Reporting Child Abuse and Neglect
Integrating Behavioral and Physical Care
Assessing Personality and Advocating for the Profession
Keeping Electronic Health Records Private and Secure
How Much Do You Know about Electronic Health Records?
Combating the Downward Spiral in Medicare Reimbursement
How Psychologists Help with Weight Management
Why Making a Sandwich Can be Hard.

1. Take bread out
2. Place bread on counter
3. Open fridge
4. Look for cheese
5. Can’t find cheese
6. Look for cheese
7. Can’t find cold cuts
8. Find cold cuts
9. Close fridge
10. Forgot cheese
11. Place toppings on counter
12. Open fridge again
13. Grab mayo
14. Forget to close fridge
15. Place mayo on counter
16. Forgot cheese
17. Look in fridge again
18. Find cheese
19. Place cheese on bread
20. Place cold cuts on bread
21. Add mayo
22. Close sandwich
23. Eat sandwich

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PUBLIC EDUCATION RESOURCE: How Psychologists Help with Weight Management

* This fact sheet educates consumers and health care professionals about how psychologists help patients manage their weight. To make photocopies for distribution and outreach activities, remove the article along the perforated edge. To download this fact sheet and other client resources, visit the APA Help Center at apa.org/helpcenter.
Reporting Child Abuse and Neglect

Learn about psychologists’ duties as mandated reporters.

All 50 states and the District of Columbia have child abuse and neglect reporting laws and policies that specify who is required to make a report as well as reporting procedures. Almost all states specifically mandate that certain types of professionals – including psychologists, physicians, teachers and others – immediately report suspected child abuse or neglect. The details of state laws vary, but the goal is the same: to protect vulnerable children from harm.

This article describes several important issues and professional considerations for practitioners related to child abuse reporting.

Limits to confidentiality

In most situations, legal and ethical duties require psychologists to keep information obtained in the course of psychotherapy confidential. The APA Ethical Principles of Psychologists and Code of Conduct (“Ethics Code”) Standard 4.01 states: “Psychologists have a primary obligation to protect confidential information...recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.”

Yet Ethics Code Standard 4.05(b) describes several situations in which disclosure of confidential information is allowed without patient consent, including “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 specifically permits covered health care providers to disclose reports of child abuse or neglect to public health authorities or other appropriate government authorities (www.apapracticecentral.org/business/hipaa/2009-privacy.pdf).
The crucial need to protect children from abuse and neglect, combined with children’s vulnerability, make this one of the few areas in which psychologists are legally mandated to release confidential information. In essence, society has determined that protecting children outweighs the right to confidentiality in these situations.

Varying requirements in child abuse reporting laws

State laws typically require psychologists (and other mandated reporters) to immediately make a report when, in their professional roles, they suspect or have reason to believe a child has been abused or neglected. However, state laws and regulations vary regarding more specific issues such as how abuse and neglect are defined and the procedures for making a report. Therefore, it is important to be knowledgeable about the reporting requirements in your jurisdiction.

The Department of Health and Human Services (DHHS) Child Welfare Information Gateway provides information on how each state defines child abuse and neglect at 1.usa.gov/ZJ7acs. The federal Child Abuse Prevention and Treatment Act defines child abuse and neglect as:

“at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm” (CAPTA Reauthorization Act of 2010, P.L. 111-320, § 3).

State laws generally include similar elements, with some states defining abuse and neglect more broadly than other states. For example, certain states define child abuse to include only those situations in which the alleged perpetrator is a parent or guardian, whereas other states define abuse more broadly to include acts perpetrated by any adult.

States may also differ regarding the reporting of past abuse. Most states’ laws or other guidance clearly limit reportable situations to those involving children currently under the age of 18. For example, Washington’s statute specifically states: “The reporting requirement...does not apply to the discovery of abuse or neglect that occurred during childhood if it is discovered after the child has become an adult. However, if there is reasonable cause to believe other children are or may be at risk of abuse or neglect...the reporting requirement...does apply” (RCW § 26.44.030(f)(2)).

Some states’ laws are unclear and could be interpreted as requiring a report even in cases of abuse alleged to have occurred many years ago. If you are unsure about whether to report past abuse of a patient who is now an adult, contact your state board of psychology, state child protective services agency, or your malpractice insurer for guidance. (Please note that the title of the agency charged with child protection in your state may be child welfare, child and family services, or another similar title.)

A potentially complex situation arises when the abuse occurred in another state and/or the abuser now lives in another state. In such cases, contact your state’s child protective services agency for advice. Your state’s child protective services agency may be able to receive a report and coordinate investigative efforts with the other jurisdiction involved. You are unlikely to be mandated to report across state lines or permitted to release confidential information to another state’s child protective services agency without your patient’s consent.

Making a report

Information about how to report suspected abuse is generally easily accessible on state government websites. Many states provide detailed online resources for mandated reporters (as well as voluntary reporters) on their websites covering topics such as circumstances that need to be reported and when and how to make a report.

The DHHS Child Welfare Information Gateway is another excellent resource for more detailed information on mandatory reporting of child abuse, including specific state requirements (1.usa.gov/ZlnCQD).

Most child abuse reports are made by calling your state’s child abuse reporting hotline. A list of hotline numbers and other relevant contact information is available at 1.usa.gov/13v8rDV.
The child abuse reporting laws tend to be constructed broadly in order to provide maximum protection for children.

The hotlines may also be used to obtain guidance, particularly if you are unsure about whether a particular situation triggers a duty to report. You should be able to obtain a consultation from the hotline staff without releasing any identifying information about yourself, the child or the alleged perpetrator.

In addition to an oral report, about 20 states require subsequent submission of a written report. For example, in Iowa, mandated reporters must call the Department of Human Services reporting hotline within 24 hours of becoming aware of suspected abuse and must submit a written report within 48 hours of the initial phone report.

