Creating a ‘Hybrid Practice’

Putting Electronic Health Records into Practice

Medicaid Expansion on the Horizon

Social Media: What’s Your Policy?

Introducing Yourself to Other Health Care Professionals

Bringing Psychology to a Medical School Setting

Cyberbullying
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Mohandas Gandhi

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Good Practice is the recipient of a Platinum Award, the highest honor, from the Association of Marketing and Communications Professionals.
Creating a ‘Hybrid Practice’

*Practitioners diversify their revenue streams to shore up their bottom line.*

As a hedge against declining reimbursement rates, practitioners are increasingly varying their sources of revenue. Steven Walfish, PhD, of Atlanta sees this creation of what he calls “hybrid practices,” characterized by involvement in a variety of revenue-producing professional activities, as an opportunity for psychologists to be creative and entrepreneurial, as well as to benefit financially.

Just as investors diversify their investments to protect themselves from fluctuations in the financial market, many psychologists are diversifying with multiple revenue streams, as well as making a portion of their practice self-pay. By doing so, “You are not subject to the whims of insurance [companies] that may drop fees at a moment’s notice,” Walfish says.

According to the APA Practice Organization’s 2011 online survey of members, 36 percent of respondents indicated that self-pay clients accounted for at least one quarter of their client base. Fifteen percent reported that they derived all their practice revenue from self-pay clients.

Those who diversify note the importance of using the broad range of their skillset. Walfish’s practice includes psychological evaluations for traffic accident personal injury cases, pre-surgical psychological evaluations prior to weight-loss surgery, and substance abuse evaluations of impaired professionals. He also derives a portion of his revenue from writing and presenting on how to earn a living practicing outside of managed care.

With a clinical specialty in treating children, adolescents and adults with ADHD, Alan R. Graham, PhD, of Chicago owns a small group practice. Other revenue streams include ADHD coaching—which teaches clients to manage their attention, hyperactivity and impulsivity—executive coaching and part ownership of a website, ADDvisor.com, that interviews well-known practitioners and researchers in the ADHD field. The site sells books and other materials for those with ADHD.

He takes insurance for some aspects of his practice, and notes that the volume of his work allows him to choose the companies with which to work. “I won’t participate in a number of panels because of the reimbursement levels,” Graham says. And with alternate sources of revenue, he doesn’t have to.

In her private practice, Spark Inspiration, and as the clinical director of the Behavioral Health and Wellness program at the University of Colorado School of Medicine, Cindy Wang Morris, PsyD, of Denver offers psychotherapy, coaching and training and helps organizations around the country create healthy workplaces. For example, she helps conduct workplace wellness evaluations for organizations looking to increase positive communications between leadership and staff, reduce turnover and increase productivity.

These psychologists, along with David Ballard, PsyD, MBA, assistant executive director of marketing and business development in the American Psychological Association Practice Directorate, offer various pointers to help guide practitioners in diversifying their practice activities and potential revenue sources.
Start with your core competencies and skills and build from them. According to Ballard, psychologists’ expertise in relationship building can be tapped to establish mutually beneficial business relationships with payers, partners, colleagues, referral sources and other professional contacts. Skills in program design and evaluation can be applied to developing a new service or consulting with individuals, organizations and communities to help them develop, implement and evaluate programs to enhance their functioning. (For more examples of core competencies and their applicability to the business of practice, see “Putting Business into Practice: Leveraging Your Skills as a Psychologist” in the Winter 2008 issue of Good Practice, available online to Practice Assessment payers at http://bit.ly/Kq5dsZ.) Graham notes he uses his core skills in all his jobs and finds unifying principles in his different duties. “When I work with a child with ADHD, I need to understand the child and the environment in which he lives,” he says. “And when I go into organizations, I need to understand the executive and the environment in which he lives.”

Be confident. Morris believes that despite their knowledge and talents, psychologists often underestimate their abilities. “Don’t be afraid to try something new and fail at it. Just because it’s not on your resume yet doesn’t mean you don’t have the ability to do it.”

Be open to ideas from many sources. Graham got into executive coaching after sitting and talking to the father of his daughter’s friend at a bat mitzvah. The man was the managing partner for a consulting organization with a work need that Graham was able to fill.

Use data-based research. Walfish began working in personal injury after reading After the Crash: Psychological Assessment and Treatment of Survivors of Motor Vehicle Accidents by Edward B. Blanchard, PhD, and Edward J. Hickling, PsyD. The book asserts that car accidents are the leading cause of Post-Traumatic Stress Disorder (PTSD) in the general population. Walfish now suggests to psychologists that they similarly read and use published research to help generate practice ideas. To do so, he says, psychologists should routinely browse the table of contents of psychology journals of interest to monitor trends and read articles about emerging opportunities and needs.

Think like an entrepreneur. Morris says when she was studying to be a psychologist she didn’t imagine she’d be taking an entrepreneurial path. But as she found herself excited by the possibilities for new ways to engage people and organizations as she helps them transform themselves, she realized what an entrepreneur she really is.

In his article, “Creating Opportunities” (www.apa.org/education/ce/opportunities.pdf), Walfish notes research that finds “entrepreneurship enables the private practitioner to see opportunities where others do not” (Baron, 2002; Baron & Ensley, 2006; Baron & Shane, 2008), and that one doesn’t need to have a certain personality to succeed as an entrepreneur (Hisrich, Langan-Fox & Grant, 2007).

Rather, Hisrich et al. talk about “entrepreneurial cognition,” suggesting that “opportunity recognition has been attributed to actively searching for opportunities, having a general
Putting Electronic Health Records into Practice

Psychologists are already enjoying coordinated care, greater efficiency and other benefits.

“Drowning in paper.” That’s how psychologist Julie Thompson Steck, PhD, describes the situation before the multidisciplinary behavioral health practice she co-owns with Dr. Dennis Rey Kinder adopted electronic health records.

The Children’s Resource Group in Indianapolis has 20 clinicians on staff, including psychologists, psychiatrists, a speech/language pathologist, a disability specialist and an assistive technology specialist. “Multiple disciplines mean multiple people see the same client,” says Steck. Before electronic health records, each clinician who saw a client would print out his or her notes and share them with everyone else who needed to see them. Says Steck, “The volume of paper was overwhelming.”

Fast forward to 2012. Today the practice uses electronic health records that allow them to see everything that’s going on with a client, coordinate care and tackle other tasks with greater efficiency than ever before, all without ever having to open a filing cabinet.

