GOOD PRACTICE
Tools and Information for Professional Psychologists

Fall 2013

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Health Insurance Exchanges: An Overview for Psychologists
ICD-10 and DSM-5
10 Tips for Selecting an Electronic Health Record System
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* This Patient Education Resource provides facts about and ways to manage diabetes. To make photocopies for your clients, or for use in networking and outreach activities, remove the article along the perforated edge. To download this fact sheet and other tools, visit the Public Education & Outreach section at apapracticecentral.org.
Duty to Protect

Roles and Responsibilities for Psychologists

Recent mass shootings heightened the focus on widespread state laws that require or allow psychologists and other mental health professionals to breach confidentiality in order to prevent harm by their potentially violent patients. This article is intended to help practitioners with the challenging task of applying these duty to protect* laws in working with these individuals.

Mandatory versus permissive laws

Most psychologists think of duty to protect laws as those that create a mandatory obligation to take action and impose liability for failing to carry out that duty. But there are closely related laws that give psychologists discretion or permission – but not the duty – to breach patient confidentiality to prevent harm to others or to the patient. Such permissive laws do not impose liability; laws generally create liability only when someone fails to meet a mandatory requirement. This article refers to the two types of laws as “mandatory” and “permissive” duty to protect laws.

Because they do not create liability, permissive duty to protect laws often have a lower threshold for the level of risk that triggers the ability to warn, and they may apply to a wider range of potential victims.

Permissive and mandatory laws frequently differ in the following respects:

Potential victim. Mandatory duty to protect laws usually require an identified or identifiable victim – someone other than the patient. Permissive laws frequently apply to a wider range of potential victims – when there is potential harm to any person (or even the public), including the patient. So, for example, a client’s threat to blow up a shopping mall would often give the psychologist the ability to take action under a permissive law, but would almost never create a duty under a mandatory duty to protect law.

Imminence, certainty and type of harm. Mandatory duty to protect laws typically apply where there is an imminent and/or rather certain threat of harm. They often specify that the harm must be serious physical harm or death. Permissive laws often lack these elements, for example, requiring only some kind of harm, or in one or two cases, even encompassing the risk that the client will simply damage property.

Beyond these general distinctions, there are considerable state-by-state variations in both types of laws. Relevant resources for further information are found in the sidebar (page 4) entitled, “Summaries of mandatory and permissive state duty to protect laws.”

According to Welfel, Werth & Benjamin (2009), among 64 jurisdictions in the U.S. and Canada: 32 states mandate a duty to protect regarding professionals’ responsibility with dangerous clients; 18 states or provinces have permissive duty to protect laws; and the law of 14 jurisdictions remains silent as to whether a duty to protect exists. In some jurisdictions, a duty to protect also exists regarding clients who are dangerous to themselves.

All of these laws serve the same general purpose: to permit or mandate psychologists’ release of confidential information in order to protect potential victims of a client’s violent acts.

A BRIEF HISTORY OF DUTY TO PROTECT

In 1976, the California Supreme Court issued its decision in Tarasoff v. Regents of the University of California after a patient carried out a threat to kill a young woman. In that case, the court ruled:

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another [person], he incurs an obligation to use reasonable care to protect the intended victim against such danger . . . [This duty] may call for [the therapist] to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances.

After the Tarasoff case, many states passed legislation defining a “duty to protect”** and the steps needed to discharge that duty. In other states, courts created a duty to protect through case law. Even in states without such a statute or case law, a court could create such a duty and impose liability for failing to meet that duty – for example, if a victim’s family members sue a mental health professional who they believe should have foreseen a patient’s violent behavior.
Permissive duty to protect laws

Permissive duty to protect provisions are typically found as exceptions to the professional obligations found in confidentiality or privilege laws. An example of a permissive duty to protect law is the Illinois Mental Health and Developmental Disabilities Confidentiality Act. The Act’s provisions for disclosure without patient consent include two types of disclosures relevant to duty to protect:

- To initiate a civil commitment or to otherwise protect the patient or another person against a clear, imminent risk of serious injury or death; and
- To warn or protect a specific individual against whom a patient has made a threat of violence.

The Illinois act provides immunity from liability for such disclosures when made in good faith. (Full text of the Act is available at bit.ly/740ILCS.)

The permissive duty to protect provision best known to psychologists is in the APA Ethical Principles of Psychologists and Code of Conduct (“Ethics Code”). Ethics Code Standard 4.05(b) allows disclosure of confidential information without patient consent “where permitted by law for a valid purpose such as to...protect the client/patient, psychologist, or others from harm.”

Further, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule also specifically permits covered health care providers to disclose protected health information without consent or authorization in order to prevent or lessen a serious and imminent threat to the health or safety of a person (including the patient) or the public. Such disclosures must be consistent with applicable law and ethical standards. They must be made to a person or persons reasonably able to prevent or lessen the threat, including potential victims. (For more information, please see the HIPAA Privacy Rule Primer at apapracticecentral.org/business/hipaa/hippa-privacy-primer.pdf.)

Importantly, the APA Ethics Code provision, the HIPAA provision and state law permitting or requiring disclosure must all be considered together. The Ethics Code and HIPAA provisions only allow disclosure without consent if state law permits it. The HIPAA standard sets a higher bar than the APA Ethics Code in terms of the imminence and type of harm. HIPAA requires a serious and imminent threat to the health and safety of a person. By contrast, the Ethics Code refers simply to protecting the patient, psychologist or others “from harm.” Unlike many mandatory duty to protect laws, the HIPAA provision applies to self-harm and does not require an identifiable victim.

