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Tools and Information for Professional Psychologists

Winter 2014

More Than Two People in the Room: Working with Couples, Families and Groups

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All 50 states and the District of Columbia have laws governing many aspects of health care services such as consent to treatment, confidentiality and access to records. However, these laws focus mainly on situations in which there is one patient in the treatment room.

As a result, situations involving more than one patient – couples, families and group counseling – or involving collateral contacts can at times become challenging to manage. This is especially true when issues such as participants’ roles, treatment goals, limits to confidentiality and access to treatment records are not clearly agreed upon at the outset of treatment.

As in many complex areas of practice, familiarity with applicable state law, knowledge of relevant ethical standards and advance planning are all important factors in managing these cases. This article is intended to provide related guidance for psychologists.

Who is a patient and who is a collateral?
Identifying who is the patient (or patients) and making sure that all involved parties are aware of this information at the outset of any treatment intervention is crucial. When there is one adult patient, establishing the patient-therapist relationship is usually straightforward. If you are providing couples or group therapy, however, there will be more than one patient and each will have certain protections and rights regarding the treatment itself and the treatment records, as described in more detail later in this article.

Individuals who may be in the treatment room but are not patients (for example, collateral contacts) will not have the same rights as patients, and therefore should not have the same expectations. An example of a collateral contact would be the husband of a depressed patient attending part or all of a therapy session with his wife to relate his concerns about his wife’s symptoms and/or learn how to support her recovery. This would not be a couples therapy session, as only the wife is the patient and the goal of the session is to address her mental health condition. Therefore, the therapist’s primary duty is to the wife, and the wife would generally control access to the treatment records.

When the patient is a child and a parent participates as a “collateral,” the situation is more complex because the parent is usually also the child’s legal representative and therefore has additional rights and responsibilities. For information about parents’ rights regarding treatment records, please see Working with Children and Adolescents (www.apapracticecentral.org/good-practice/secure/winter11-working.pdf).

The Trust offers a useful “Sample Outpatient Services Agreement for Collaterals” (apait.org/apait/download.aspx) that defines collaterals as follows: “A collateral is usually a spouse, family member, or friend, who participates in therapy to assist the identified patient.” The document also outlines the role of collaterals and clarifies the attendant rights, risks, benefits and limits to confidentiality.

Please also note that billing and payment arrangements do not determine who is identified as a patient or a patient’s legal representative. For example, if you are treating a 20-year-old man who asks that bills be sent directly to his parents, the parents still do not have the right to access treatment records without their son’s express consent. Your patient would need to agree in advance to release to his parents any information about the treatment included on your bills (for example, dates of service).

Confidentiality and privilege
The establishment of a psychotherapist-patient relationship determines how to handle issues such as confidentiality,
privilege and access to records. The concepts of confidentiality and privilege are closely related and often confused. “Confidentiality” refers to laws and ethical standards that require professionals to protect the privacy of patients’ records and other communications. “Psychotherapist-patient privilege” refers to the patient’s legal right to keep treatment information from being disclosed as evidence in court proceedings.

State laws, the Health Insurance Portability and Accountability Act (HIPAA) and the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (Ethics Code) all provide confidentiality protections for health care information (with narrow exceptions for situations such as child abuse reporting). However, most of these resources do not provide detailed guidance regarding how to handle confidentiality in situations involving more than one patient or collateral contacts.

Similarly, state laws on psychotherapist-patient privilege may not provide clear guidance regarding therapy involving multiple parties. According to Knauss & Knauss (2012):

[Application of privilege] to family or group therapy varies depending on the state law or local interpretations of state law. The traditional view is that privilege is automatically waived when discussions are held in front of casual third persons (making them public as opposed to private discussions) and that the privilege laws…must be interpreted narrowly. As a consequence, the application of privilege in family or group therapy could be inconsistent and depends on the specific wording of the state’s statute or judicial interpretations of that statute. Psychologists are urged to be familiar with their state laws in this area. (p. 36)

For example, even if your state law waives the psychotherapist-patient privilege in situations involving “casual third persons,” the privilege arguably still applies to therapy involving multiple patients or collateral contacts because these participants are not “casual” – they are an integral part of treatment. This is essentially the approach taken by California law, which states that confidential communications between patient and psychotherapist are privileged if the information is disclosed to “no third persons other than those who are present to further the interests of the patient in the consultation” [emphasis added] (California Evidence Code, §1012).