States also vary regarding the specific information that must be provided for an initial report, as well as the types of information that may later need to be released for purposes of any investigation. Before releasing any information beyond what is clearly required for an initial mandated report, be sure that you have legal authority to do so under the child protection laws and regulations, or that you have authorization from the child’s legal representative, usually the parent. Of course, obtaining authorization for release of information from the legal representative will only be a reasonable option if the parent or other legal representative is not the alleged perpetrator.

Anonymity and immunity

The DHHS Child Information Gateway also provides state-specific information on anonymity and immunity (1.usa.gov/ZlnCQD; 1.usa.gov/ZloeFW). According to DHHS, all states have statutory provisions to maintain the confidentiality of abuse and neglect records. In addition, most states permit mandated reports to be made anonymously and specifically protect the reporter’s identity from disclosure to the alleged perpetrator. However, release of the reporter’s identity may be allowed in some jurisdictions in specific circumstances – for example, by court order when there is a compelling reason.

DHHS also confirms that all states and the District of Columbia provide some form of immunity from liability for individuals who in good faith report suspected child abuse or neglect. Most states provide immunity not only for the initial report, but also for many of the actions that a reporter may take following the filing of a report. One example is assisting with an investigation or participating in a judicial proceeding based on the alleged maltreatment.

Beyond mandated reporting

Not all reports result in investigations. For example, you may have insufficient information about the alleged perpetrator for an investigation to go forward. The child abuse reporting laws tend to be constructed broadly in order to provide maximum protection for children, so they may capture situations such as those in which you have only minimal information about the abuse or where an investigation is already under way. Keep in mind that as a mandated reporter, you are not responsible for investigating or proving the suspected abuse.

Even if you are not mandated to report child abuse in a particular situation, there may nonetheless be clinical or ethical issues that need to be addressed. For example, if a child you are treating describes inappropriate physical contact by a neighbor and mandated reporting in your state is limited to situations in which the alleged abuser is a parent or legal guardian, you will nonetheless want to take action. In this case, you might decide to alert the child’s parents and encourage them to take legal and/or other protective actions. You may also be in a unique position to help your patient and your patient’s family by continuing therapy with the child and providing resources such as information about support groups to the parents.

Another example of a situation that requires action other than reporting to a child abuse hotline is when you believe your patient or another person is in imminent danger of serious harm. In such cases, you may be permitted or mandated to release confidential information pursuant to Ethics Code Standard 4.05(b) and relevant state laws, including those governing the “duty to protect.” (For further information, see “A Matter of Law: Psychologists’ Duty to Protect” at www.apapracticecentral.org/business/legal/index.aspx.)
The critical role of informed consent

Thorough informed consent procedures will make it easier for you to work with children and their families if you are later confronted with a reportable situation. Your informed consent procedures should address, preferably both in writing and verbally, exceptions to confidentiality – including the duty to report child abuse or neglect.

Ethics Code Standard 4.02(a) states: “Psychologists discuss with persons (including to the extent feasible persons who are legally incapable of giving informed consent and their legal representative)...the relevant limits of confidentiality.” Especially when working with older children and adolescents, there should be a clear understanding that is documented in your informed consent agreement about the specific types of information that will be considered confidential and the circumstances under which such information may be disclosed.

If you do need to make a report, it may make sense to discuss the situation with your patient and/or a minor patient’s parents, even if you are allowed to make the report anonymously. The advisability of doing so will depend on factors such as the age of your patient, the nature of the family members’ involvement and clinical considerations. Explaining your legal obligations and emphasizing the goal of child protection may help to maintain the family’s trust and enable you to continue in a therapeutic role.

If you have further questions about mandated reporting of suspected child abuse, please contact the APA Practice Legal and Regulatory Affairs Department at praclegal@apa.org or 800-374-2723.

*The terms “abuse” and “abuse or neglect” may be used interchangeably in this article.

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


If Robin Henderson, PsyD, gets her way, the hospital where she works will slowly contract. “I have a running joke with our CEO that I’ll know we’re successful when the hospital’s fifth floor becomes a yoga studio,” says Henderson, director of government affairs at St. Charles Health System in Bend, Ore.

Henderson hopes to improve the health of central Oregon’s residents so much that hospitalization rates drop dramatically, a goal she’s helping to achieve by integrating psychologists into every level of the health system.

Henderson isn’t the only one driving such integration. With health care reform encouraging greater consolidation among health service professionals and organizations, the trend is toward integrating mental health, behavioral health and substance use services in all kinds of treatment settings.

Of particular interest to psychologists are emerging opportunities in new types of settings, such as patient-centered medical homes and accountable care organizations. But whether integration takes place in primary care or at the health system level, the “triple aim” goals are the same: enhancing the experience of care, improving the health of populations and reducing costs.

Integrating primary care

Primary care as traditionally practiced can’t achieve that triple aim, says Frank V. deGruy, MD, who chairs the department of family medicine at the University of Colorado School of Medicine. That’s because traditional primary care is problem-focused, not patient-centered, he says.

“Primary care practices are built on the assumption that the basic problems we’re set up to deal with are acute care problems,” says deGruy, citing as examples cystitis and ear infections. Yet 80 percent of health care dollars are spent on chronic conditions, he says, which can’t be handled the same way acute problems can. “You can’t wait until diabetic people can’t see or need their foot amputated,” he says. “You have to get people into a program of care before they’re physically or psychologically symptomatic.”

Enter the patient-centered medical home, which offers care that goes beyond what’s offered in what deGruy calls the traditional “reactive” form of primary care. Focusing on chronic disease, patient-centered medical homes at their most basic feature care managers who coordinate services, quality improvement initiatives and disease registries that help clinicians keep track of patients with specific diseases and identify gaps in care.