Mandatory duty to protect laws

As noted earlier, mandatory duty to protect laws generally create liability for failure to act. Therefore, they often set a higher bar in terms of imminence and certainty, and they generally apply to a narrow range of potential victims. Beyond those generalizations, mandatory laws vary considerably, so it is important to understand the specific requirements in your jurisdiction.

Be aware of variables in these laws such as:

- How imminent and certain must the threat be?
- Must the potential victim be identifiable?
- How is the duty discharged? Are required methods of warning or protecting specified, such as hospitalizing the patient, warning the potential victim or notifying the police?
- To which types of mental health and/or other professionals does the duty apply?
- Is immunity provided for good faith efforts to discharge the duty?
- Is the duty established by statute or case law?

Clinical and ethical considerations

Dr. Stephen Behnke, APA Ethics Director, notes that whether or not practitioners have a mandatory or permissive duty to protect in a potentially dangerous client situation, it is important to always “keep their clinical hat on.” While duty to protect laws direct when a practitioner can and must take action, Dr. Behnke notes that clinical judgment informs both a psychologist’s assessment of risk and how he or she carries out legal duties and options.

For example, unless mandated by state law, warning the intended victim is only one of several possible interventions you should consider. Other less intrusive, therapeutic options that don’t involve a breach of confidentiality should be considered first. For example, you may be concerned that a patient is increasingly angry and impulsive, and may become violent, but the danger does not rise to a reportable level in your state. In this situation, you might decide to increase the frequency or intensity of treatment, get a medication consult or urge the patient to seek voluntary hospitalization.
SUMMARIES OF MANDATORY AND PERMISSIVE STATE DUTY TO PROTECT LAWS


National Conference of State Legislatures, Mental health professionals’ duty to protect/warn. bit.ly/NCSL50


Alternatively, you may be able to address safety concerns without breaching confidentiality through a combination of:

- informed consent procedures
- establishing and maintaining a good therapeutic alliance
- carefully assessing for violence and suicide, and
- implementing an appropriate treatment plan.

Involving the patient in decisions about treatment and needed interventions is often helpful. For example, a patient may agree to be evaluated at a hospital if he or she understands that otherwise an involuntary admission may become necessary.

If you do need to warn a potential victim or otherwise reveal confidential information, it is generally preferable to discuss the situation with your patient in advance, if doing so is possible, safe and clinically appropriate. Your patient will better understand the rationale for your actions if you explain your legal obligations and emphasize the goal of preventing violence that could have devastating consequences for your patient and potential victims.

Remember also to limit the information disclosed to that which you believe is needed for the immediate goal of protecting individuals from potential harm.

If you have concerns about a potentially dangerous client, take prompt action to address the situation. Confidentiality and clinical issues are very important, but if you truly believe someone is in immediate, serious danger, protecting your patient or another from harm will likely become even more critical.

If you are concerned about the safety of others, you should also consider issues such as whether your patient may be suicidal, may be abusing a child, or may endanger you or your colleagues. (For additional information, see our Good Practice magazine articles, “Dealing with Threatening Client Encounters” (Winter 2012) and “Reporting Child Abuse and Neglect” (Spring/Summer 2013).

In all of these situations, clinical and/or legal consultation is advisable, as is risk management consultation with your professional liability insurer. In addition, be sure to keep careful documentation.

Informed consent

The prior section discusses informed consent discussions you may want to have with your client after a duty to protect issue arises. It is also important to include these issues in your informed consent procedures at the start of therapy. You should address, preferably both in writing and verbally, exceptions to confidentiality such as duty to protect. A thorough informed consent process will make it easier to work with your patients if you are later confronted with a situation in which you need to make disclosures for safety reasons. Your patient is already aware that you may have to breach confidentiality in this situation.

APA Ethics Code Standard 4.02 states: “Psychologists discuss with persons...with whom they establish a scientific or professional relationship...the relevant limits of confidentiality.” Standard 10.01 states: “When obtaining informed consent to therapy...psychologists inform clients/patients as early as is feasible in the therapeutic relationship about ... limits of confidentiality.”
Sample informed consent forms, including language explaining possible duty to warn/protect limits to confidentiality, are available online from the APA Insurance Trust at apait.org/apait/download.aspx. (Similar provisions are the therapist-patient agreement contained in HIPAA for Psychologists, the APA Practice Organization/Insurance Trust HIPAA Privacy Rule course/compliance product. It is available at the APA Practice Organization’s website: apapracticecentral.org.)

**Be prepared**

Duty to protect issues are complex and difficult. They can be particularly stressful if a practitioner is not prepared to respond when a patient expresses violent thoughts or intentions. It is important for practitioners to be familiar with their legal, ethical and clinical responsibilities when treating a potentially dangerous patient. Many mental health professionals do not receive extensive training in treating a potentially dangerous patient. Many mental health professionals do not receive extensive training in behaving emergencies in graduate school.

The following actions will help you reduce the risk that a duty to protect situation will arise, and let you respond more appropriately if it does occur:

- reading more about these issues (see sidebar at right, “Additional References and Resources”)
- taking continuing education on topics such as violence assessment and risk management
- consulting with expert colleagues or attorneys about patients who concern you, and
- learning and staying up-to-date on laws in your state.

Practitioners with further questions about duty to protect may contact the Legal and Regulatory Affairs Department at praclegal@apa.org or call the APA Practice Organization’s toll-free Practitioner Helpline at 800-374-2723.

* The terms “duty to protect” and “duty to warn” are often used interchangeably. However, some authors use the term “duty to warn” to refer specifically to a duty to warn an identified victim, whereas the term “duty to protect” is broader and allows for alternative means of protection from violence, such as notifying the police or initiating hospitalization.