Given these complexities and potential gray areas, it is especially important to be aware of the applicable rules in your jurisdiction and to implement an informed consent process that ensures all parties understand the relevant limits to confidentiality and privilege. It is also important to remember that psychologists should be careful about giving clients guidance on legal topics and should recommend that clients obtain legal counsel if the situation warrants. Psychologists may also need to seek legal advice if a situation is unclear.

**Working with couples and families**

The APA Ethics Code provides a helpful framework for establishing therapeutic relationships involving couples or families. Standard 10.02 states: “When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist’s role and the probable uses of the services provided or the information obtained.”

Many states have adopted the Ethics Code or similar ethical standards or rules for professional conduct for psychologists. For example, Ohio’s Rules of Professional Conduct include the following: “When services are provided to more than one patient or client during a joint session (for example to a family or couple, or parent and child, or group), a psychologist…shall, at the beginning of the professional relationship, clarify to all parties the limits of confidentiality” (codes.ohio.gov/oac/4732-17).

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**Many states have adopted the [APA] Ethics Code or similar ethical standards or rules for professional conduct for psychologists.**

APA’s Record Keeping Guidelines (www.apa.org/practice/guidelines/record-keeping.pdf) are also relevant. Guideline 11 states: “Multiple Client Records: The psychologist carefully considers documentation procedures when conducting couple, family, or group therapy in order to respect the privacy and confidentiality of all parties.” The application section of Guideline 11 explains that the informed consent process may include providing information about how the record is kept (for example, jointly or separately) and who can authorize its release. In addition, it suggests that in some situations such as group therapy it may make sense to create and maintain a complete and separate record for all identified clients; whereas if a couple or family is the identified client, then a single record may be appropriate.
Issues regarding access to records and confidentiality rarely arise when a couple is actively engaged in couples’ treatment. However, if the couple later decides to split up, one spouse may subpoena the record as part of a divorce or child custody proceeding. In such cases, the psychologist should refer to the informed consent documents, relevant laws and ethical requirements. Generally, however, you would need a court order or the consent of both parties in order to release couples therapy records – and both parties’ consent is an unlikely scenario in such cases.

A similar analysis would apply to any request for release of family therapy records. According to Atkins (2009): “When receiving a request for records or a subpoena for records of an individual member of a family or couple...you will need permission from each member of the family or couple, or the representative for the client in the case of a child...Without authorization from each member you should not release records unless you are mandated by the court.”

For information about determining who is a minor’s legal representative for purposes of consent to treatment and release of records, please see Working with Children and Adolescents (apapracticecentral.org/good-practice/secure/winter11-working.pdf). For more general information and resources on family therapy, please visit the APA Division 43, Society for Family Psychology website (www.division43apa.org).

**Group therapy**

As with couples and family therapy, thorough informed consent procedures are essential when conducting group therapy. Ethics Code standard 10.03 (Group Therapy) states: “When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.”

As described in the Ethics Code Commentary and Case Illustrations: “Psychologists are professionally obligated to maintain the confidentiality of group clients/patients, except when required by law to reveal child or elder abuse, or threats of harm to self or others. However, although group members must be advised to maintain confidentiality about other group members, they are not held to professional codes of conduct.”

In other words, the psychologist cannot guarantee that all group members will maintain confidentiality regarding information disclosed during group sessions.

Some of the potential limits on confidentiality in group therapy can be mitigated by careful record-keeping procedures. Knauss & Knauss (2012) recommend that group therapists keep separate records for each member of the group. They also note that separate records may be kept in a variety of ways that allow individual members’ access to their own records without compromising the confidentiality of other members. For example, either completely separate records can be kept for each group member, or a brief paragraph description of each session (using initials to identify group members) can be included in each member’s file and then supplemented with information pertaining only to that particular patient.

Additional information on group therapy, including Bresskin’s (2011) “Procedures and guidelines for group therapy” (bit.ly/49GroupTherapy) is available at the APA Division 49, Group Psychology and Group Psychotherapy website (bit.ly/Div49). The Association for Specialists in Group Work (ASGW): Best Practice Guidelines (www.asgw.org/pdf/Best_Practices.pdf) may also be helpful. Although the ASGW guidelines are aimed primarily at professional counselors, much of the information is relevant to all mental health professionals who provide group therapy.