But to truly achieve better care, health and costs, says deGruy, patient-centered medical homes have to be comprehensive. Up to two-thirds of deGruy’s patients meet the diagnostic criteria for mental health disorders, have psychological symptoms or substance abuse problems that are impairing their health or have chronic physical conditions that require difficult behavior change, he estimates. “Lucky for us, there’s an easy way to become comprehensive,” he says: incorporating behavioral health care into everything a patient-centered medical home does.

In addition to joining patient-centered medical homes in primary care settings, psychologists can help in other ways. “The patient-centered medical home is no more than a small island in a sea of health care resources,” says deGruy. “I invite you to be in our patient-centered medical homes, but you also need to be in a lot of other places.”
Psychologists and other specialists in the community can help individuals make their personal care plans work, for example. They can use the same integration model that works in primary care in more specialized settings such as neurology practices and pain clinics.

Working this way creates practice opportunities for some psychologists. However, according to deGruy, hospitals and the health system as a whole “face a very interesting predicament.” That’s because when health care is done right, he says, the result is fewer hospital admissions and lower revenues for health systems.

“Why would a hospital that depends on admissions contribute to the development of a system that results in fewer hospital admissions?” deGruy asks. “It’s a question that hospitals are answering right now.”

**Integrating health systems**

St. Charles is one of the health systems busy answering that question. The answer lies in new financing mechanisms, such as bundled payments, capitation and shared savings programs, in which hospitals and health systems are beginning to assume some risk.
Assessing Personality and Advocating for the Profession

Practitioner Profile: Mark Alan Blais, PsyD

Back when Mark Alan Blais, PsyD, was a psychology major at the State University of New York at Cortland in the 1970s, behavioralism ruled.

“I remember my personality instructor telling us personality was a construct that occurred as you interacted with the environment, that there weren’t really these traits inside you,” he remembers. “That didn’t strike me as real, because I was 450 miles from home but still pretty much the same person.” That experience prompted Blais’ interest in personality. And, he says, “I’ve been hooked ever since.”

After earning a clinical psychology doctorate from Nova Southeastern University in 1990 and doing a post-doc at Massachusetts General Hospital, Blais now directs the Psychological Evaluation and Research Laboratory at Mass General. He’s also the hospital’s associate chief of psychology and an associate professor at Harvard Medical School.

Over the course of his career, Blais has conducted personality and neuropsychological assessments of adults with all kinds of issues. His patients have included individuals about to enter religious orders, business executives whose companies want to ensure they’re capable of greater challenges, and the Boston Red Sox.

Blais’ specialty, however, is complex cases – individuals with multiple psychiatric diagnoses, psychological problems that don’t map onto one clear diagnosis, along with neurological problems like head injuries and other medical issues that have “baffled their treaters,” says Blais, who won the Theodore Millon Award for advancing the science of personality psychology from the American Psychological Foundation and APA’s Div. 12 (Society of Clinical Psychology) in 2009.

Blais’ findings can help those treaters – many of them psychiatrists – decide how to change treatment plans so patients make better progress.

Based on findings from what’s typically a four-hour battery of personality assessment instruments, Blais might recommend that a clinician focus more on psychotherapy than psychopharmacology. He might suggest more aggressive treatment of a mood disorder. Or he might discover that an individual could better benefit from a more structured, behaviorally-oriented, problem-solving form of psychotherapy than the type of intervention currently being used.

Psychologists are uniquely qualified for this work, says Blais.

“We’re the only discipline really trained to do personality assessment” says Blais, co-editor of Clinical Applications of the Personality Assessment Inventory (Routledge, 2010). “It’s an area where psychologists at a medical facility like Mass General can have their own area of authority, set guidelines and create their own policies and procedures.”

Opportunities and challenges

According to Blais, health care reform is bringing new hope as well as concerns for psychologists specializing in personality assessment.

On the plus side is reform’s emphasis on integrating behavioral and physical health care. “Health care reform is going to move a lot of services into primary-care settings, which is going to be great,” says Blais, explaining that there will be increased emphasis on rapidly identifying common psychological conditions like depression, anxiety and substance misuse. Psychologists will have a crucial role to play in designing such screening programs and determining how to use resulting data. But, he says, “We can’t let people think that because you’ve screened for
depression, anxiety and alcohol misuse, you’ve done a comprehensive evaluation.”

Another new role for psychologists specializing in personality assessment is demonstrating treatment outcomes. Blais and his colleagues have already developed an innovative model for tracking their patients’ treatment progress.

At their first appointment, patients fill out an intake version of the treatment monitoring instrument. Every 13 weeks thereafter, the system triggers the generation of a form with standard outcome measures. Patients use a “smart pen” to fill out the form. Although they write like regular pens, these devices photograph the information inscribed and then upload it to a server when docked at night. The information then flows into the hospital’s electronic medical record system.

Blais notes that the process was developed with the hospital’s information technology department and complies with Health Insurance Portability and Accountability Act (HIPAA) requirements.

This technology allows clinicians to easily track whether patients are progressing or deteriorating. The data generated by this system is analyzed using the Reliable Change Index and Clinically Significant Improvement methods developed for psychotherapy research. “These indices were created by psychologists,” says Blais, adding that these analyses take into account statistical factors, such as regression to mean along with score variations due to differences in standard deviations and sample sizes.

“We’re the only mental health discipline – or even health care discipline – trained in measurement and psychological evaluation,” says Blais. “We’re also unique in that we’re all trained in statistics.”

As health care reform implementation continues, psychologists must also get involved in designing appropriate electronic medical records, says Blais. And they should get involved now.