**Please note:** Legal issues are complex and highly fact-specific and require legal expertise that cannot be provided by any single article. In addition, laws change over time and vary by jurisdiction. 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.

**ADDITIONAL REFERENCES AND RESOURCES**


Rockville, MD: The Trust.


Health Insurance Exchanges: An Overview for Psychologists

Learn the basics and consider issues for practitioners.

One of the goals of the Affordable Care Act (ACA) is to expand access to affordable private health insurance coverage to tens of millions of Americans currently lacking it. The ACA seeks to increase access to coverage through a number of health care reforms, such as: requiring insurance companies to allow young adults to remain on their parents’ health plans until age 26; prohibiting discrimination in health plan designs; expanding Medicaid eligibility; and establishing health insurance exchanges (HIEs) for individuals and employees of small businesses.

Beginning in 2014, health care coverage for individuals and small business employees will be available through HIEs – marketplaces designed to offer “one-stop shopping” for consumers to compare and purchase private health care coverage from those health plans that are certified as meeting specified federal and state law requirements. These exchanges will also enable Americans with low-to-moderate incomes to check their eligibility for enrollment in public health programs (such as Medicaid or the Children’s Health Insurance Program, CHIP) or for financial assistance (tax credits) to pay for health care premium costs.

Open enrollment for health insurance exchanges begins October 1, 2013 for coverage to take effect on January 1, 2014 – assuming Congress does not pass legislation delaying or otherwise changing the schedule for implementation.

This article provides an overview of health insurance exchange requirements and highlights issues that might impact psychologists who provide health services. A map on page 7 indicates the exchange model for which each state has opted.

Key components of health insurance exchanges

Health insurance exchanges must offer an integrated and simplified online system that allows consumers to submit a single application to determine eligibility, apply for and enroll in any of the eligible health plans certified to offer coverage through the exchange, or public programs such as Medicaid or CHIP. The system also will provide assistance to help consumers navigate the exchange.

The online system that consumers will access offers one-stop shopping. Consumers will be able to:

- view and compare plan choices through a standardized format
- determine their eligibility for coverage for any programs available through the exchange
- verify eligibility for federal tax credits to pay for coverage or for cost-sharing reductions, and
- enroll for coverage.

All health plans offered through the exchanges must be certified by federally recognized accreditors as a “qualified health plan (QHP).” To be accredited as a QHP, plans must meet certain criteria as defined by the Department of Health and Human Services (HHS). For example, QHPs must offer essential health benefits, which must include mental health benefits (as further described below), maintain cost-sharing limits (such as deductibles, copayments and out-of-pocket maximum amounts), and must meet federal requirements for parity in insurance coverage of mental health and physical health services.

In addition, a qualified health plan must demonstrate that it: does not market its plan in any way that would discriminate against people with serious or chronic illness; has sufficient numbers and types of providers for its networks; and offers coverage for the entire geographic area of the state covered by the exchange.

Essential health benefits

Beginning in 2014, all non-grandfathered health plans offering coverage in the individual and small group markets must offer essential health benefits (EHB) in ten categories defined by the ACA as well as any state-mandated benefits in effect prior to December 31, 2011. The EHB categories are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
Health Insurance Exchange Models by State

- Laboratory services
- Preventive and wellness services and chronic disease management, and
- Pediatric services, including oral and vision care.

The essential health benefits required by ACA will be equal in scope to those benefits typically offered in employer health coverage.

States must identify a “benchmark plan” within the state that offers the defined essential health benefits as well as any state-mandated benefits. All plans eligible to offer coverage through the exchange must offer benefits substantially equal to those offered by the benchmark plan. However, if the identified benchmark plan lacks coverage in any of the ten categories, the state may supplement the benchmark plan in that particular category.

Consumer protection provisions

The ACA includes consumer protection provisions to enhance access to coverage, including:

- federal requirements pertaining to parity in insurance coverage of mental health compared to physical health services
- non-discrimination in plan design
- prohibitions against lifetime coverage limits and coverage rescissions for persons who become ill or whose insurance applications contain unintentional errors
- coverage for young adults through their parents’ plans until age 26, and
- no coverage exclusions for children with pre-existing conditions.

The federal Mental Health Parity and Addiction Equity Act

continued on page 15
October 1, 2014 marks a fundamental shift in how psychologists and other health care providers in the United States will be required to code and bill for their services. At that time, the U.S. will finally adopt the World Health Organization’s (WHO) International Classification of Diseases, 10th revision (ICD-10).

While the transition to this diagnostic coding system has been expected, the forthcoming adoption of ICD-10 raises a host of questions for psychologists. Much of the uncertainty coincides with the May 2013 publication of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

This question-and-answer article addresses several current issues and concerns related to ICD-10 and DSM-5. The sidebar on page 9 contains additional references and resources.

**Why do both the ICD and DSM systems exist?**

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) has been widely used for training and diagnostic purposes across mental health professions in the U.S. The rest of the health care industry has used the ICD for diagnostic codes.

The ICD is the global standard in diagnostic classification for health reporting and clinical applications for all diagnoses, including mental health and behavioral disorders. The U.S., as a member of the World Health Assembly, is expected to report morbidity and mortality data using the World Health Organization’s international standard, the ICD.

**To what do ICD-10 and ICD-10-CM refer? How does ICD-10-CM compare generally to ICD-9-CM?**

The number – for example, ICD-10 – indicates the version of ICD being used. All countries are allowed to modify the ICD to suit their own particular circumstances. The Centers for Disease Control (CDC) has that responsibility for the U.S., and its modification is tagged with “CM” – meaning clinical modification. The CM versions of the ICD provide additional morbidity detail.