**Multiple or sequential roles**

Another complex issue that often arises when multiple participants are involved in treatment is whether multiple or sequential roles are appropriate. For example, should...
group therapists also treat group members individually? Should a couples’ therapist treat one member of the couple individually during and/or after the couples’ course of treatment? Some basic information is presented below, yet a thorough discussion of these issues is beyond the scope of this article.

The Ethics Code provides an excellent framework for initial consideration of these questions. Standard 3.05 (Multiple Relationships) defines multiple relationships and requires psychologists to refrain from entering into such relationships “if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness...or otherwise risks exploitation or harm.” Standard 3.06 (Conflict of Interest) similarly requires psychologists to refrain from “taking on a professional role when...professional, legal, financial or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence or effectiveness in performing their functions as psychologists or (2) expose the person...with whom the professional relationship exists to harm or exploitation.” Standard 10.02, which specifically addresses couples and family therapy, states: “If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately.”

For example, it is important to maintain a clearly defined role in cases involving custody issues. The APA Guidelines for Child Custody Evaluations in Family Law Proceedings include the following: “7. Psychologists strive to avoid conflicts of interest and multiple relationships in conducting evaluations. Psychologists conducting a child custody evaluation with their current or prior psychotherapy clients and psychologists conducting psychotherapy with their current or prior child custody examinees are both examples of multiple relationships” (www.apa.org/practice/guidelines/child-custody.pdf).

In many cases, while it may be legally and ethically permissible to engage in multiple or sequential roles, there are important clinical and risk management issues that should be taken into consideration. Risk-management experts advise against sequential roles such as providing couples counseling and then switching to individual therapy for one member of the couple or treating an individual and then shifting to couples’ therapy. If one member of the couple later feels harmed by the switch in roles, he or she could complain to a licensing board that you had an unethical conflict of interest and your objectivity was impaired.

Although it is not uncommon for a psychologist to treat the same patient concurrently in individual and group therapy, these arrangements can also lead to dilemmas regarding issues such as: confidentiality of information revealed in individual sessions; group dynamics when some but not all group members are in concurrent individual treatment; and potential conflicts of interest when the therapist self-refers an individual patient to group therapy or vice-versa (Knauss & Knauss, 2012).

Given the significance of clinical considerations (in addition to legal and ethical requirements) in deciding whether multiple and/or sequential roles are appropriate, it is important to be familiar with relevant scholarly literature and best practices. In addition, consulting with colleagues may be helpful.

**More on informed consent**

As described previously, informed consent is particularly important in situations where there are more than two people in the room, since there may be limits to the level of confidentiality that can be assured and participants’ roles and responsibilities may not be as clear as in individual therapy. In addition, individual participants in families or couples therapy may have conflicting agendas or expectations, which can be managed most effectively by establishing at the outset of treatment a solid, basic framework for working together. Therefore, your informed consent procedures in all treatments involving multiple participants should clearly address, preferably both in writing and verbally, topics such as how records will be kept, who will have access, and limits to confidentiality.

Ethics Code Standard 10.01 describes the general requirements for informed consent as follows: “When obtaining informed consent to therapy...psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers.”

Ethics Code Standard 4.02 offers more specific guidance regarding discussing the limits of confidentiality: “Psychologists discuss with persons (including to the extent feasible persons who are legally incapable of giving informed consent and their legal representative)...with whom they establish a scientific or professional relationship: 1) the relevant limits

*continued on page 20*
Providing psychological services remotely can enhance access to psychological services. But the trend toward telepsychology – the use of communication technologies in the provision of psychological services – has opened the door for evolving legal, ethical and practice issues.

To begin addressing these issues, the American Psychological Association (APA) established the Joint Task Force on the Development of Telepsychology Guidelines for Psychologists in 2011 to create guidelines for the practice of telepsychology. Underscoring the importance of the topic and this work, APA jointly developed the guidelines with the Association of State and Provincial Psychology Boards (ASPPB) and the Trust.

At its July 2013 meeting, the APA Council of Representatives approved the new Guidelines for the Practice of Telepsychology.

The guidelines are intended to both educate and inform practicing psychologists about applying current standards of professional practice when using telecommunication technologies in providing psychological services. The new guidelines are not intended to change or define the scope of practice of psychologists. Rather, they are intended to provide guidance on issues to consider prior to engaging in telepsychology.

The Task Force focused on identifying aspects of the use of telecommunication technologies that differ from the in-person provision of services. Two components taken into consideration throughout the guidelines are:

1. The psychologist’s knowledge of and competence in the use of the telecommunication technologies being utilized; and,
2. The need to ensure the client/patient has a full understanding of the potential increased risks to patient confidentiality and security of data when using telecommunication technologies.