While electronic medical records may not be implemented for a few years, the groundwork is being laid now. “If psychologists, especially those at institutions, aren’t actively giving input about what instruments and what kind of data manipulation they want to do in the beginning, it’s going to be very hard to have much impact when it’s rolled out at the end,” he warns.

A “mosaic” of a career

Blais doesn’t just conduct psychological assessments. In fact, he conducts just half a dozen a month.

“I’m one of those lucky people with a job that’s like a quilt or mosaic,” says Blais.

In addition to personality assessment, Blais sees patients, mostly men around his own age, for short-term psychotherapy. “Men of my generation – say 45 to 65 years of age – underutilize mental health services in general and psychotherapy in particular,” he says. “It can be helpful when a primary care doctor says, ‘I have someone you can see who specializes in talking with men.’”

Blais also supervises psychology interns and post-doctoral fellows. He teaches a seminar on personality assessment. And he conducts assessment research and test development projects.

One of the things Blais is proudest of is his work with colleagues to create the Schwartz Outcome Scale (SOS-10), a 10-item measure of well-being versus distress that asks patients questions like whether they have peace of mind or can have fun, not whether they’re depressed or have severe mood swings. The scale has been translated into French, Arabic, Chinese, Spanish and other languages.

Blais has also created a model of personality that helps those conducting personality assessments write integrated comprehensive reports. “One of the most difficult things to do is integrate the vast amount of data an assessment creates,” says Blais, explaining that comprehensive evaluations can produce more than 150 points of information that must be incorporated with the patient’s clinical history and psychologist’s clinical observations. “It can be overwhelming,” he says. “You can wind up picking and choosing the data that’s easiest to report.” To prevent that, Blais’ personality model – and the worksheets that

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Keeping Electronic Health Records Private and Secure

Some basic practical guidance for psychologists

Alan Nessman, JD, of the American Psychological Association (APA) Practice Directorate knows how a lot of professional psychologists react when the subject of ensuring the privacy of electronic health records comes up: They either fall asleep, or they panic.

“There’s all this jargon,” admits Nessman, senior special counsel for legal and regulatory affairs. “It can feel like 10 techno-geeks got together to write the rules.”

But while security issues for electronic health records can seem daunting, psychologists shouldn’t be intimidated, says Nessman. Nor should they ignore the issue, thinking, “Well, I haven’t seen the HIPAA police take anyone off in handcuffs, so I’m not going to worry about it,” he says. Instead, practitioners should familiarize themselves with the terminology involved, take some easy steps to protect their patients’ privacy and reach out for help as needed.

“My message is that there are simple ways to do it,” says Nessman.

Understanding the lingo

The first step is simply to understand the terms used in the realm of electronic health records, says Stacey Larson, JD, PsyD, the APA Practice Directorate’s director of legal and regulatory affairs. The directorate fields many calls from psychologists asking even the most basic question: What is an electronic health record?

Basically an electronic version of all of a patient’s paper records brought together in one place, electronic health records focus on a patient’s total health. They are designed to be “interoperable,” meaning they can be shared with other health care providers. If used meaningfully, she says, they can improve the accuracy of diagnoses and quality of care, improve coordination among all the health care providers patients see and even lower practitioners’ costs, thanks to savings from reduced paper use and office space.

Don’t confuse electronic health records with office management software, adds Larson. While both are electronic, office management software is designed to help practitioners with such tasks as appointment scheduling, messaging and billing. The key difference is office management software’s lack of interoperability, or the ability to exchange information with other health care providers.

It’s the interoperability of electronic health records that gives many professional psychologists pause, says Larson. Many fear that the very feature that makes it possible to share information with other providers also heightens the possibility that information will fall into the wrong hands.

Plus, professional psychologists are often confused by the language used in debates about electronic health records. Privacy, Larson explains, is a patient’s right to decide what information providers can share or should withhold. Confidentiality is the provider’s responsibility to protect that privacy. Security is the means by which providers achieve that goal of preventing unauthorized access.
Electronic health records are covered under the Health Insurance Portability and Accountability Act (HIPAA). Psychologists using electronic health records may not know it, says Nessman, but they’re required to comply with the HIPAA Security Rule. That means you must conduct a structured analysis of the various risks patient data could experience – such as unauthorized access or loss in a fire or flood – and take measures to protect against those security risks.

In January 2013 the federal government released the HIPAA Final Rule, which further enhanced patient privacy protections. (See “HIPAA Final Rule highlights for practitioners” in the March 14, 2013 issue of the PracticeUpdate e-newsletter at www.apapracticecentral.org/update/2013/03-14/final-rule.aspx.)

Take breach notification, for example. “It used to be that if information was encrypted, you didn’t have to worry,” says Nessman, citing a stolen laptop or hacked computer system as examples of potential breaches. After the compliance deadline of Sept. 23, 2013 arrives, however, a little more will be required.

Recognizing that the breach may be the work of a staff person who has the encryption key, the government now requires practitioners to perform a relatively simple risk assessment to determine if there is a low probability that protected health information was compromised. If the probability is higher, practitioners must alert the patients affected as well as the federal government. Except in cases where a staff member with the encryption key is suspected in the breach, encryption will generally save the practitioner from having to give breach notification because of the low risk.

The APA Practice Organization will provide further information to members on how to conduct this risk assessment, and how to adapt to other key changes in the HIPAA Final Rule before the September 2013 compliance deadline.

Putting security in place

You can’t just ignore all this and hope for the best, warns Nessman, acknowledging that the rules are extremely complicated.

For one thing, the government has stepped up enforcement efforts. In previous years, he says, the government seemed to only investigate major breaches involving hundreds of thousands of records. These days, they’re actually on the lookout for problems and have even made examples of a few small providers. “An ounce of prevention is worth a ton of cure,” he says.

The government is especially interested in practitioners who haven’t even invested that ounce of prevention, says Nessman. “The highest penalties are for people who haven’t tried to do anything,” he says. “People who haven’t taken any steps to comply: Wake up.”