It is important to note that WHO published ICD-10 in 1992. While most countries in the world have since converted to ICD-10, the U.S. has not. ICD-9-CM is the official version of ICD currently used in this country. WHO anticipates publishing ICD-11 in 2015, shortly after the U.S. is scheduled to convert to ICD-10 on October 1, 2014.

The CDC hopes to use an annual updating process to bring ICD-10-CM closer in alignment to ICD-11 so that the conversion from version 10 to 11 will not take as long nor be as abrupt with the next transition process. However, for now, psychologists should focus solely on the transition from ICD-9-CM to the ICD-10-CM.

The broad categories of disorders are much the same in ICD-10-CM compared to ICD-9-CM. But while ICD-9-CM uses numeric codes, ICD-10-CM uses alphanumeric codes. For example, major depressive disorder, single episode is coded as 296.2 in ICD-9-CM but appears as F32.9 in ICD-10-CM.

**What code set should be used for billing?**

The Department of Health and Human Services will not require providers to use the ICD-10-CM code sets to report diagnoses until October 1, 2014. At that time, the ICD-9-CM code sets will be replaced by ICD-10-CM code sets. The transition to ICD-10-CM is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA).

For coding purposes related to billing, psychologists
should continue to use the ICD code sets they are currently using. ICD-9-CM codes are essentially the same as those contained in the DSM-IV-TR, the predecessor to DSM-5. (The American Psychiatric Association switched from using Roman to Arabic numerals with publication of DSM-5.) The American Psychiatric Association has published “crosswalks” between DSM-5 diagnoses and ICD codes for those who opt to use the DSM-5 manual.

How might DSM-5 be used in practice?

Psychologists are licensed to independently assess and diagnose the individuals who seek care from them. The DSM, with its descriptions of various mental disorders and their respective diagnostic criteria, historically has served as the industry standard among mental health professionals for use in the process of assigning a diagnosis. Recognizing their professional and ethical obligation to use up-to-date diagnostic criteria, many psychologists have consulted the current edition of DSM for that purpose.

As far as timing for psychologists who intend to switch to using the new DSM-5 as their primary diagnostic resource, be aware that some hospitals along with the Department of Veterans Affairs seem to be preparing to adopt use of the DSM-5 diagnostic criteria for the process of making clinical diagnoses by the end of 2013.

Also be aware that some laws – especially those concerning diagnosis in a school setting – may specify or encourage the use of DSM for designated purposes. For example, the federal No Child Left Behind law grants the states some leeway in directing how psychologists arrive at a diagnosis for a child in order to fulfill requirements for an Individualized Education Plan (IEP). Some states require use of the DSM, where other states allow psychologists’ professional clinical judgment to suffice for making a diagnosis. Certain states suggest the use of DSM but grant the practitioner license to use another diagnostic resource that entails “similarity of function” – for example, the ICD.

What do psychologists who use DSM for diagnostic purposes need to do in order to capture ICD codes for billing purposes?

Because DSM diagnoses must be coded and billed using ICD codes, psychologists must have some familiarity with ICD or use a crosswalk from some other system (such as DSM) to ICD in order to identify the appropriate codes and be paid for their services.

ADDITIONAL REFERENCES AND RESOURCES

ICD-10 resources from the Centers for Medicare and Medicaid Services (CMS) cms.gov/Medicare/Coding/ICD10/index.html

InstaCode Institute’s DSM-5 code FAQ instacode.com/DSM-faq


The role of the DSM in IDEA case law nasponline.org/publications/cq/mocq395RoleofDSM.aspx

Transition to the ICD-10-CM: What does it mean for psychologists? apappracticecentral.org/update/2012/02-09/transition.aspx

APA’s continuing education (CE) office has a presenter under contract who is willing to travel to sponsoring agencies, organizations or associations interested in more intensive training in relation to either the DSM-5 or the ICD.

State psychological associations may also offer workshops for their members on diagnostic classification systems.

Manuals are not the sole resource to guide diagnostic decision making. Research literature, clinical expertise and practice guidelines are among the additional resources that aid the process. The health care professional is presumed to have that knowledge, or access to that knowledge, and the expertise to use the knowledge appropriately.

APA and the APA Practice Organization (APAPO) are continuing to develop tools and resources to assist psychologists with the ICD transition. APAPO will continue to monitor the revision process for ICD, highlight important transition points and identify additional valuable resources for APA members in anticipation of the Oct. 1, 2014 transition date.
Deciding to use an electronic health record (EHR) system in your practice has many potential benefits, including facilitating integrated service delivery, accessing your patients’ records from almost anywhere, and helping to optimize office efficiency. However, given the multitude of EHR vendors in the market, the selection process can seem daunting, even for those who are technologically savvy. This tip sheet is designed to help you with the decision making process.

The following 10 tips touch on core considerations that individual and group practitioners should assess and discuss with colleagues as applicable when selecting and transitioning to an EHR system:

1. **PREPARE TO GET STARTED.**
   In starting the process, practitioners in settings of various sizes and types may find it helpful to familiarize themselves with the information and resources available at the healthit.gov web site. Further, psychologists in group practices or organizational settings might consider forming an EHR advisory group that can help guide activities related to selecting an EHR. Advisory group members should work together to: identify any expected challenges (such as training and cost); review systems; and create new, standard operating procedures to follow when an EHR is fully implemented.

2. **MATCH SYSTEM OPTIONS TO YOUR PRACTICE SIZE.**
   Some EHR systems are designed to meet the needs of large practices and systems (for example, hospitals), whereas others are better suited for small groups or solo providers. Selecting a product that is appropriate for your practice size will help to narrow down the options – and avoid unnecessary cost.

