Is That Insurance Company Avoiding the Parity Law?
• Leading Psychology into the Telehealth World
• Reimbursement for Telehealth Services
• Cultivating a Role in Parenting Coordination
• Bringing Psychology to the Community
• Is Your Practice Client-Friendly?
• Get Ready for Mandatory Medicare Reporting
• Removable Public Education Resource: Building Your Resilience