And take the detailed, comprehensive approach required by the Security Rule, he says. The following tips can get you started, and will be important components, but they will not result in a practitioner being fully compliant:

• **Cover the basics.** Make sure home and office wireless connections are password-protected, says Nathan Tatro, project manager for practice research and policy in the Practice Directorate. When wireless connections aren’t secure, he warns, “A smart hacker could use your wireless connection to track keystrokes from your computer.” Similarly, if you’re using a mobile device to communicate with patients, make sure all data are encrypted, lock the device with a password and set it to go into locked mode if a few seconds go by without use. There are even applications that allow you to remotely erase your device’s files if it has been lost or stolen. And you should probably go ahead and delete text messages from patients after you’ve read them, says Tatro, urging practitioners to limit what information they keep on mobile devices in the first place.

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How Much Do You Know about Electronic Health Records?

Electronic health records (EHRs) are designed to replace a patient’s paper record while integrating care across practice settings. As health care reform proceeds with an emphasis on integrated care, the ability for mental health professionals to collaborate with other health providers across practice settings will be critical to participation in the health care system. The use of EHRs is a key element of collaborative care.

This quiz highlights several core components of EHRs and is designed to raise awareness of professional considerations when transitioning from paper records to EHRs.

1. The primary difference between office management software (OMS) and an EHR is:
   - A. The applicability of standards related to the Health Insurance Portability and Accountability Act (HIPAA) and The Health Information Technology for Economic and Clinical Health (HITECH) Act
   - B. The capacity for interoperability
   - C. Billing functionality
   - D. User-based access functions

2. True or false? If a patient asks for a copy of his or her record, a psychologist must provide it.

3. Many EHRs now offer mobile applications (“apps”) that allow providers to access patient records on a smart phone, iPad or similar mobile device. HIPAA and the HITECH Act require a psychologist using apps to take precautions to ensure that “protected health information” (PHI) remains secure. PHI includes which of the following:
   - A. A patient’s phone number
   - B. A patient’s insurance information
   - C. Text messages to/from the patient
   - D. A patient’s medical record number
   - E. None of the above
   - F. All of the above

4. What can you do in order to safeguard your mobile device or tablet against a potential breach?
   - A. Make sure that you are accessing records through a secure wireless (wi-fi) internet connection
   - B. Ensure that your data is encrypted
   - C. Deactivate mobile-to-mobile sharing functions on your device
   - D. None of the above
   - E. All of the above

5. True or false? Role-based access for EHRs means that all practitioners who have the same role in a practice use the same login credentials – the same username and password – to access and amend patient records.

6. Data segmentation refers to:
   - A. Separating patient data within your EHR to make it easier for you to find
   - B. Using separate billing codes for different patient diagnoses
   - C. Identifying which portion of your patient’s records may be shared with other providers
   - D. The ways in which EHR user roles are defined
ANSWERS

1. The correct answer is B. Electronic health records (EHRs) are intended to share information across practice disciplines and settings, and to enable interconnectivity for clinical and treatment purposes. This capacity is known as interoperability. Office management systems provide electronic business management and data storage, and they can support electronic billing. But an OMS is not interoperable with other office management systems or EHRs.

2. The correct answer is true, whether you maintain records in electronic or paper format. However, there are exceptions to the general rule. For example, psychologists can withhold information contained in the record if they think there is a risk to the physical safety of the patient or others by providing that information. Further, some states allow psychologists to withhold psychotherapy notes while other states do not.

If you already maintain patient records electronically, you are expected under HIPAA to provide a copy electronically to the requesting patient. It is important for psychologists to understand both HIPAA and relevant state law governing the release of records to patients.

A thorough analysis of the state-specific issue of responding to patient requests for records is provided in HIPAA for Psychologists, an online product developed jointly by the APA Practice Organization and the APA Insurance Trust. This resource is found at the Practice Central website: apapracticecentral.org.

3. The correct answer is F. All four items are considered protected health information. The development of new technology facilitates access to records on the go, and mobile devices such as cell phones and tablets often allow access to PHI. Therefore, it’s up to the provider to ensure that their mobile devices remain locked when not in use and that the information contained therein is encrypted.

4. The correct answer is E. In addition to these precautions, additional measures include password protecting all devices and using an application or software that can remotely remove or delete all patient data in the event the device is lost or stolen.

5. The correct answer is false. The concept of “role-based access” for EHRs relates to who can access particular levels of information in a patient’s record. In EHRs, each provider and practice staffer with access to patient records retains his or her own unique login credentials. Role-based access allows system users to access only the information they need in order to perform their jobs. For example, a practitioner requires access to a different level of information than does an administrative assistant.

6. The correct answer is C. Data segmentation allows for specific parts of the patient’s record to be shared with practitioners across disciplines who have been identified as needing to know the information. The level of customizability differs among various types of EHR software. Decisions about data segmentation may result from discussions involving the practitioner, the EHR vendor and the patient.

In the event of an emergency, such as hospitalization when the psychologist is unavailable, data segmentation can be suspended so providers can access additional needed data. Any access to a patient’s record would leave an electronic “paper trail” indicating who accessed a patient’s record, what was viewed and when it was accessed.
Psychologists and other Medicare providers experienced a two-percent decrease in Medicare payment effective April 1, 2013 as a result of the Budget Control Act of 2011 known as sequestration. That decline followed an average two-percent decrease in reimbursement for psychologists’ services owing to the 2013 Medicare fee schedule that took effect in January.

And the four percent drop in just three months would have been considerably more had Congress not postponed for one year the 26.5 percent reduction in Medicare payment scheduled for the beginning of January 2013 as a result of the Sustainable Growth Rate (SGR) formula, a major component of Medicare payment.