Steck is just one of many psychologists, in both private practice and large institutions like hospitals and the Veterans Affairs (VA) system, who have embraced electronic health records. (For an introduction, see “Charting the Course of Electronic Health Records” in Good Practice, Winter 2012, http://bit.ly/KHBYPf.) Realizing many psychologists are still wary of making the shift to electronic records, Steck and other psychologists are also doing what they can to eradicate myths and encourage other practitioners to get started (see sidebar on page 5).

Embracing efficiency

Some psychologists still aren’t sure what electronic health records are, says Stacey Larson, JD, PsyD, director of legal and regulatory affairs in APA’s Practice Directorate.

“Electronic health records are basically just an electronic copy of a patient’s records,” she explains. What’s different is that they gather all of a patient’s records — from visits to a psychologist, physician, occupational therapist or other clinicians — all in one place, which facilitates exchange of information among those who need it.

Indeed, a goal of electronic health record keeping is “interoperability,” meaning information can be exchanged among systems. To be eligible for federal incentive payments for purchasing systems, a benefit psychologists aren’t currently eligible for, health care professionals must use electronic health records in a “meaningful” way, meaning they’re used to improve care, increase safety and promote coordination of care.

For Steck, that coordination is one of the main reasons she has fallen in love with electronic records. “You have everything about the patient right in front of you,” she says. That means she can easily review every contact anyone in her practice has had with a patient, whether it’s a psychiatrist’s notes or phone calls a patient or parent has made between visits. She can also send information from the system to clinicians outside her practice. After seeing two sisters with attention-deficit hyperactivity disorder, for instance, she clicked a single button and sent a copy of her notes to the girls’ physician.

Steck can also access the system from anywhere, even from her iPhone. “If I get an emergency call at night, I have all my records right there, without taking anything out of my office,” she says. One night a patient’s parents...
called on the way to the hospital with their suicidal daughter. Within five minutes, Steck was able to review her notes, see what medications the girl was on and brief the emergency room physician.

**Dispelling the myths**

Despite these advantages, some psychologists are reluctant to adopt electronic health records.

Often psychologists aren’t comfortable with the idea because they’ve heard myths rather than reality, says Vanessa K. Jensen, PsyD, a pediatric psychologist at the Cleveland Clinic Children’s Hospital. She and others cite common misconceptions:

- **Electronic health records are exorbitantly expensive.** It’s true that systems can be expensive. Start-up costs alone were $24,000 for software and another $22,000 for a server high-powered enough to run it for the four offices of Heritage Professional Associates in Hinsdale, IL, for example. Then there are ongoing fees per workstation, says practice co-owner Keith A. Baird, PhD. Comparatively, Steck’s web-based system, which doesn’t require a server, costs about $6,000 a year for each physician and psychologist. But other systems are much cheaper. Nathan Tatro, project manager for practice research and policy in the American Psychological Association Practice Directorate, has found products geared toward smaller practices as inexpensive as $69 per year per licensed provider — after upfront training and implementation costs.

Plus, electronic health records can save practices big money. Take Baird’s practice. “We’ve been in business for over 20 years and had three-quarters of a million pages of patient records,” he says. “We were starting to spend a lot of money for off-site storage.” Electronic health records can also save the practice space, adds Steck. “If we redesigned our office right now, we would have a much smaller one,” she says. “And when we outfit an office now, we do it with just a table with a drawer.” That means no more filing cabinets or the large room once used to store charts. The system also has built-in e-faxing and billing and scheduling software, which means savings on those costs as well as photocopying.

GETTING STARTED

When Julie Thompson Steck, PhD, decided to introduce electronic health records to her multi-clinician practice in 2003, she wondered at first if she’d made a big mistake. “On our first day of training, the trainer said, ‘Everyone right click,’ and 10 voices said, ‘What’s right click?’” she remembers. “I panicked.”

By now, practitioners at the Children’s Resource Group have embraced electronic health records. But to avoid growing pains, Steck and others offer suggestions:

- **Do a needs assessment.** “You may not need all the bells and whistles,” says Nathan Tatro of APA’s Practice Directorate. Training options may also be à la carte, he says, adding that training may consist of on-site sessions, webinars, web modules or 24-hour customer service. Be sure to consider future as well as current needs to avoid outgrowing a product.

- **Get recommendations from other practices.** Ask potential vendors for names of similarly sized practices and ask how well the product actually works, says Keith A. Baird, PhD, of Heritage Professional Associates. Ask how easy training was, how appropriate the product is and what tech support is like, he suggests.

- **Invest time up front.** “Electronic health records are meant to be tailored to your needs,” says Steck. “Take time to think about how you want them to work for you.” Instead of creating their own templates, Steck’s practice adopted some used by another practice and now must go back and tweak the system.

- **Put young employees’ technology know-how to work.** Steck’s practice includes tech-savvy recent college graduates who want experience in the behavioral health field. “It’s a win-win situation,” says Steck. “We gain quick learners who can help us with our technology needs if we get stuck. They get some experience with mental health, and many go back to get graduate degrees after they’ve been here.”

continued on page 19
Medicaid Expansion on the Horizon

*Psychology looks to new opportunities while facing challenges.*

Medicaid is already the single biggest payer for mental health services in the United States. And the Patient Protection and Affordable Care Act (ACA) provides for 16 million more Americans to become eligible for the program.

“But just because mental health services will expand doesn’t necessarily mean that psychologists’ services will be covered,” warns Carrie Valiant, JD, a partner at the Epstein Becker Green law firm in Washington, D.C.

While the prospective Medicaid expansion offers many opportunities for psychologists, there are also impediments — including many states’ reluctance to cover telehealth, health and behavior codes or some psychotherapy services — that could keep psychologists from taking full advantage of those prospects. Fortunately, some states, such as Maryland, are already working to remove these barriers. (See the chart on page 9 for a comparison of covered psychological services in four states’ Medicaid programs.)

**Taking advantage of opportunities**

If all goes according to plan, ACA will increase the number of Americans covered by Medicaid from 36 million to 52 million in 2014 by expanding eligibility to individuals with incomes up to 133 percent of the federal poverty level. And because people with severe mental health disorders are more likely to have low incomes, Valiant points out, Medicaid will be the primary source of coverage for those who gain access to psychological services through health-care reform. About one in six low-income adults who currently lacks health insurance has a severe mental illness, she adds.