The guidelines address eight key issues related to the provision of telepsychology services: competence of the psychologist; standards of care in the delivery of telepsychology services; informed consent; confidentiality of data and information; security and transmission of data and information; disposal of data and information and technologies; testing and assessment; and interjurisdictional practice (see sidebar at right).

Highlights of the Joint Task Force process

The Joint Task Force is composed of 10 members representing APA (four members), ASPPB (four members) and the Trust (two members).

Prior to its first meeting, the task force reviewed an extensive bibliography and initiated a survey mechanism sent to all APA governance groups, other related organizations and individuals in order to provide input for the task force on important issues for consideration. The task force established four guideline writing teams to draft guidelines in specific content areas – psychologist’s competence, standards of care in the provision of psychology, interjurisdictional
practice, and confidentiality and security. The entire task force reviewed the writing teams’ input during the spring of 2012. Finalized draft guidelines were disseminated widely during a public comment period that summer. The guidelines were submitted to APA’s Board of Professional Affairs in early 2013 and then forwarded to the Board of Directors for approval in June.

APA guidelines typically take three to five years to establish, but the Telepsychology Task Force completed the Guidelines for the Practice of Telepsychology in two years, with adoption by the APA Council of Representatives during the 2013 APA annual convention in Honolulu, HI.

For more information about the Guidelines for the Practice of Telepsychology, contact the APA Practice Directorate Office of Legal & Regulatory Affairs by email at praclegal@apa.org or by phone at (202) 336-5886.

THE EIGHT CORE GUIDELINES

The new telepsychology guidelines were published in the December 2013 issue of the American Psychologist magazine and also are available online at apapRACTICEcentral.org/CE/Guidelines/Telepsychology-Guidelines.pdf.

The eight core guidelines appear below. The published guidelines also contain rationale and application that elaborate on each of the core guidelines.

**Compliance of the Psychologist**

**Guideline 1:** Psychologists who provide telepsychology services strive to take reasonable steps to ensure their competence with both the technologies used and the potential impact of the technologies on clients/patients, supervisees or other professionals.

**Standards of Care in the Delivery of Telepsychology Services**

**Guideline 2:** Psychologists make every effort to ensure that ethical and professional standards of care and practice are met at the outset and throughout the duration of the telepsychology services they provide.

**Informed Consent**

**Guideline 3:** Psychologists strive to obtain and document informed consent that specifically addresses the unique concerns related to the telepsychology services they provide. When doing so, psychologists are cognizant of the applicable laws and regulations, as well as organizational requirements that govern informed consent in this area.

**Confidentiality of Data and Information**

**Guideline 4:** Psychologists who provide telepsychology services make reasonable effort to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks to loss of confidentiality inherent in the use of the telecommunication technologies, if any.

**Security and Transmission of Data and Information**

**Guideline 5:** Psychologists who provide telepsychology services take reasonable steps to ensure that security measures are in place to protect data and information related to their clients/patients from unintended access or disclosure.

**Disposal of Data and Information and Technologies**

**Guideline 6:** Psychologists who provide telepsychology services make reasonable efforts to dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts for safe and appropriate disposal.

**Testing and Assessment**

**Guideline 7:** Psychologists are encouraged to consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation when providing telepsychology services.

**Interjurisdictional Practice**

**Guideline 8:** Psychologists are encouraged to be familiar with and comply with all relevant laws and regulations when providing telepsychology services to clients/patients across jurisdictional and international borders.
The Changing Landscape of Telepsychology

There’s no comprehensive road map to guide psychologists as new laws are passed and reimbursement policies evolve.

Over the past several years, heightened legislative and regulatory activity at both the federal and state level has removed barriers and increased patient access to telehealth services. Some of the activity has involved telehealth more broadly, while certain developments pertain to specific areas of health care services such as radiology, remote home monitoring or mental health.

Despite the growing demand for telehealth services, there is still no comprehensive road map guiding health care providers in how to incorporate technology into the remote delivery of health care services to patients – whether the patient is located in the same city or county, in another part of the same state or in another state, or even outside of the U.S. As a result, providers are still navigating a patchwork of federal, state, organizational and/or professional policies to determine how to provide telehealth services appropriately and lawfully.