3. **CONSIDER THE KIND(S) OF HEALTH CARE PROFESSIONALS IN YOUR PRACTICE AND WHAT THEY MAY NEED AN EHR TO DO.**
   Is your practice staffed solely by psychologists, or will other health care providers be using the EHR system? For instance, if you practice with health care professionals who can write prescriptions, electronic prescribing is a feature that you may want in your EHR. Also, some providers such as psychiatrists are eligible for federal health information technology (HIT) incentive payments to adopt EHRs. This eligibility may have a bearing on cost and other considerations during the selection process, depending on whether and with whom you share a practice.

   The job functions of any staff in your practice will determine who should have particular levels of access to different parts of your EHR, including scheduling, billing and charting.

4. **DON’T REINVENT THE WHEEL: LOOK AT YOUR CURRENT SOFTWARE.**
   If you are already using office management software (OMS), contact your vendor to see if they have – or know of – an EHR that is compatible with their OMS product.

5. **CONSIDER YOUR FUNCTIONALITY NEEDS.**
   Beyond practice management functions like billing, scheduling and charting, what do you want the new system to do? Do you want it to provide for data segmentation? If you are storing psychotherapy notes in your EHR, be aware that the Health Insurance Portability and Accountability Act (HIPAA) stipulates that extra protection must be added for this information. In this case, you would want your EHR to have data segmentation capabilities. Do you want your EHR to offer “glass wall” features that will allow for other practitioners – within and outside your practice – to have access to patient information in an emergency? Other features, such as voice dictation, decision/diagnosis...
Electronic Health Record System Selection Tool

This selection tool allows you to compare system functionality, vendor services and support, and cost for up to five different EHR vendors in order to help you select the EHR that may best meet your professional needs.

Directions: List up to five vendors whose products you are considering. Review the glossary below to help you understand terms used in the tool. For each EHR vendor, place a plus one (+1) or a minus one (-1) for each item under “Functionality” and “Vendor Services and Support,” indicating whether a particular vendor meets or doesn’t meet your practice’s needs or preferences with respect to those characteristics. Calculate the total for these two sections by vendor. For the “Cost” section, enter cost estimates as provided by the EHR vendor, and calculate the sum total.

Then place point totals from Functionality and Vendor Services and Support, along with the Cost total, in the final row in order to compare your results.

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APAPO Takes Aim at Declining Medicare Reimbursement

One factor has been a particular problem since 2007.

Any practitioner involved with third-party reimbursement is painfully aware of the downward spiral in payment rates. The national Medicare payment amount for the most commonly billed psychotherapy service, a 45-minute session, dropped from $98 in 2000 to $82 in 2012 – a 37 percent decrease adjusted for inflation.

Even so, there have been some high points along with the unfavorable developments related to Medicare payment for psychologists’ services since the federal government published the final regulation in 1998 defining the term “clinical psychologist” for purposes of Medicare participation (see timeline below).

What factors into Medicare payment

Medicare pays for all services based on a formula that values services relative to each other. The formula includes three main variables: work, practice expense and malpractice expense. The first variable – work – is intended to capture the time, skill and intensity involved in providing a service. Overall, the work values related to Medicare payment for psychological services have been stable in recent years. The third variable – malpractice – has a negligible impact on payment for psychological services.

Medicare Payment Timeline, 1998 to 2013 — 15 Years of Highs and Lows

1998
Final federal regulation defines the term “clinical psychologist” for Medicare participation and governs reimbursement for psychologists’ services.

2000
National Medicare payment rate for a 45-minute psychotherapy session: $98

2002
Medicare implements payment for new “health and behavior assessment and intervention” (H & B) billing codes developed by APA.

2004
Congress postpones the “Sustainable Growth Rate” cut from taking effect and continues doing so every year through 2013 as advocated by the APA Practice Organization (APAPO).

2006
Revised billing codes for psychological and neuropsychological testing are implemented. APA sought the codes to provide more appropriate reimbursement for psychologists who provide testing services.

2007
New process and subsequent adjustments to Medicare calculation of “practice expense” result in reduced payments to clinical psychologists annually through 2013.
That leaves the portion of the payment formula that captures overhead costs—including rent, utilities, equipment, supplies and staff—known as “practice expense.” It’s the main culprit behind plummeting payment rates for psychologists over the past several years.

Under the payment formula, the Medicare program increasingly pays more for technology-driven services. These services involve high overhead costs, and therefore high practice expense (PE). By contrast, clinical psychologists’ services are highly cognitive and work-intensive with low overhead.

Over the years, Medicare has adjusted the weighting of the work and PE values in a way that increases the PE value’s impact on the total payment amount. The upshot: Psychologists are penalized by a statutory payment formula that increasingly favors services involving higher costs for equipment and supplies.

According to Avalere Health, LLC, a leading health care advisory firm, the recent precipitous decline in Medicare reimbursement for psychologists is largely attributed to changes in methodologies used by the Centers for Medicare and Medicaid Services (CMS) to develop the “practice expense” component of reimbursement.

Though other Medicare providers are in a similar situation under the payment formula, various changes in PE valuation over the last several years have disproportionately affected psychologists. The PE portion of payment for psychological services has been reduced every year since 2007.

**Some high points**

Yet over the past 15 years, there have been high points along with the unfavorable developments in Medicare reimbursement.

In 2002, CMS began paying for new “health and behavior assessment and intervention” (H & B) codes developed by the American Psychological Association (APA). The H & B codes apply to services that address behavioral, cognitive and biopsychosocial factors in the treatment or management of patients with physical health problems.

**2007 (continued)**

Psychologists become eligible to participate in the Medicare reporting program known as PQRI (now PQRS) and receive bonus payments.