“And you can’t only look at those 16 million people who will be added to Medicaid,” says Valiant, pointing to the additional 24 million Americans expected to participate in new state-based health insurance exchanges. “Depending on what the economy looks like, many of those individuals may [move] in and out of Medicaid.”
The sheer numbers alone represent a huge opportunity, says Valiant. Because mental health and substance use disorder services are included in the list of essential health benefits mandated by the law, she says, “The expectation is that there will be lots of mental health services that are required to be furnished in the new paradigm.”

Health-care reform has the potential to bring other areas of opportunity as well. One area is initiatives related to “dual-eligibles,” individuals who are entitled to both Medicaid and Medicare and account for a disproportionate amount of spending. “Right now 80 percent of that population is in fee-for-service rather than managed care,” says Valiant. “They’re in systems that don’t coordinate their care, and presumably that’s why they account for so much of the spending and why they are such a focus.” Fifteen states have received grants to create patient-centered demonstration projects, including behavioral health services, for this population.

Other demonstration projects — including those aimed at improving coordination between physicians and mental health providers — are also worth watching. One such effort is the state option to provide “health homes” for enrollees with chronic health conditions. While some health homes will be based in medical primary care, others will be housed with mental health service providers.

Whatever states do, says Valiant, there aren’t enough mental health professionals or sites to handle the anticipated increase in demand. To tackle that problem, health-care reform also includes initiatives to shore up the mental health infrastructure. These include education and training grants for interdisciplinary training of psychology graduate students, funding to establish national centers of excellence for depression and new investments in community health centers.

“We are expecting all these new programs to create new opportunities for psychologists,” says Valiant. “The challenge will be to show that psychologists can actually deliver value in this system.” Psychologists, she says, must demonstrate that their services can help save money and improve the quality of services.

**Overcoming barriers**

Psychologists must also come together to eliminate barriers to their full participation in Medicaid. Seventeen states currently do not allow reimbursement for psychologists’ services. Another impediment to Medicaid participation is the failure of state plans to cover health and behavior codes, which focus on the behavioral aspects of medical conditions.

Although such integration is key to helping patients manage chronic conditions and thus lowering health-care costs, says Valiant, most states don’t cover them. Similarly, even though telehealth could help fill the gap between an already strained mental health infrastructure and an expanded Medicaid population, states aren’t required to cover such services.

Another barrier is the fact that states don’t uniformly reimburse psychologists for psychotherapy services. Some offer reimbursement only for children’s services, for example, or only for services provided in clinics rather than private practice settings. Plus, not all states allow psychologists to order their own services.

“**If your state hasn’t recognized the full array of possibilities and the services you’re providing, now may be a great time to start having that dialogue and becoming more of a participant in what’s going on.**”

Low rates keep many psychologists from participating in the program at all. “Not all of the rates are as low as you might expect, but they do vary considerably among states,” says Valiant.

Overcoming such barriers will require psychologists and their state associations to get involved in shaping the evolving system, Valiant emphasizes. “Now is the time to start talking to your states about how you can be part of the new dynamic here,” she says. “If your state hasn’t recognized the full array of possibilities and the services you’re providing, now may be a great time to start having that dialogue and becoming more of a participant in what’s going on.”
One state’s experience

Maryland is one state that is already working hard to eliminate these and other barriers. The state is streamlining regulations, for example, and re-examining its Medicaid mental health carve-out.

“We want to be number one in the country for health-care reform,” says Brian Hepburn, MD, executive director of the Maryland Mental Hygiene Administration. “We are totally committed to health-care reform.”

That pledge makes Maryland a potential model for other states interested in helping psychologists make the most of opportunities within Medicaid, says Paul Berman, PhD, professional affairs officer of the Maryland Psychological Association.

Maryland’s Medicaid program may be unique in its willingness to reimburse psychologists for working with both children and adults in clinics and on an outpatient basis, covering health and behavior codes and even some telehealth services, Berman says. “What I’m talking about in Maryland is a little different from what people will be experiencing in other states, but it does provide a template.”

The state’s Medicaid program will soon offer even more opportunities for psychologists. With a population of six million, Maryland already has about one million residents covered by its medical assistance program. Health-care reform will bring another 1.4 million people into the medical assistance program and the state’s new insurance exchange.

The exchange will cover individuals with incomes up to 400 percent of the poverty level. For a family of three, that means income up to $76,000, while Maryland’s median income is about $70,000. “It’s the middle-class and working-class folks who really benefit,” says Berman, adding that this expansion represents a huge opportunity for the state’s psychologists.

Yet the “vast majority” of psychologists in private practice in the state aren’t currently participating in the Medicaid program, he says. That’s not just because of the low reimbursement rate, Berman says, explaining that the program’s rate is actually on par with that of commercial carriers. Instead, he says, they’re reluctant to participate because of the no-show rate typically associated with Medicaid patients. As higher-income individuals become eligible for Medicaid, Berman predicts, the percentage of no-shows will begin to resemble that of general outpatient practice.

As higher-income individuals become eligible for Medicaid, the percentage of no-shows will begin to resemble that of general outpatient practice.

And the newly covered won’t just be higher-income, says Hepburn. They’re also likely to have less severe problems. “We anticipate more mild and moderate mental illness and various levels of substance abuse,” he says.

Psychologists don’t just need to participate in their states’ Medicaid programs, says Hepburn. They also must get involved in shaping the country’s reformed health-care system.

“With health-care reform, there’s so much that needs to be accomplished,” he says. “Going forward, I encourage psychologists to be involved with health-care policy and get involved with decision-makers.”

NOTE: This article is based on a workshop presented during the March 2012 State Leadership Conference in Washington, D.C. sponsored by the American Psychological Association (APA) and the APA Practice Organization. The Supreme Court will render a decision in June 2012 related to Medicaid expansion and other aspects of the Patient Protection and Affordable Care Act.
## Four-State Comparison of Psychologists' Services Covered in Medicaid Programs