Nevertheless, there has been notable progress in the area of telepsychology practice. This article outlines developments at the federal and state levels governing the delivery of telepsychological or telemental health services and includes an overview of current public and private payer reimbursement policies.

What is telehealth?

Telehealth practice is often addressed in state licensing laws and regulations insofar as scope of practice for licensed health professionals is traditionally determined by states. State laws governing telehealth typically fall into one of two categories: general telehealth law broadly applied to various health care disciplines; or a telehealth provision included in the licensing laws for a specific health care discipline.

A majority of states address telehealth in some capacity. They may focus on defining telehealth and address how telehealth services are delivered. State-level provisions may also address whether a separate telehealth license or credential is required and may also specify which health care disciplines are covered under the provision.

It is important to note how a particular state law defines telehealth. Some laws use the term “telemedicine.” While there is no universal definition, “telehealth” is often defined as the practice of health care delivery, diagnosis, or the transfer of medical data using interactive audio, video or data communications in providing services to a patient at another location. Consultation by telephone, fax or email is often specifically excluded from the definition.

How states regulate telehealth

While most state telehealth issues focus on medicine or particular medical disciplines, an increasing number of states cover telepsychology or telemental health services under telehealth laws. Several states including Arizona, California, Georgia, Oklahoma and Texas have enacted telehealth or telemedicine laws that include telepsychological services.

But these state laws vary in detail. For example, Arizona’s law does not apply to telehealth consultations between two providers where the patient is not physically present. California includes both synchronous (“real-time”) and asynchronous (“store and forward”) interactions as well as services provided by telephone or email. Arizona, California, Oklahoma and Texas specify that patient consent for telehealth services must be obtained prior to engaging in telehealth. California allows for patient consent to be either written or verbal but must be documented in the patient record. Arizona and Oklahoma require that patient consent must be provided both verbally and in writing.
Some states including Delaware, Idaho, Kentucky, New Hampshire, Ohio, Utah and Vermont have specific telepsychology provisions included in the psychology licensing laws. As in California, Ohio’s definition is broad – it includes telephone, email and Internet-based communications as well as videoconferencing under the definition of telepsychology, and includes supervision in its definition. Vermont’s telepractice provision specifies disclosure requirements for psychologists who engage in telepractice: name and contact information, area of practice and limitations of telepractice. Delaware and Kentucky both require psychologists to obtain patient consent for telepsychological services, develop a written emergency contingency plan, document a risk-benefit analysis for telepractice, and use secure communications when possible.

Some states broadly define the practice of psychology to include psychological services that are provided remotely or provided to individuals located within that state even if the psychologist is located elsewhere. For example, Kansas and North Dakota state that if a person, regardless of location, engages in any activities defined under state law as the practice of psychology, regardless of the means by which the service is provided, and provides services to individuals within the state, that person must be licensed by that state’s (Kansas or North Dakota) psychology board. Similarly, Mississippi defines the practice of psychology to include psychological services provided in-person, by phone, Internet or via telehealth. Montana includes real-time audio-video conferencing in the definition of a professional relationship between a licensed psychologist and the client. Likewise, South Carolina and Wisconsin include psychological services provided by electronic or telephonic means in the definition of the practice of psychology as regulated by the psychology board.

Licensing boards weigh in

In nearly a dozen states, the psychology licensing board has issued declaratory statements or advisory opinions indicating how the board would view telepractice in the context of a licensing board complaint.

These opinions are particularly useful in those jurisdictions with no law or regulation governing telehealth practice. Practitioners in these states are encouraged to check with their licensing board for any guidance the board may have developed.

Massachusetts, Nevada, New Hampshire, New York, North Carolina, Pennsylvania and West Virginia have published board policy statements on telepsychology that are available on the psychology licensing board’s web site. Psychology licensing boards in the District of Columbia, Louisiana, Maryland, New Jersey, Texas and Wyoming have published guidance about telepsychology in their newsletter, which may be available online.

In many of these board statements, the board defines telepractice broadly to include a wide array of technologies, including telephone, fax, email, Internet-based applications and videoconferencing. Although board opinions do not have the same force and effect as a state statute or regulation, many of the licensing boards expect psychologists to obtain appropriate informed consent and to discuss the potential risks and benefits of telehealth with patients.

Notably, licensing boards seem to share a common perspective about interjurisdictional telehealth practice. In nearly all instances, the licensing board views the delivery of health services as occurring where the patient is located. As a result, the provider, regardless of his or her location, is expected to be licensed in the jurisdiction where the patient is located.