**2008**

New law increases psychotherapy payment by five percent following Medicare payment cuts in 2007. Psychology gains the psychotherapy payment restoration annually until 2012.

**2012**

National Medicare payment rate for a 45-minute psychotherapy session: $82 — 37 percent less than in 2000 adjusted for inflation.

**2012**

Review process spearheaded by Medicare results in revamping the psychotherapy code set used for all third-party billing effective 1/1/13.

**2013**

Key congressional committees beginning work on Medicare payment reform proposals invite input from APapo.

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**NOTE:** References to “Medicare” include the Centers for Medicare and Medicaid Services and its predecessor, the Health Care Financing Administration.
As such, they recognize psychologists’ services as encompassing health services delivery.

Four years later, revised billing codes for psychological and neuropsychological testing were implemented following successful advocacy by APA. The updated codes reflected who does the testing – a psychologist, technician or computer – and provided more appropriate reimbursement for psychologists who provide testing services.

Other developments in 2006 were not so auspicious. The Tax Relief and Health Care Act slashed Medicare reimbursement for mental health services by nine percent beginning in 2007. The APA Practice Organization (APAPO) immediately launched a grassroots advocacy campaign whose initial victory was the Medicare Improvements for Patients and Providers Act of 2007. That law included a provision increasing psychotherapy payments by five percent beginning in 2008. Thanks to sustained grassroots advocacy, combined with direct lobbying by representatives of APAPO, psychology gained this psychotherapy payment “restoration” every year until 2012.

Our advocacy agenda
Still, the bottom line is hardly rosy. Medicare payments to clinical psychologists have declined a cumulative 24 percent since 2007. Most of the decrease has resulted from changes in the process that CMS uses to value the practice expense component of services.

As evidenced by recent payment trends, the Medicare payment formula increasingly results in unfair and inappropriate reimbursement for clinical psychologists. APAPO and APA are advocating on both the regulatory and legislative fronts to gain necessary changes to the formula.

In addition to talking and meeting with the Centers for Medicare and Medicaid Services (CMS), Government Relations lobbyists and other APAPO representatives continue to work with key members and committees of Congress in anticipation of needing a legislative remedy.

Major elements of our ongoing advocacy include:
- Gaining meetings with top CMS officials, most recently another meeting with Jonathan Blum, deputy administrator of CMS
- Submitting formal comments to CMS in early September in response to the proposed Medicare fee schedule rule for 2014
- Securing regular meetings of APAPO lobbyists with key congressional health care committee members and staff
- Emphasizing Medicare payment issues in meetings during APAPO-PAC events
- Collaborating with Medicare payment experts to explore ways the formula could be modified slightly to ensure more appropriate reimbursement for psychologists
- Providing extensive input to congressional committee deliberations in response to invitations extended in 2013 by key House and Senate committees considering Medicare payment reforms
- Convening meetings of grassroots psychologists from throughout the U.S. with their elected officials on Capitol Hill about the need for Medicare payment reform. A record 330 visits to Capitol Hill took place during APAPO’s March 2013 State Leadership Conference.
Health Insurance Exchanges: An Overview for Psychologists  
continued from page 7

of 2008 applies to essential health benefits. Plans that do not already include mental health and substance abuse services, or include these benefits but not at parity with medical/surgical benefits, must supplement their plans to comply with federal parity requirements. However, HHS does not specify the process by which plans should supplement behavioral health benefits.

In addition, health plans may not discriminate against persons with chronic conditions. The ACA prohibits cost-sharing structures, utilization management techniques and benefit designs that discriminate against beneficiaries based on race, age, disability status, health status, life expectancy, having extensive health care needs or other characteristics. States will be required to monitor and identify discriminatory health benefit designs.

Also beginning in 2014, health plans in the individual and small group markets must meet certain actuarial values (AV). Each AV level is assigned a metal level indicating differing levels of coverage: 60 percent for the bronze plan; 70 percent for the silver plan; 80 percent for the gold plan; and 90 percent for the platinum plan.

The metal levels must all offer essential health benefits. However, there will be variability among the metal levels as to the percentage of costs covered. And within each metal level, there will be further coverage variability among the plans offered.

Nevertheless, these metal levels will enable consumers to compare plans within a similar level of coverage with comparable deductibles and copayments in order to make informed decisions about health care coverage. For example, in comparing plans under the silver level, consumers would view those plans that would pay an estimated 70 percent of costs for all covered benefits in that plan, making the consumer responsible for approximately 30 percent of costs. In addition, there will be an annual limit on out-of-pocket costs for individuals and families. This amount will vary according to the metal levels.

Health insurance exchange models

The exchanges are being established in one of three ways:

- State-based exchange where the state is responsible for creating and managing its own exchange
- State partnership exchange where the state partners with the federal government and each performs certain functions in support of the exchange’s operations, or
- Federally facilitated exchange (FFE) where the federal government will manage exchange operations in those states that have not chosen to establish their own exchange or partner with the federal government.

In a majority of states, the health insurance exchanges will either be managed by the federal government as a FFE or as a partnership between the federal and state governments. In those states, HHS and the Centers for Medicare and Medicaid Services (CMS) have been coordinating with local, state and/or regional leadership in developing the FFE and state partnership exchanges to meet the October 1, 2013 deadline.

The map on page 7 identifies the model that each state is pursuing.

Information about each state’s exchange is available on the CMS website: go.cms.gov/19oQFmS.

Issues for psychologists to consider

While the purpose of the health insurance exchanges (HIEs) is to benefit consumers, there are issues related to the development and implementation of HIEs that impact psychologists and other health care providers.