<table>
<thead>
<tr>
<th>MARYLAND</th>
<th>MASSACHUSETTS</th>
<th>NEW YORK</th>
<th>NORTH CAROLINA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services That Psychologists May Provide</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maryland HealthChoice: Individual and group psychotherapy, and psychological testing are covered. Only licensed psychologists and licensed psychological associates may perform psychological testing.</td>
<td>MassHealth: A state-licensed psychologist must also be a Medicare provider to be eligible to participate in the state Medicaid program. Psychologists may only be reimbursed for services other than testing — for example, psychotherapy — if the services are provided in an outpatient mental health clinic.</td>
<td>New York Partnership Plan: Reimbursable services by licensed psychologists include psychological testing, evaluation and therapeutic procedures that are appropriate for a given personality or behavioral disorder. Certain clinical psychologists may also bill for neuropsychological services subject to specified criteria.</td>
<td>Community Care of North Carolina/Carolina ACCESS: Individual and group psychotherapy, and psychological testing in providers’ offices are covered. Licensed psychologists are also reimbursed for outpatient behavioral health services.</td>
</tr>
<tr>
<td><strong>Reimbursement Rates for Psychologists’ Covered Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range from $23.93 to $117.05 for psychological services other than health &amp; behavior. Rates for covered H &amp; B codes range from $20.84 to $102.00. (2010) Reimbursement for 90806 (individual psychotherapy, office-based, 45 to 50 minutes): $70.23</td>
<td>Range from $81.11 to $121.36 (2012)</td>
<td>Non-facility reimbursement rates for licensed clinical psychologists range from $18.67 to $83.32. Facility reimbursement rates range from $14.54 to $81.00. Neuropsychological services are reimbursed at $150 per service. (2010) Reimbursement for 90806: $54.00</td>
<td>Non-facility reimbursement rates for licensed psychologists range from $7.25 to $133.12. Facility reimbursement rates range from $7.25 to $116.72. (2011) Reimbursement for 90806: $76.88</td>
</tr>
<tr>
<td><strong>Coverage for Health and Behavior (H &amp; B) Services</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Yes for H &amp; B codes 96150, 96151 and 96152</td>
<td></td>
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</tr>
<tr>
<td><strong>Coverage for Telehealth Services Provided by Psychologists?</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Licensed psychologists enrolled in the Medicaid program may bill for “telepsychiatry” professional services.</td>
</tr>
<tr>
<td><strong>Key Limitations on Service Delivery</strong></td>
<td>A psychologist may be compensated for psychological testing only if a designated agency or individual responsible for providing services to the member requests it.</td>
<td>Patients need a referral — from their physician or nurse practitioner, or other designated sources — to see a licensed psychologist in private practice.</td>
<td>A limit of 16 unmanaged outpatient visits a year applies to Medicaid recipients under the age of 21 and 8 unmanaged outpatient visits for adults.</td>
</tr>
</tbody>
</table>

**NOTE:** This chart provides basic information about Medicaid fee-for-service and Medicaid managed care organizations in only four sample states. Details may be different where services to Medicaid recipients are provided through a behavioral health carve-out company. This information is subject to change and should not be used to help make decisions about Medicaid participation. Readers are encouraged to verify the information in this chart with their state psychological association, Medicaid office or applicable insurance company.
Social Media: What’s Your Policy?

Dr. Keely Kolmes, a psychologist pioneer in the professional use of social media, answers questions related to establishing social media policy for a psychology practice.

According to the Pew Research Center, 79 percent of adults use the Internet and 59 percent of those users are on at least one social networking site. So psychologists and their clients are sure to cross paths online.

More practitioners are instituting a social media policy as part of their informed consent procedure, with many using or adapting the policy drafted by Keely Kolmes, PsyD.

Dr. Kolmes is in private practice in San Francisco, where she writes, blogs and tweets to her approximately 88,000 followers extensively on mental health professionals’ use of social media.

Why is a social media policy important?

Who needs one?

Anyone who is on the Internet and providing clinical care should have some type of social media policy for their practice, even if they are only using email or accessing the Internet for personal use. It can just be a brief statement or paragraph and need not be a long document.

The research is showing us that clients and clinicians are having incidental contacts all of the time on the Internet. Clients are frequently searching for information about their therapist online and they often discover personal as well as professional information. The research is telling us that some clients experience shame and discomfort with finding personal information and for having engaged in the searches, and that the majority do not bring this up with their providers.

Introducing a social media policy in treatment helps frame these encounters as an issue that can be discussed together; it helps normalize the experience of incidental contacts, and it creates boundaries and sets expectations for both parties in the clinical relationship.

How has your social media policy evolved?

Shortly after writing my social media policy, I deleted my Facebook business page, so that part of my policy is no longer applicable. I decided that I did not want to have to attend to who became a fan of the page and I had some experiences in which friends posted information on the page that was too personal for my comfort. Monitoring and cleaning up my page activity became more trouble than it was worth to me.

However, nothing else has really changed in my policy since I created it.

I do plan to implement something new during informed consent to obtain permission from clients to send them post-treatment surveys about their experiences with me as a provider of psychotherapy services with a notice that I may post aggregate data (but not testimonials) on my website.

This won’t be part of the social media policy, per se, but it is relevant to social media, consent and treatment. I see this as a way to continue to develop my skills as a clinician, to be transparent with potential clients about my strengths and weaknesses as a provider, and as a way to provide an alternate to the types of information found on consumer review sites such as Yelp. Since this will be an exchange that I have directly with a client, it will be part of the treatment interaction, rather than something that occurs outside of treatment that I find out about later. I will also not be disclosing people’s words or identities to the public or their friend networks.

What is especially important for psychologists venturing into social media to do/avoid doing?

Do not discuss anything related to a client’s treatment in a status update. Even without identifying data, posting about
your feelings about “my last session” or whether or not you met with someone with a particular diagnosis on a certain day can both influence your relationship with that client and potentially identify them to others who may know they seek care from you. Do not post quotes from clients or complain about your work. We have a right to personal social networks for friendship and support, but we also have a responsibility to represent our profession and understand how it impacts public perception of our work if we use social media to vent about the challenges of our job or otherwise objectify the folks who seek our care.

What issues related to social media do you think practicing psychologists will have to grapple with in the future?

I see two huge hot-button issues for psychologists right now that I expect to continue to present challenges in the future. The first is varying beliefs on whether it is ethical to use Internet searches and social media profiles to gather additional data on clients and whether clients should be informed of this practice. It is a strong belief of mine that clients have a right to know if you use the Internet to collect information about them that you will use in treatment. The second issue is the worry and helplessness psychologists experience when they get negative reviews of their services on consumer review sites since they cannot respond due to confidentiality restrictions. I believe that the best way to manage this is to develop standardized ways to collect this information directly from clients and to find ways to ethically incorporate the information into your own web presence with informed consent and share this feedback while protecting confidentiality.

What guidance on social media do psychologists solicit most from you?

I get a lot of consultation requests from people who have had a negative review from a client, looking for some way to respond or have the review removed. I also hear from people who need assistance making sure their Facebook profiles have the privacy settings they want. So I sometimes provide tech support and check their profiles to ensure they are using the privacy settings they want. Sometimes people contact me after discovering a sensitive social overlap via social media and want help on how to bring this up clinically. I help them work through whether it seems important to bring this back into the treatment relationship and how they might do so.