... an increasing number of states cover telepsychology or telemental health services under telehealth laws.

Florida has issued two declaratory opinions confirming its view that delivery of psychological services occurs both where the psychologist is located and where the patient is located. Therefore, whether the patient or the psychologist is in Florida, the Florida board has jurisdiction and the psychologist must be licensed to practice psychology in Florida.

Though psychology licensing laws generally require licensure in both the jurisdiction where the psychologist is located and the jurisdiction where the patient is located, psychologists may be able to provide telehealth services to patients in another jurisdiction on a temporary basis through temporary or guest licensure provisions. Under these provisions, states permit psychologists who are licensed in good standing in another state to practice for some fixed number of days per year in their state without obtaining licensure. Additional requirements may apply, such as advance notification and/or approval of temporary practice by the psychology board. State provisions vary considerably and any psychologist relying on these provisions must understand them well.
While reimbursement for telehealth services has increased over the past decade, coverage for telehealth services is still inconsistent and varies by payer. In determining whether telehealth services are covered, it is important to consider who the payer is, where telehealth services are provided and what service is provided via telehealth.

As of November 2013, 21 states have enacted legislation requiring private insurance companies to cover services delivered through telehealth. This means that insurers cannot refuse to cover a health care service simply because it was provided using telehealth. These state laws mandate coverage for telehealth services, if medically necessary, subject to the same terms and conditions that apply to coverage for those services provided in-person. However, the states vary as to what technologies are acceptable for coverage and reimbursement rates as compared to in-person services.

For example, some states – such as Arizona, Georgia, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Hampshire, New Mexico, Oklahoma, Oregon, Texas, Vermont and Virginia – require coverage for telehealth services provided using interactive audio, video or data communications. But telephone, fax or email messaging is specifically excluded so payers are not required to reimburse for consultations provided by these modalities. Certain states including Montana, New Mexico and Vermont specify that the communications must be encrypted (see sidebar on page 11) and comply with relevant state and federal privacy laws, such as the Health Insurance Portability and Accountability Act (HIPAA).
According to the Department of Health and Human Services, encryption is defined as “a method of converting an original message of regular text into encoded text. The text is encrypted by means of an algorithm. If information is encrypted, there would be a low probability that anyone other than the receiving party who has the key to the code or access to another confidential process would be able to decrypt (translate) the text and convert it into plain, comprehensible text.”

**States with Telehealth Coverage Mandates**

States shown in blue have enacted laws requiring insurance coverage of telehealth services.

Act (HIPAA). A few states specifically exclude consultations between providers where the patient is not present.

Other states are more expansive in the types of telehealth technologies that may be reimbursable by insurance companies. California, Colorado, Hawaii, Missouri, Montana, New Mexico and Texas appear to allow for the use of store-and-forward technology as well as real-time audio-video conferencing under the state telehealth coverage laws.

Some of the states have geographic restrictions for reimbursable telehealth consultations. For example, Arizona requires health insurance policies issued on or after January 1, 2015, to cover health care services provided through telemedicine if the health care service would be covered if provided through in-person consultation between the patient and a health care provider; and the patient is located in a rural region of the state. Arizona’s law also specifies mental health disorders and neurological diseases among those health care services covered under its telemedicine mandate and defines what constitutes a “rural region.”

Certain states’ laws do not mandate coverage for telehealth services by providers who are not part of an insurer’s approved telehealth network. Arizona, Kentucky, Massachusetts, Mississippi, Missouri and Vermont allow insurers to limit coverage to their in-network providers.

Most of the states require payers to provide coverage for health services provided via telehealth subject to the contract terms and conditions applicable to covered in-person services. Interestingly, however, Louisiana’s law appears to require reimbursement only for physicians and mandates reimbursement to be at least 75 percent of the “reasonable and customary amount” paid for in-person physician office visits. All other types of providers, including psychologists,

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Using Technology in Practice: Pointers for Proceeding with Caution

Most people now have access to computers and mobile devices, and many use multiple devices including desktops, laptops, tablets and smartphones. All of this technology makes it much easier to communicate with others wherever one may be located. So it is not surprising that health care professionals, including psychologists, are using technology in their interactions with patients.