As many psychologists are painfully aware, the recent cuts are part of a longstanding downward spiral in Medicare reimbursement. The trend continues with a Congress focused on slashing provider payments rather than reducing beneficiary services.

One key indicator of plummeting reimbursement rates for psychologists involves Medicare payment for psychotherapy. In 2000 the program paid a national rate of $98 for a 45 minute psychotherapy session, the most common Medicare service provided by psychologists. Today Medicare pays just $81 – a 39 percent drop, adjusted for inflation.

Meanwhile, Medicare falls behind psychologists’ reimbursement by private insurers. According to a 2012 analysis by Healthcare Visions, Inc. conducted on behalf of the APA Practice Organization (APAPO), psychologists receive as much as 15 percent less in reimbursement for Medicare services compared to private market indemnity plans.

The “practice expense” component of Medicare payment is a primary driver in lowering reimbursement rates for psychologists. The practice expense portion of the Medicare fee schedule captures the direct and indirect costs of providing a service – including rent, utilities, supplies, equipment and staff.

Over the past several years, the Centers for Medicare and Medicaid Services (CMS) has modified the practice expense share of the Medicare payment formula multiple times to the detriment of low-cost providers including psychologists.

Impact on beneficiary access

Psychologists provide 40 percent of outpatient and 70 percent of inpatient psychotherapy services and most of the diagnostic services to Medicare beneficiaries. Along with social workers, psychologists provide the vast majority of Medicare mental health services to patients.

But the precipitous decline in Medicare reimbursement in recent years has caused psychologists to leave the program, reduce their Medicare patient loads or refuse to take new patients. A 2008 survey of members by the American Psychological Association Practice Organization (APAPO) found that although 28,000 psychologists were Medicare providers, 3,000 who once participated had dropped out, primarily due to low reimbursement rates.

Advocacy to combat the downward spiral in payment

Calling for Congress to provide improved and fair reimbursement for psychologists’ Medicare services remains a top legislative advocacy priority for the APA Practice Organization. But the battle is an uphill climb given current political and economic realities.
During the March 2013 State Leadership Conference (SLC) sponsored by APAPO, nearly 500 psychology leaders from throughout the U.S. visited Capitol Hill for more than 330 meetings with their members of Congress and staff. One of the “asks” was for Congress to fix the Medicare payment formula to provide for fair and adequate psychologist payment. The Medicare payment formula is set in statute so Congress must act to amend it.

Another of the requests made during these congressional meetings was for Congress to repeal the SGR formula related to Medicare payment and replace it with an alternative that treats all physician and non-physician services equally. Congress already has blocked the SGR payment cut from taking effect 15 times. The latest congressional action delayed the SGR cut until January 1, 2014, when a 25 percent drop in payment is scheduled to occur.

Yet another “ask” during the Hill visits involved the Medicare payment cuts resulting from sequestration, a nine-year process whereby automatic across-the-board cuts will occur when spending caps are exceeded in broadly defined spending categories, including Medicare. Psychologists called on their elected officials to eliminate the two percent Medicare sequestration cut and find a more targeted approach to address Medicare spending.

The SLC constituent meetings buoyed APAPO lobbyists’ efforts to gain better reimbursement rates for psychologists. Lobbyists have been meeting with key committee members and staff to focus on problems with Medicare payment, the SGR formula and sequestration.

The U.S. House of Representatives is taking the lead on finding alternatives to the SGR formula, and there are clear signs that Congress is considering repealing the SGR formula. The House Ways and Means and Energy and Commerce Committees have floated outlines for reform that would repeal the SGR formula and provide for a lengthy period of stable payment updates. Reform would also include an eventual movement away from fee-for-service payment to one that ties reimbursement to quality, including through outcomes and treatment measures.

APAPO lobbyists have been meeting with Ways and Means and Energy and Commerce Committee staff to ensure that psychology’s perspectives and payment issues are fully addressed in reform. On April 11, 2013, APAPO submitted comments to the committees on their reform outline. APAPO comments focused on the need to repeal the SGR formula, challenges of applying quality measures to mental and behavioral health services, the need for changes to the underlying payment formula to better value psychologists’ services and the need to integrate Medicare mental and physical health services.

To supplement these efforts, APAPO’s newly formed political action committee, APAPO-PAC, has focused on contributions to policymakers who sit on the Senate and House health committees. As a result, APAPO lobbyists have had the opportunity to educate a number of Senators and Representatives on these committees on the need to repeal the SGR formula and to improve psychologists’ reimbursement rates in the Medicare program.

Window of opportunity

The Congressional Budget Office has cut in half last year’s estimate of the cost to the government of repealing the SGR formula. That cost is now estimated at $138 billion. Though the cost is still substantial, Congress may find a way for repeal, as well as other reforms to the Medicare payment system. APAPO is working to ensure that professional psychology’s voice is heard in this process, with the result of improved payment in any new system that develops.

Grassroots advocacy is a crucial element of the APA Practice Organization’s legislative advocacy efforts. Your members of Congress need to hear from you immediately about doing what’s right to ensure access to needed psychological services for Medicare beneficiaries and about finding a sustainable alternative to the SGR cut.

Visit the Legislative Action Center at http://capwiz.com/apapractice/home/ to urge your Senators and Representative to halt Medicare cuts to psychological services. Please take action as soon as possible for your patients and the profession.
Keeping Electronic Health Records Private and Secure  continued from page 11

• **Encrypt your data.** Encrypting protected health information to government standards will protect your patient’s privacy if you experience a breach. In fact, says Nessman, “Encryption is becoming the standard of care.”

• **Take advantage of built-in safeguards.** Electronic health records have built-in features to help safeguard information, says Tatro. With access controls, for example, you can decide what staff members should have access to which information. While an administrative assistant needs to be able to schedule appointments and code for billing, that person shouldn’t have access to a patient’s full record. Audit functions allow you to see who has accessed what information and when.