HIGHLIGHTS OF DR. KOLMES’ SOCIAL MEDIA POLICY

Keely Kolmes’ social media policy, excerpted below, outlines her practice policies and how she conducts herself on the Internet. The complete document can be found on Dr. Kolmes’ website, www.drkkolmes.com.

FRIENDING

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact me between sessions, the best way to do so is by phone. Direct email at drkkolmes [at] hushmail [dot] com is second best for quick, administrative issues such as changing appointment times.

USE OF SEARCH ENGINES

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

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Introducing Yourself to Other Health Care Professionals

Guidance on making yourself and your services known to potential referral sources

A network of strong referral sources can be crucial to helping grow a new practice and to maintaining or building referral streams for an existing one. Marketing tools that help inform others about you and the services you offer include having a website and practice brochure, as well as a listing in the APA Practice Organization’s Psychologist Locator (see ad on page 13). The overarching strategy involves being active and visible in your community.

One tool to connect with local health care professionals is a letter of introduction. Below are pointers to consider in preparing such a letter. A sample template letter to physicians that psychologists can adapt for their own use appears at right.

Keep it brief. Director of Behavioral Health Services at St. Luke’s Humphreys Diabetes Center in Boise, ID, Amy Walters, PhD, says, “I work in a medical setting and the number-one thing I hear from doctors is that their time is limited.” Be short and to the point.

Describe yourself. Formulate and present your sound bite: Clearly describe who you are, the services you provide and the clients you serve. In her letter of introduction, Valerie Shebroe, PhD, of East Lansing, MI, notes her practice areas, including chronic pain, depression and disordered eating. She also makes clear her openness to working with health care providers and school personnel, naming two local registered dieticians with whom she collaborates in caring for patients with eating disorders.

Communicate the value proposition. How can you be of help? Explain the benefits and value of what you can provide to the professional to whom you are writing and his or her clients. Write about problem areas and issues you can address, not treatment modalities, Shebroe says. She cautions that a physician might not be familiar with certain kinds of psychological treatment, so it’s best to avoid including a laundry list of techniques. Consider giving a couple examples of the kind of issues you handle and the benefits you can

July 9, 2012
Dr. John D. Jones
1234 First Avenue
Anytown, USA
Dear Dr. Jones,

You know how important it is for your patients to change their unhealthy behaviors, especially when they have chronic medical conditions. Unfortunately, many patients struggle with this challenge.

As a licensed clinical psychologist, I can help your patients adopt healthier lifestyles and adhere to treatment plans so they can better manage their illnesses and improve their clinical outcomes.

One of my areas of expertise is treating depression and anxiety in patients with chronic pain. According to the National Institute of Mental Health, depression and chronic pain are closely linked. Psychotherapy can be effective in treating both conditions and improving patients’ health.

My new practice is conveniently located in Harrison, New York. I also serve the surrounding suburbs of Rye, Larchmont, Mamaroneck and New Rochelle.

I participate with [list individual insurance company affiliations, along with Medicare and Medicaid as applicable] and also have self-pay patients. New referrals are welcome, and I can usually see them within [designate time frame, for example, one week].

Please visit my website at [add your website URL] to learn more about my training, professional experience and the services that I offer. I will follow up shortly to arrange a convenient time to meet you in person and answer any questions.

Thank you for your consideration. I look forward to speaking with you.

Sincerely,

*If located close to the physician, consider adding a phrase in your letter such as “less than [X] minutes from your practice.”
provide. For example, for an OB/GYN you could cite how common postpartum depression and anxiety are and explain that you can help improve maternal and infant health. For an oncologist you could discuss the prevalence of comorbid depression in patients with cancer, as well as family and relationship issues. Mention that treating the whole person, including the related mental/behavioral health issues, not only helps address the mental health aspects, but can improve physical health outcomes and adherence to difficult treatment regimens and management of unpleasant side effects.

Focus on an appropriate target audience. Don’t try to be all things to all people. Target your mailing to those professionals whose patients can benefit from your areas of expertise. You can search online for particular specialists in your geographic area by combining the specialty name and your zip code. In addition, you can search many physician review websites by zip code.

Tailor your message to your audience. You may have an extensive curriculum vitae and offer a broad range of services, but when trying to connect to another health care professional many of your services may not be applicable. Identify the particular services that pertain directly to what the target provider does and focus on those areas.

Back yourself up. Consider including a nugget of research or a statistic to substantiate your claims. Phyllis Koch-Sheras, PhD, of Charlottesville, VA, is a partner in a women’s therapy group. In her letters to physicians, she points to research showing women who suffer from fibromyalgia and other immune deficiency disorders benefit from psychotherapy in combination with their medical treatment.

Say where your practice is. In addition to giving the address of your practice space, indicate the neighborhoods your practice serves and the convenient commute to the health care practitioner’s office. If you are close to the downtown office area of your city, point out that working clients can easily come to see you during their lunch break. If you offer evening or weekend hours, be sure to include that information.

Include the insurance you accept. Julie Steck, PhD, has been in practice in Indiana for 20 years. Recently, her practice started accepting insurance from two additional payers. So she sent a letter to physicians who already referred to her group, as well as additional medical groups, and her referrals doubled. She plans to send a similar letter every six months to remind the administrative staff of medical offices what insurance her group accepts.

A few days later, visit the office. “When I set up practice in my rural area, I sent out 50 or 60 letters of introduction,” says Michael Schwartz, PsyD, of Liberty, NY. Then he stopped in the offices and in the few minutes he had with each professional, he introduced himself again, told them what kinds of issues he works with, and offered to speak to their staff when it was convenient for them. Schwartz says it was crucial to “make the connection visually [and] verbally.”

Include additional materials. Along with the letter of introduction, include your business card and a copy of your practice brochure or a recent article you have had published. Be sure to note the URL for your website in your letter so the professional can learn more about you and pass on the information to those he or she refers to you. Pauline Wallin, PhD, of Camp Hill, PA, suggests including tip sheet handouts with information of interest to patients and encouraging the physician to make copies for his or her clientele.

Keep the momentum going
When your letter yields referrals, it’s important to keep the momentum up. Here are some next steps.

continued on page 20
When Brittany E. Canady, PhD, started college at Virginia Tech in Blacksburg, she was intent on becoming a physician. That changed soon after she took her first psychology class. “I very quickly switched allegiances,” says Canady. “I fell in love with psychology.”