CMS has been reviewing applications submitted by health insurance and managed care companies seeking certification as Qualified Health Plans (QHPs), enabling those plans to be offered through the exchange. The companies must demonstrate that the plan maintains a network with a sufficient number and type of health care providers, including those providers specializing in mental health and substance abuse services, to ensure that the plan offers benefits under all ten identified essential health benefits categories.

Importantly, while the plans must ensure that there are a sufficient number of providers and types of providers to provide the essential health benefits, the ACA does not specify what providers, or how many, must actually be included in the provider network to satisfy the network adequacy criterion. So while mental health and substance abuse services are an essential health benefit category, that requirement does not necessarily mean that the provider panel must be substantially composed of psychologists.

Psychologists should find it worthwhile to educate themselves as to which plans will be offered through the exchange in their state to help them decide whether they would like to participate in any of those provider networks. With the anticipated increased number of Americans gaining access to coverage for mental health and substance abuse services in 2014, QHPs arguably will need to supplement their networks with additional providers, especially in behavioral health, to accommodate their insureds.
Likewise, it is important to understand how your state defines the scope of mental health and substance abuse services. The EHB-benchmark plan identified by your state will indicate the coverage benefits and limitations. It is worthwhile to review that information to determine if there are any applicable coverage limitations for mental health and substance abuse services, to understand the mental health benefits that will typically be offered in your state and to ensure that those benefits comply with federal parity requirements. Additional information is available from the Centers for Medicare and Medicaid Services at go.cms.gov/16lEk6.

Most states have been actively working with local stakeholders to design and implement health insurance exchanges. Members can check with their state psychological association to find out how the association is involved as a local stakeholder in the HIE implementation process. While much work already has been done to prepare for the January 1, 2014 deadline, the HIEs will continue to evolve in the coming plan years.

Psychologists who are currently in-network providers should consider the following issues:

- **Confirming your in-network status.** Although you may currently be an in-network provider for an insurer that has been certified as a QHP to offer coverage through the exchange, it is possible that you may not be in-network for that insurer’s exchange plans. Psychologists are encouraged to check their provider contract for an all-products clause, which would prevent providers from opting out as in-network providers for the exchange plans unless the provider chooses to terminate his/her in-network status altogether. Some insurers may be using narrow networks for their exchange plans, offering substantially smaller networks of providers and hospitals than what is offered under current commercial plans. So it is important to clarify your status with the insurance company if you are serving on any network panels.

- **Assignability provisions.** Psychologists who now contract with insurance companies as in-network providers should review their provider contract for an assignability provision. This kind of provision would allow the insurance company to assign you to another company’s network for specified reasons (for example, the company may agree to “lease” its network to another company, or if the company is acquired by or merges with another company). This provision would also mention whether the insurance company is required to notify you of this assignment and if so, what the notification requirements are.

### HOW MEDICAID AND HEALTH INSURANCE EXCHANGES INTERACT

Implementation of the Affordable Care Act (ACA) is expected to lead to the enrollment of tens of millions of uninsured individuals who will become newly eligible for health insurance through Medicaid and the health insurance exchanges (HIEs). The expansion of state-level Medicaid programs and the development of HIEs are meant to work together to improve access to coverage.

See the August 29, 2013 PracticeUpdate e-newsletter article, “Medicaid and the New Health Insurance Exchanges: Do You Know How They Interact?” from the APA Practice Organization for details. The content appears at apapRACTICECENTRAL.ORG/UPDATE/2013/08-29/medicaid-hie.aspx. This e-newsletter article concludes a four-part series in PracticeUpdate about HIEs that began on April 25, 2013.

- **Provider notifications.** If you are an in-network provider, review any provider notifications that you receive either by US mail or e-mail to check for any changes to your contract.

- **Network directories.** Check to see if you are listed in the insurance company’s online provider directory and if so, whether your listing is accurate. If you had previously served on a network panel but no longer accept insurance, check to see that you are not still listed in the provider network directory. CMS expects the network directory to include contact information, location, specialty (if applicable), and any institutional affiliations for each provider in the network.

- **Cost-sharing requirements.** As an in-network provider, it will be important to be aware of any cost-sharing requirements, as mental health services are a specified category that CMS will be evaluating for discriminatory practices.

- **Complaints and appeals processes.** QHPs are required to comply with specific requirements governing internal claims and appeals and external review. Psychologists should review their provider contract and any addenda containing contract changes that may revise the appeals process. Also, it is important to note what kind of exchange will be established in your state to determine who or what agency will be responsible for addressing consumer complaints.
10 Tips for Selecting an Electronic Health Record System  continued from page 10

support tools, a web portal that enables patients to view their health records, and an internal email system might also be available.

Does the EHR meet various federal standards, such as HIPAA compliance and Meaningful Use Criteria? For the former, you want to ensure the utmost safety and security of your records. For the latter, if you meet these criteria, your practice may be eligible for federal HIT incentive payments. While psychologists are not currently eligible for these incentive payments, sharing a practice with other health and mental health professionals such as a psychiatrist or nurse practitioner may make your practice eligible.

6  DETERMINE WHETHER YOU WANT A SYSTEM BASED IN YOUR PRACTICE OR A CLOUD-BASED SYSTEM.

Some EHRs hosted at your office require that you purchase additional hardware (for example, an upgraded computer and server) and use proprietary software to run the product. Other EHRs provide access to a cloud-based system that can be accessed from anywhere – including a work PC, tablet or even a smartphone. Be aware that proprietary systems tend to be more expensive, for example, if they require technical support from an expert outside the practice.

7  MAKE SURE THE VENDOR IS CLEAR ABOUT ALL COSTS INVOLVED.

Many factors affect the cost of transitioning to an EHR, although not every EHR is accompanied by a hefty price tag. Each EHR vendor will be able to provide you with information regarding the following costs: fees for initial start-up costs (including software/hardware purchases and training); monthly subscription fees; how subscription fees are allocated (charged per provider or globally as a practice); and special à la carte options that can be added onto the software at your request.