• **Maintain minimal clinical records.** “The whole point of electronic health records is that they’re easier to share,” says Nessman. “But that greater ease of sharing means that electronic health records are more likely to be read by a lot of people.” Be circumspect about what you put in an electronic health record while still providing information other health care providers need to better coordinate care and understand the value psychology brings. Keep the minimal clinical record appropriate for release in most circumstances, he says, adding that third party payers and states may have requirements about what type of information practitioners must keep. If it is important to your practice to keep detailed notes, Nessman recommends keeping separate psychotherapy notes inside or outside of the EHR. If kept within the EHR, they should be in a separate, clearly identified, more secure part of the electronic health record or in an electronic format outside the electronic health record system. “If you’re really old school, you can have them on paper,” says Nessman.

• **Focus on the risks you can control.** The average practitioner isn’t going to be able to confirm, for example, that a cloud storage vendor has the right encryption standards, says Nessman. Instead of worrying about highly technical issues, he says, focus on things you can control – such as how protected health information gets from your office to the cloud. Other processes that practitioners can control are the use of passwords and staff training.

• **Get help.** The APA Practice Organization has resources that can help you comply with regulations for safeguarding electronic health records. The HIPAA Security Rule primer and other materials available at Practice Central – [apapracticecentral.org](http://apapracticecentral.org) – can help you better understand the security rule. Members also can contact the APA Practice Directorate’s Office of Legal and Regulatory Affairs at [praclegal@apa.org](mailto:praclegal@apa.org) or 800-374-2723, ext. 5886. And while the APA Practice Organization does not endorse particular electronic health record products, says Tatro, staff can walk members through what they need and review several options.

Larson, for one, hopes that professional psychologists will use these tips to overcome any remaining fears about the privacy of electronic health records.

Says Larson, “Electronic health records can’t reach their full potential unless both patients and providers are confident that patients’ data are private and secure.”

**NOTE:** This article is based on a workshop presented during the March 2013 State Leadership Conference in Washington, D.C. sponsored by the American Psychological Association (APA) and the APA Practice Organization.
“How are we going to get paid in the future? For the outcomes we produce,” says Henderson. With these new financing models, hospitals and health systems do better when their patients get better.

That’s the case for St. Charles, which is part of one of Oregon’s coordinated care organizations. Overseen by the Central Oregon Health Council, which Henderson directs, the coordinated care organization has launched several initiatives that show that integrating physical and behavioral health care improves patients’ outcomes and reduces Medicaid costs. Thanks to a shared savings agreement with Medicaid, the health system gets to keep some of the money saved. As a result, says Henderson, the incentive is now to provide better care rather than to drive admissions.

And that means integrating behavioral health care into just about every corner of the health care system. The coordinated care organization’s “transformation initiatives” include embedding psychologists into a wide range of settings to offer behavioral interventions to individuals of all ages who have medical problems. In obstetrics, psychologists help women comply with recommended regimens; provide screening, brief intervention and referral to treatment for substance use problems; and are on the look-out for post-partum depression.

Putting a psychologist in the neonatal intensive care unit, which Henderson says is the most expensive place in any hospital, has already reduced lengths of stay and costs. The psychologist also identifies children with special health care needs, so that intervention can begin right away. “Five percent of children are responsible for 60 percent of pediatric health care spending,” says Henderson. “When we intervene earlier, we lower lifetime health care costs.”

At the pediatric level, a psychologist is helping young patients learn how to better control their asthma, a major source of expensive emergency room visits. Psychologists also help patients transition out of the hospital. “It’s been remarkable to see the impact on re-admissions,” says Henderson.

The same strategy works for adult patients with complex health care needs, says Henderson, explaining that just 12 percent of patients account for 82 percent of costs. By embedding psychologists in primary care, the coordinated care organization is beginning to identify and intervene with patients on their way to developing chronic conditions.

Behavioral health integration is even beginning to happen outside the formal health care system. The coordinated care organization’s next initiative is to put mental health professionals in school-based health centers. Doing so will not only benefit children, says Henderson, but also parents and everyone else in the neighborhood. “We want to bring mental health to where people are,” she says.

**Opportunities for psychologists**

Some of these changes have made psychologists and other mental health professionals in central Oregon anxious, says Henderson.

Some worried that they would have to give up their independent practices and join the staff of the coordinated care organization. Others worried that the psychologists embedded in primary care would “steal their referrals,” says Henderson. That didn’t turn out to be the case.

When Henderson put two psychologists in a primary care clinic in the small town of Redmond, for example, specialty mental health providers – including both psychologists and master’s level practitioners – worried that their work would dry up. Instead, says Henderson, the psychologists in the clinic typically see clients for a few visits, decide they need therapy and refer them to a provider in the community. “The next thing you know, we didn’t have anyone to refer to in Redmond,” says Henderson, adding that the need was so great she soon opened an outpatient mental health clinic across from the primary care clinic that has since become the community providers’ main referral source.

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Integrating Behavioral and Physical Care  continued from page 17

How can psychologists take advantage of the opportunities health care reform is bringing? The first step should be to apply for medical staff privileges at your local hospital, says Henderson. “That’s where you build relationships,” she says, encouraging psychologists to join physicians on grand rounds and invite medical colleagues out for coffee. Together, she says, you can start brainstorming about ways to integrate services and thus improve care.

And you can start small, Henderson adds. Even an experiment with a handful of patients or even just one can become the basis for improvements on a larger scale, she says, urging psychologists to launch pilot projects.

“All of our transformation initiatives were small ideas someone had that we took and turned into big action and big cash,” she says. “That’s how we’re going to change health care.”