Today Canady has a career that combines both interests. Soon after earning her doctorate in clinical psychology from the University of Houston in 2008 and doing a postdoctoral fellowship at Geisinger Medical Center in Danville, PA, she became an assistant professor in the department of physical medicine and rehabilitation at Eastern Virginia Medical School in Norfolk, VA.

Treating pain

Canady now specializes in pain management, an interest that arose after watching her friend and family members back home in West Virginia suffer with chronic pain.

Working in the school’s pain clinic, Canady thrives on the variety of patients and problems she treats. “You see things you really wouldn’t necessarily get to see if you were just focused on mental health,” she says. “Some of these patients wouldn’t be comfortable seeing a psychologist in a traditional mental health setting, but they will come in to see you because you’re in a hospital or pain clinic. You become part of their medical treatment team.”

Canady does psychotherapy — mostly cognitive behavioral therapy — with her pain patients, as well as evaluates patients considering pain-relieving medical procedures, such as morphine pumps and spinal cord stimulators. She draws on the current literature to identify problems, such as untreated psychological factors, that could interfere with pain management and response to medical interventions. For example, a patient with severe depression, she explains, may need mental health treatment prior to considering a procedure. According to Canady, treatment of psychological factors may help in several areas, such as improving the patient’s ability to cope with pain, as well as assisting the patient with becoming more active in his or her own post-procedure care.

As part of a multidisciplinary team, Canady sees her role as a psychologist as helping her colleagues consider patients within a broader context. “My role comes in helping us really step back and look at our treatment plans and try to understand the whole person, not just what meds they’re on or what procedure to do next,” she says. For one patient, that meant uncovering a previously undisclosed history of abuse that was complicating her ability to manage back pain.

“Some of these patients wouldn’t be comfortable seeing a psychologist in a traditional mental health setting, but they will come in to see you because you’re in a hospital or pain clinic. You become part of their medical treatment team.”

That holistic perspective also informs Canady’s research, which currently focuses on how psychoeducation affects patients’ attitudes toward pain management options. Still in the data collection phase, the study will explore whether such education can broaden patients’ receptiveness to treatments beyond medication or surgery. That might mean psychological options, such as psychotherapy, hypnosis or biofeedback, or other medical options such as physical therapy.
“I often see patients who say, ‘I tried physical therapy, and it didn’t work for me,’” says Canady. “I explain that there are all different kinds of physical therapy, and that they’re at a different stage in their pain than they were five years ago, so maybe it’s time to talk to their doctor again.” Of course, Canady’s job also involves teaching—a task she has loved since her grad school days instructing undergrads. “Being involved in training is just very energizing,” she says. “The students are so enthusiastic that it helps keep my own enthusiasm strong.”

In addition to supervising psychology interns and practicum students, Canady teaches medical residents. Her most recent effort? Training physiatry residents in communication and interpersonal skills. “Pain seems to be an area with which many health care providers are uncomfortable, particularly as many of the most commonly used medications can be addictive,” says Canady, who observes residents’ interactions with patients and then provides feedback to help them balance the need for caution with empathy for patients in pain and recognition of key psychosocial or behavioral factors. She also regularly provides lectures to the residents on a variety of areas from research methods to assessing suicide risk.

**Encouraging advocacy**

When Canady isn’t at the medical school, she is busy raising two children with her husband. She is also actively involved with her local psychological associations — the Virginia Psychological Association, Virginia Academy of Clinical Psychologists and Tidewater Association of Clinical Psychologists. “When I came to Virginia and started working at the medical school, I knew I needed interaction with psychologists since I was surrounded by physicians all day,” she laughs. “I was desperate for time with psychologists!”

When she asked the president-elect of the Virginia Academy of Clinical Psychologists how she could help out, the answer was clear: Take on legislative advocacy.

Canady’s role as chair of the academy’s legislative affairs committee is a perfect fit, given her family background. “I was raised in a family where my parents were very involved in legislative advocacy as teachers,” says Canady, whose mother worked for the West Virginia Education Association for many years. “I was raised in that environment.”

Canady also got a taste of advocacy during her internship at Geisinger Medical Center, where her internship director was very active in advocacy and encouraged students to respond to the APA Practice Organization’s (APAPO) Action Alerts and contact their elected officials on behalf of psychology.

Recently, health-care reform has been one of Canady’s biggest priorities as an advocate. “As psychologists, we need to be aware of how health-care reform will impact us and how it will impact our client base,” she says. “On the one hand, there is potential for so many people who haven’t had services in the past to receive psychological services, but we also need to make sure that the process is shaped in a way that will make sense for our practices and for our clients.”

Canady realizes that that will be a huge task. That’s one reason she is working so hard to get other psychologists to advocate alongside her.

“What I’m trying to do is get more people involved, rather than being the sole contact and calling the legislator myself. It can be particularly helpful for the information or request to come from a constituent,” she says.

She’s especially interested in enlisting the help of other early career psychologists and getting them the advocacy skills they’ll need throughout their careers.

The next generation needs to step up and take on advocacy roles, says Canady, adding that she heard this theme expressed repeatedly at APAPO’s State Leadership Conference, which she attended as an early career delegate.

“We’ve had excellent leaders in psychology, but many of them are moving on in their lives,” she says. “We need people who are enthusiastic and willing to work to come in and take on those roles.”
Several cases of suicide among young victims of cyberbullying have garnered recent national attention in high-profile media. The National Crime Prevention Council estimates that almost half of all American teens are affected by cyberbullying, raising important questions about its impact on adolescent mental health and psychological development.

While the definition of cyberbullying varies, it is generally characterized as using an electronic device for aggressive, repeated and intentional acts of bullying such as name calling, sending threatening emails, placing photos of persons on the Internet without permission and sending viruses.

Cyberbullying differs from traditional bullying, for example, due to the lack of physical and social cues. Technology allows would-be bullies to separate themselves from their targets and disseminate cruel content to wider audiences. Additionally, messages and pictures can be sent or posted anonymously, further distancing the perpetrators from detection.

Cyberbullying, while popularly seen as an adolescent problem, also occurs among younger children and adults.

The sources listed in this article highlight the growing literature base that can inform psychologists about cyberbullying and how to help perpetrators and victims.