Psychologists can communicate with their patients in various ways using any of these devices. You can call, email, text or use instant messaging with your patient. There are also several free web-based applications for video phone conferencing that often are already installed on computers and mobile devices. Given the convenience, ready availability and ease of use, patients often ask to use these apps when they are unable to make their in-person appointments because they are traveling, ill or for other reasons.

But before psychologists launch into using Skype, FaceTime or instant messaging with their patients, there are a number of considerations to take into account. Many are outlined in the APA Guidelines for the Practice of Telepsychology (see article on page 6).

If you live in a jurisdiction where telehealth is governed by statute or regulation, it is imperative to review your state’s requirements for telehealth services to ensure your compliance. State laws vary considerably as to what technologies are included in the definition of telehealth. For example, while some states include email and telephone communications, many states specifically exclude email and phone from the definition of telehealth under laws mandating insurance coverage of telehealth services.

Informed consent

An overarching question to consider is how telepsychology fits within your practice. Consider your policies and procedures. In particular, review your informed consent agreement. Does it mention the possibility of providing services remotely, or is it geared toward in-person appointments and services?

As discussed more fully in the APA Telepsychology Guidelines, there are additional factors at play when providing services remotely compared to in-person settings. For those patients for whom telepsychology service delivery may be appropriate, your informed consent needs to address the potential benefits and risks of telepsychology.

Though the following list is not exhaustive, here are several issues to communicate in writing with your patient in advance as part of the informed consent process:

• **Patient confidentiality** – When communicating with your patient via Skype, phone or other modes, you are unable to ensure patient confidentiality to the same degree as when you meet with the patient in-person in your private, secure office. Does your patient understand...
that patient confidentiality may be at risk when each of you is in a different location? Are you complying with the Health Insurance Portability and Accountability Act (HIPAA) in using these technologies for telepsychology services? For example, how is the electronic patient health information transmitted and stored?

• **Emergency situations** – You likely have protocols in place for handling emergency situations that may arise with patients in your office. Likewise, your outgoing phone message probably instructs callers to go to the nearest emergency room if they are having an emergency. But what do you do if your patient is in crisis during a telepsychology session? And what if your patient is either in another part of the state or even in another state? Have you discussed with your patient how to handle an emergency situation in such cases? Is there a designated emergency contact for your patient?

• **Technology failure** – You can count on technology failure. Your internet connection might drop or hardware may crash. You need to be prepared for the possibility of technology failure during a telepsychology session. Have you discussed with your patient in advance an alternate plan for either continuing the session or rescheduling the session should either of you experience technology problems?

• **Email or text messaging** – If you use email to communicate with patients, it is advisable for you to use secure email messaging when possible. You might also consider limiting use of email communications with your patients to administrative matters, such as scheduling or rescheduling appointments. If you choose to use email with your patients, you should also explain your policy for responding to emails to manage patient expectations and maintain boundaries. Further, if your patient asks to communicate with you via text, be aware that text messaging is not considered a secure means of communications.

• **Billing/reimbursement** – While a growing number of insurers appear to cover telehealth services, there is still variability among payers about whether telehealth is covered and if so, how such services ought to be billed. It is important to discuss this matter with your patient as he/she might assume that telehealth sessions will be covered similarly as in-person sessions. Your patient should review and understand his/her coverage. And if the session is not covered by insurance, it is advisable for the psychologist to clarify whether the patient wants to proceed with a telepsychology session or agree to pay out-of-pocket for the session. Also importantly, be aware that there may be “hidden” costs associated with telepsychology – for example, data plan overages and fees for service interruptions or technology failure.

### HIPAA/security issues

While certain issues unique to telepsychology can be addressed in the patient informed consent, there are additional requirements that psychologists should consider. You need to assess how your use of telehealth affects your compliance with HIPAA requirements, particularly the Security Rule.

**Before psychologists launch into using Skype, FaceTime or instant messaging with their patients, there are a number of considerations to take into account.**

The HIPAA Security Rule protects electronic patient health information (ePHI) from unauthorized disclosure to or access by third parties. Therefore, psychologists who provide telepsychology services need to make sure that any ePHI generated during telepsychology services is protected. It is advisable to reexamine your policies and procedures for securing and maintaining ePHI to ensure that the information is appropriately protected.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 modified obligations under HIPAA in several critical ways:

- Business associates are now directly liable under HIPAA for unauthorized disclosures of PHI that may result from performing certain functions on behalf of covered entities.