8  LEARN HOW VENDORS CAN DEMONSTRATE THEIR PRODUCTS.

After reviewing several EHR products while being mindful of the above considerations, begin contacting vendors in order to obtain additional information that may not be provided on their websites. Many vendors offer free product demonstrations over the Internet and will be happy to walk you through their product.

If you want a more comprehensive overview of their EHR system and how the vendor intends to help you in the transition process, submit a Request for Proposal (RFP). Completing an RFP can be time-consuming for vendors, so be sure only to submit an RFP to companies whose products you are seriously considering buying. Knowledgeable colleagues may be able to suggest a sample RFP that you can customize for your practice.

9  USE THE VENDOR SELECTION TOOL ON PAGE 11 TO HELP YOU COMPARE OPTIONS.

Given the range of considerations inherent in the EHR selection process, you might experience a sense of information overload. Use the selection tool on page 11 in order to rate and compare your top five vendors.

Check the website of Certification Commission for Health Information Technology (CCHIT) to determine whether a vendor product you are considering is certified by CCHIT.

10  LOOK AHEAD TO TRANSITIONING TO THE NEW EHR SYSTEM.

Depending on the type of EHR you select, your transition experience will vary. For instance, many cloud-based EHR systems will help you to train your staff in the use of the new system remotely via a webinar. Alternatively, if you decide to purchase a server and host your own EHR, a vendor may send staff to train you and any employees in your practice.

A related tip: Have one or two individuals in your practice designated as being in a “train-the-trainer” position. Typically, an EHR vendor will train you and/or an administrative staff member to teach others, including new employees, how to use the software.

For additional information about electronic health records, including recent articles and webinars, please visit the APA Practice Organization’s Practice Central website at apapracticecentral.org. If you have additional questions regarding health information technology, you may contact APA Practice Directorate’s Practice Research & Policy Department at prcresearchpol@apa.org.
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Type 1 and Type 2 Diabetes

Type 1 diabetes, or insulin-dependent diabetes, is usually diagnosed in children and young adults. There are few known risk factors, though family history may play a role. Type 2, or insulin-resistant diabetes, is most often diagnosed in adults, though the rate of type 2 in youth is on the rise. In contrast to type 1 diabetes, type 2 may not require insulin injections and can often be controlled with lifestyle changes, oral medications or both. Obesity, inactivity, family history and poor diet are risk factors for type 2 diabetes.
You’ll talk about all aspects of your life, such as work, home, family and social situations, to help you identify specific challenges you might face. For example, do members of your family prefer to keep unhealthy food in the house or is there a tempting candy jar at work? The psychologist will also discuss what you are already doing well and which behaviors related to diabetes management you can improve. He or she may ask you to keep a diary of different things, such as your eating behaviors, activities, emotional reactions or thoughts. After the initial visit, you and the psychologist will schedule follow-up visits and begin to create a treatment plan.

### Six Steps to Living Well With Diabetes

Consider the following steps that can be helpful in changing unhealthy habits and managing thoughts and behaviors.

1. **Get the facts.** Learning about diabetes and understanding your specific diagnosis will help you make informed decisions to manage your condition. Prior to a visit to your physician or other health care provider, consider making a list of questions or concerns to address.

2. **Accept your feelings.** Studies show that people who acknowledge negative feelings about their diabetes are better at caring for themselves and keeping glucose levels stable. For example, if you get anxious by the sight of a sugary snack and how it can affect you physically, pay attention to the feeling instead of ignoring it. Avoiding negative thoughts and feelings about diabetes, like worrying about what to eat, can bring on stress.

3. **Maintain a balanced perspective.** Don’t allow diabetes to become your main focus; the disease doesn’t have to define you. You’re the same person you were before your diagnosis, so continue to do things you enjoy as you learn to live well with your disease.

4. **Be realistic.** Rules that are too rigid are more likely to be broken. Set small goals that are easily attainable, such as walking for 10 minutes a day and slowly building up to 30 minutes or more over several weeks to increase your exercise.

5. **Try new things.** While diabetes may require significant changes to your lifestyle, it also provides an opportunity to try new recipes, foods or activities.

6. **Develop a strong support network.** Studies show that people are more likely to follow health regimens when they have a support network. And research specific to diabetes patients found those who have support from family and friends have healthier blood sugar levels during times of high stress. So, communicate with family and friends about how they can help you.

### Diabetes and Stress

Stress has been associated with an increased risk of type 2 diabetes.

When you’re under stress, your body signals its nervous system and pituitary gland to produce epinephrine and cortisol, known as “stress hormones.” When cortisol and epinephrine are released, the liver produces more glucose, a blood sugar. For people who are already diabetic or at risk for diabetes, that extra blood sugar can be dangerous to their health.

Studies show that if you learn how to manage stress, you can better control your blood sugar levels. So regulating stress levels is an important component of treating diabetes.

The American Psychological Association gratefully acknowledges Teri L. Bourdeau, PhD, ABPP, Clinical Assistant Professor of Behavioral Sciences and Director, Behavioral Health Services, Oklahoma State University; Gareth R. Dutton, PhD, Associate Professor, Division of Preventive Medicine, University of Alabama at Birmingham, Nutrition Obesity Research Center; and Amy Walters, PhD, Director of Behavioral Health Services at St. Luke’s Humphreys Diabetes Center in Boise, Idaho, for contributing to this fact sheet.
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STEP 2: Customize
STEP 3: Preview, Edit
STEP 4: Launch Site