**Summary**

In 2008, 20,406 ninth- through twelfth-grade students in Massachusetts completed surveys assessing their bullying victimization and psychological distress in a study aimed at documenting the prevalence of cyberbullying and school bullying, and the correlation between both types of victimization and increased risk of psychological harm. About one third of respondents indicated being a victim of some kind of bullying (6.4 percent cyberbullying, 16.4 percent school bullying, 9.4 percent both). A majority (59.7 percent) of cyberbullying victims in the study were also school bullying victims; 36.3 percent of school bullying victims were also cyberbullying victims. Victimization was higher among nonheterosexually identified students. Girls were more likely than boys to report cyberbullying whereas there was no gender difference in reports of being victims of school bullying. Victims reported lower school performance and school attachment, and analyses indicated that distress was highest among victims of both cyberbullying and school bullying.

The study concluded that there is a need for prevention efforts that address both school and cyberbullying and their relation to school performance and mental health, as well as a clear need to address and protect students who identify as gay, lesbian or bisexual or who may be questioning their sexual orientation.

**Practical Implications**

Not surprisingly, girls reported more cyberbullying than boys, which is consistent with girls’ increased use of social media in peer relationships. It’s important to note that cyberbullying is often more prevalent via text messaging and cell phone use, even more so than via websites such as Facebook. Again, not surprisingly, individuals who do not identify as heterosexual are more likely to be victims of bullying. Targeted prevention and intervention programs for girls and gay, lesbian, bisexual and questioning youth may be necessary in order to reach those most at risk for victimization. Additionally, research suggests that victims of cyberbullying frequently reciprocate cyberconflict; differentiating between instances of sole victimization and instances of mutual cyberbullying may be important in driving intervention efforts. Given that the impact of such bullying can manifest directly in the school environment with low performance and problems with mental health, psychologists and other providers in schools...
can be critical to identifying and reducing risks and incidents of all forms of bullying.


**Summary**

According to the contemporary General Strain Theory (GST), when a person experiences strain, such as failure to achieve goals, the loss of positive stimuli or the presentation of negative stimuli, they are more likely to experience negative emotions that, in turn, lead to deviant behavior. In order to determine if traditional and cyberbullying were deviant outcomes of negative emotions caused by strain, the authors conducted a survey on the occurrence of both types of bullying, as well as the experience of strain and negative emotions. The sample consisted of approximately 2,000 middle school students from one of the largest school districts in the United States. Results indicated that both forms of bullying were directly associated with strain and the experience of negative emotion. However, contrary to the GST, the experience of negative emotions did not mediate the relationship between strain and either type of bullying. Rather, strain and negative emotions' influence on bullying seem to be independent of each other.

**Practical Implications**

It is clear from this study that both strain and negative emotions influence the likelihood of bullying. To prevent youth from attempting to cope with strain and negative emotions in an unconstructive or deviant manner, for example through bullying, clinicians can help youth recognize what triggers problematic behavior and develop more positive coping methods. This could be in the form of encouragement to participate in physical and mental extracurricular activities that occupy students’ time and help them find satisfaction and self-assurance. Health care providers can also help students identify ways to build peer support. Furthermore, actions could also be taken to diminish the causes of strain among youth in different environments. Clinicians should keep in mind that some sources of strain among youth, such as broken romantic relationships or parental divorce, may not be evident as an antecedent to bullying at first. Identifying and alleviating these sources of strain may also prove fruitful in reducing corresponding experiences of negative emotions and resulting bullying.


**Summary**

To shed light on the developmental, legal and mental health issues surrounding the occurrence of bullying and cyberbullying, this article provides an overview and case examples of the different types of bullying situations, participants and tactics to thwart bullying. Most recently, bullying and cyberbullying have become a more visible problem due to the influx of high-profile school violence and suicide incidences associated with bullying victimization. Accordingly, 32 of the 48 states with anti-bullying legislation have added a section on cyberbullying to enable school administrators to respond to these situations that occur outside of school. The authors note that bullies are more likely to develop or have an externalizing disorder, for example ADHD, while victims are more likely to suffer from anxiety or depression. Moreover, by their early twenties, the majority of school bullies have been convicted of some sort of crime.

Cyberbullying is differentiated from traditional bullying by the greater potential for escalation, due to the lack of physically present barriers, and expansion of the conflict to “cybergangbullying.” The authors introduce a continuum of bullying inclusive of the bully, the victim and the bystander(s), such as accomplices and defenders. By providing a functional assessment of the factors that sustain each of the participants’ behaviors, the authors are able to address the long-term negative effects of bullying, which include the development of conduct disorder for bullies and PTSD for the victims and potentially observers. Furthermore, developmentally sensitive strategies for avoiding and responding to bullying-type situations are provided to assist individuals and their support systems to foster an environment that precludes involvement in bullying-type situations.

**Practical Implications**

Expanding and distinguishing the individual roles in social interactions will help clinicians better understand the dynamics of the bullying situation and identify the residual...
Creating a ‘Hybrid Practice’ continued from page 3

alertness (conscious and unconscious) for opportunities and an ‘ability to connect the dots’ in order to bring opportunities together from seemingly disparate areas.”

Psychologists are well suited for entrepreneurship, according to Walfish. They can use their “therapy skills, research skills, teaching skills, consultation skills and … ability to develop products that people want in order to branch out,” he says.

Get the proper training. Psychologists are ethically obligated to build the competencies necessary for any work they engage in. This can be achieved through a variety of channels, including formal coursework, continuing education, getting supervision from an expert in the area in which you wish to practice, having a mentor, self-study—such as reading journals and other publications—and peer supervision.

In his book Earning a Living Outside of Managed Mental Health Care: 50 Ways to Expand Your Practice, Walfish presents essays by 50 practitioners who also share the additional training they undertook to branch out. For example, a psychologist who offers a marriage skills workshop advises those who are interested to “first become expert in emotional regulation, cooperative communication and conflict resolution skills.”

More psychologists are branching out, fixing their sights on ventures that are a good fit for them and their practice, external environment and target market. When Graham went into practice 35 years ago, his business partner counseled him never to have all his eggs in one basket. “That has held for me,” he says. The variety of work keeps his finances on even keel and “it’s never dull.”

Social Media: What’s your policy? continued from page 11

How do clients respond when you introduce your social media policy? What questions or concerns have they raised?