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Assessing Personality and Advocating for the Profession  continued from page 9

go with it – help psychologists align test data with the personality structures most related to the test construct.

Blais is also active in the Society for Personality Assessment (SPA), chairing the Personality Assessment Proficiency Committee. In 2010, APA recognized personality assessment as an area of proficiency within professional psychology. SPA is responsible for implementing the proficiency, which includes awarding of proficiency status to qualified psychologists along with creating educational materials to serve as models for proficient personality assessment training and practice.

“The society is dedicated to using proficiency status to help enhance training at the doctoral and internship levels and help guide psychologists interested in having personality assessment be a significant portion of their practice,” says Blais.

Changing payment models and the need for advocacy

Noting that it can be difficult to get psychological testing authorized and to get an adequate number of hours authorized to do a good job, Blais is also an advocate for personality assessment on the reimbursement front. As the health care system shifts from fee-for-service to a bundled care model, he says, “We have to be ever vigilant that our services are not only recognized for their value but reimbursed at a level that makes it possible for us to make a living.”

Blais is working with SPA and other groups to encourage psychologists to adopt a model similar to that used by radiologists in the 1990s, when the proliferation of imaging technologies prompted pushback from insurers. In response, radiologists examined different clinical scenarios, identified appropriate imaging procedures for each of them, and then determined the relative value and time involved.

Psychologists specializing in personality assessment should do the same, Blais says, urging his colleagues to identify 20 to 30 clinical indications that warrant a comprehensive evaluation, identify the tests that are appropriate to conduct those evaluations, then determine how much they could impact patient care and how much time those evaluations would take.

“If we could create that kind of model and get buy-in from payers,” says Blais, “we would take back control.”
What happens during visits with a psychologist

An initial visit with a psychologist usually involves a discussion about your history and concerns. This may include your weight management goals and past efforts to lose weight, medical history, stress levels, current life situation, and your sources of social support like family and friends.

In order to help, psychologists also want to learn about your habits and attitudes about food, eating, weight loss and body image that may not support your health goals. Common unhealthy beliefs that patients express include: having to clean their plate; needing dessert after meals; and feeling like a failure when weight loss stalls. Some typical behaviors include: eating whatever they want after exercise; using food to cope with feelings of boredom or stress; and continuing to eat when they are no longer hungry.

These types of behaviors and beliefs often sabotage weight loss efforts. Psychologists talk to patients about their challenges to making healthy choices and identify the triggers that prompt the patient to make unhealthy choices. A psychologist may also evaluate a patient for anxiety, depression and eating disorders such as binge eating. These conditions can sometimes contribute to weight issues.
Many psychologists concentrate on one health behavior at a time. For example, if evenings are a challenging time to maintain good eating habits, the psychologist may ask the patient to keep a log of food eaten in the evenings and make notes about their environment, how they felt and what they were thinking at that time. These factors provide important information about what is driving eating behaviors and help the psychologist and patient figure out a way to address the behaviors.

Progressing and Improving
After even a few sessions, most patients begin to notice changes. For example, patients may start to challenge old beliefs about food and practice new ones that support their health goals.

Together with the psychologist, a patient can determine how long treatment should last. People with extreme anxiety and depression, eating disorders or chronic physical health conditions may require longer and/or more frequent treatment.

The ultimate goal is to help people develop skills so they can lead healthy lives.

Changing Your Eating Habits
Consider the following steps that can be helpful in changing unhealthy eating behaviors and thoughts:

**Monitor your behaviors.** Research is clear that people who write down what they eat in a daily log are more successful at losing weight. Record your thoughts, feelings and information about the environment such as where you ate, when and what you were doing. This will help you understand your eating behaviors and identify areas to change.

**Track your activity level.** This is another important aspect of self-monitoring. It includes not only how much you exercise but also the extent to which you move around during the day rather than remaining seated or inactive. One helpful tactic involves using a pedometer to record the number of steps you take each day.

**Eat regular meals.** Patients often skip breakfast with the thought they are reducing calories or can “save up” calories for later. But skipping meals can slow your metabolism, make you prone to later eating binges and have a negative effect on your health.

**Practice “mindful” eating.** Research shows that individuals with eating problems often don’t pay attention to whether they are really hungry when they eat. Psychologists can help you learn mindfulness exercises to heighten your awareness of hunger levels and to make eating more enjoyable.

**Understand the things you associate with food.** Behaviors are habitual and learned. Sometimes people may associate certain emotions, experiences or daily activities with particular behaviors. For example, if you typically eat while watching TV, your brain has made an association between food and TV. You may not be hungry, but in your mind TV and eating are paired together. So when you watch TV you suddenly feel the urge to eat. You can begin to break this association by not eating while watching TV.

**Identify your emotions.** It’s important to figure out what is happening emotionally while snacking, overeating or choosing unhealthy foods. Identify the feeling: is it boredom, stress or sadness? Patients need to determine if they are really hungry or just responding to an emotion. If you aren’t hungry, find another way to meet that need.

**Modify your unhealthy thoughts and behaviors.** Reinforcing healthy behaviors is important to achieving your weight management goals. Too often, people have negative thoughts and feelings about changing their health behaviors and see the process as punishment. Some people have an “all or nothing” attitude and think about weight loss in terms of being “on” or “off” a diet. Psychologists work with people to address negative feelings and find ways to reward healthy changes to their eating habits.

The American Psychological Association gratefully acknowledges Amy Walters, PhD, director of behavioral health services at St. Luke’s Humphrey Diabetes Center in Boise, Idaho, and Kathleen Ashton, PhD, Bariatric and Metabolic Institute at the Cleveland Clinic in Ohio, for contributing to this fact sheet.
“The best way to find yourself is to lose yourself in the service of others.”

Mohandas Gandhi

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