Most clients don’t say much about it, although some have said that they thought it was really “cool” that I spelled it all out for them so there were no surprises. A few have expressed reassurance that I won’t be Googling them without their knowledge. Since I live in San Francisco, which is a bit of a social media bubble, many of my clients work in tech. I think that for these folks, having a psychologist who has a social media policy feels pretty comfortable and helps them understand the choices I’ve made in more consumer-friendly language. Some clients specifically choose to work with me since I seem so attuned to social media issues because this is becoming such a common space for relationship issues to arise for them.
• **Learning how to use electronic health records is difficult, and using them is more time-consuming than paper.** Training wasn’t a big deal for Steck’s practice. “They do give you training, but it’s so intuitive,” she says. Plus, software typically includes tutorials, help buttons and other resources. Using electronic health records can be just as straightforward. With the Cleveland Clinic’s system, Jensen can quickly access the “smart text” templates she has created, or draw from thousands of others within the system, for documentation. Templates automatically include much of the information needed such as current date, patient demographics, provider details and consent information. Jensen has customized more than 100 forms to date, such as referral and other common letters and school absence excuses. According to Jensen, additional useful clinical tools include customized questionnaires and rating scales where data can be graphed over time, along with individualized patient handouts and reading lists. She adds that using electronic records decreases time spent on administrative tasks such as appointment tracking and processing requests for treatment records.

• **Electronic health records won’t let me take notes the way I want to.** “People say, ‘I like my notes the way they are,’” says Jensen, explaining that many psychologists object to the impersonality of electronic records and are reluctant to use forms. Many psychologists start out simply typing regular notes into electronic records, she says, but soon discover that taking advantage of the software makes everything so much easier.

Once psychologists have embraced electronic health records, adds Aaron Harris, PhD, a clinical health psychologist at the Robert J. Dole Veterans Affairs Medical Center in Wichita, they often find themselves rethinking the content of their notes as well as the format. Although some psychologists worry they’ll forget things if they don’t write detailed notes, he says, that kind of detail isn’t as necessary as many psychologists believe. Harris’ own notes include symptoms, changes and the type of approach being used — just like in a medical record. “I’m thinking a nurse in primary care is going to see this note, so what does he or she need to know,” says Harris. “It’s definitely a change from what I learned in graduate school a dozen years ago.”

**ADDRESSING PSYCHOLOGISTS’ PRACTICAL NEEDS**

Electronic health records are becoming more widespread and psychologists are considering adopting such technology for their practice. APA Practice has formed an electronic health records (EHR) staff work group to address psychologists’ practical needs in this area. Among its activities, the work group has compiled a checklist of criteria that will be used to evaluate selected EHR products. System overviews and cost information will be shared with members in the coming months.

Meanwhile, members of the staff work group are participating in a multi-organizational group that the Substance Abuse and Mental Health Services Administration (SAMHSA) convened to identify necessary features of electronic health records for behavioral health providers.

We will continue to use this magazine and the PracticeUpdate e-newsletter to educate members about electronic health records.

• **Electronic health records don’t protect patients’ information.** Security and confidentiality of records are obviously big concerns for psychologists. But electronic records are actually more secure than their paper counterparts, says Harris, and electronic record keeping ensures the records’ integrity.

“People often believe that anything you chart is available to anyone else,” says Jensen. That’s just not true, she says, explaining that most systems can be customized with different levels of security for different components of the record, with access provided on a need-to-know basis.” Plus, “footprint” trails allow auditors to see exactly who has accessed what information and for how long. It’s not just non-clinical staff who get locked out of certain areas. In Steck’s practice, clinicians aren’t allowed to make changes in the scheduling and billing areas. “It’s so we don’t mess things up,” laughs Steck.

For Steck, the benefits of electronic health records have made her an enthusiastic supporter. Says Steck, “I wouldn’t go back to paper — ever!”

For Steck, the benefits of electronic health records have made her an enthusiastic supporter. Says Steck, “I wouldn’t go back to paper — ever!”
Introducing Yourself to Other Health Care Professionals continued from page 13

Communicate regularly. Don’t let too much time go by without being in touch with your referral sources. Depending on your relationship with a particular individual, call, email, send a follow-up letter or meet for lunch periodically to build and maintain the relationship.

Express your gratitude. When professionals begin to refer to you, call to thank them personally. If someone refers to you regularly, be sure to periodically let that person know you appreciate him or her sending business your way. During the winter holidays, send a card or a nominal token of thanks.

Make referrals to your referral sources. Your contacts will view their relationship with you as mutually beneficial and will be more likely to reciprocate.

Grow your referrals exponentially. Once you have an established relationship with referral sources, consider asking them to send information to, or put you in touch with, other professionals they know who might be interested in your services. In some cases, your referral sources may even be willing to put a stack of your business cards and brochures in their waiting area.

Cyberbullying continued from page 17

effects bullying has on each participant, including bystanders. Identifying the different roles individuals may play in cyberbullying situations may determine different intervention strategies and coping mechanisms. Additionally, clinicians must be mindful of the duality of bullying roles in that one person might be in more than one role at different times. Teaching students how to deflect rather than reciprocate cyberbullying may help to reduce the incidence of mutual bullying. Clinicians may also need to identify their state’s legislation on bullying and cyberbullying to inform their decisions regarding necessary actions to help parents intervene or prevent the cyberbullying. The importance of contextual factors surrounding bullying is emphasized, illuminating the need to consider the systemic and environmental factors when addressing bullying. Lastly, although different mental health problems are associated with bullies compared to victims, treating those problems in full recognition of the impact of bullying on the individual’s life may serve to both improve the mental health disorder as well as reduce the incidence of bullying.


Summary

Using the same data described in the previous article, the authors evaluated the relationships among bullying, cyberbullying and suicide. Twenty percent of the almost 2,000 middle school respondents reported seriously thinking about suicide. Youth who had either engaged in bullying behaviors or been victims of bullying behaviors (both traditional and cyber) were more likely to report suicidal ideation, although being a victim was a stronger predictor of having suicidal ideation. Bullying victims and offenders (both traditional and cyber) were more likely to have attempted suicide than those who were not exposed to bullying. The researchers caution, however, that exposure to bullying (traditional or cyber, offender or victim) was only a small contributor to youth experience of suicidal ideation or attempt at suicide. The researchers noted that a variety of other factors also contributed to these outcomes.

Practical Implications

Just as traditional forms of peer aggression are known to be linked to increases in suicidal thoughts, cyberbullying is linked as well to increased suicidal ideation. Prevention and intervention programs related to cyberbullying may need to incorporate a component on suicidal thoughts and behavior. While cyberbullying itself may not lead to suicide attempts, cyberbullying may be another factor that adds to a young person’s feelings of isolation or hopelessness that ultimately can lead to suicidal ideation.

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STEP 3: Preview, Edit
STEP 4: Launch Site