### MORE RESOURCES AT PRACTICE CENTRAL

September 23, 2013, was the deadline for implementing changes required by the Health Insurance Portability and Accountability Act (HIPAA) Final Rule. To aid the process of compliance with the HIPAA Privacy and Security Rules, the APA Practice Organization (APAPO) has developed and updated several resources found in the HIPAA Compliance section of APAPO’s Practice Central website at [www.apapracticecentral.org/business/hipaa/index.aspx](http://www.apapracticecentral.org/business/hipaa/index.aspx).
Examples of business associates may include: third-party billing or practice management service; health care provider’s accounting firm or law firm that may have access to protected health information and transcriptionists or answering services. Not only is it important to have valid, signed business associate agreements with persons or entities who provide services such as claims processing, billing, utilization review or practice management; it is critical that those agreements reflect the business associate’s liability under HIPAA. Also be mindful that liability extends to any “subcontractors” of a business associate. However, you do not need a business associate agreement with other entities covered under HIPAA such as medical doctors, hospitals, clinics or insurance companies.

• In addition to paper files, patients are entitled to a copy of their ePHI in an electronic form and format requested by the patient. Generally, the covered entity must provide access within 30 days of the patient request.

• Breach notification requirements have changed. Originally, covered entities had to report any breach of PHI where there was a risk of harm to those whose data was disclosed without authorization. Now, covered entities must provide breach notification unless after conducting a documented, post-breach risk assessment, the covered entity can demonstrate that there was very little probability of PHI being compromised.

• Penalties for non-compliance with HIPAA requirements have increased. Civil penalties range from $100–$50,000 per HIPAA violation and maximum penalties for additional violations totaling up to $1,500,000. Criminal penalties include significant fines and/or imprisonment.

**Implications for practitioners**

So what does this mean for psychologists who would like to engage in telepsychology? Relevant considerations include the following:

• Is the technology or equipment you use HIPAA-compliant? This means that, consistent with the Security Rule, you should be able to control who can access certain equipment, software or data. You should have the ability to encrypt/decrypt ePHI when appropriate. (See sidebar on page 11 for a brief definition of encryption.) You ought to be able to monitor any unauthorized access or attempt to access electronic PHI. Any transmission of electronic PHI
should be done through a secured network. For example, locking your wireless connection and setting a robust password for access will help protect your network from unauthorized access by strangers or unauthorized persons. By comparison, logging into a Wi-Fi hotspot at a coffee shop may not provide the same level of security or protection from unauthorized intrusions.

• If the vendor markets its product(s) as “HIPAA-compliant,” you need to do your homework and make sure that using that product fits within your existing policies and procedures for complying with HIPAA. Ask the vendor about authentication controls, audit controls, transmission security and breach notification functions. You may request a signed business associate agreement from the vendor acknowledging that the vendor is directly liable under HIPAA for any unauthorized breaches of patient health information.

• Be aware of the concern that many of the free, web-based telepsychology platforms do not comply with HIPAA. The platforms may not be able to provide an audit trail function to allow you to track who has access, to provide notification when an information breach occurs or to provide other capabilities including verified secure transmissions.

4 COMMON WAYS TO SECURE YOUR COMPUTER

Taking the following basic steps should help secure your electronic network:

1. Ensure that you are using antivirus protection.
2. Have robust passwords set for access to your wifi connection.
3. Have individual passwords for all family members or employees who may access your computers/system.
4. Set your computer, tablet or smartphone to automatically lock if it is idle for more than several minutes.

• With the increasing interest in telehealth technologies in health care, there are companies offering videoconferencing capabilities that claim to be HIPAA-compliant. Some even offer a business associate agreement. However, these companies charge a fee varying from monthly subscription to per session for videoconferencing services.

Sookasa allows you to enjoy the benefits of Dropbox without the risk of a HIPAA breach:

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Overseeing Disaster Health and Mental Health Services for the American Red Cross

Practitioner Profile: Valerie Cole, PhD

Psychologist Valerie Cole, PhD, was on sabbatical in Mexico when Hurricane Isidoro slammed into shore in 2002. Despite being out of power for 10 days, Cole jumped into action. Working with La Cruz Roja Mexicana, she delivered baby formula and other supplies to villages in the area.

Back then, Cole was just an American Red Cross volunteer, chairing a local chapter of about 65 mental health volunteers in New York. Today she’s on staff at Red Cross headquarters as the manager of disaster health and mental health services for the entire nation. As a national leader, Cole ensures that people affected by disaster get the health and mental health services they need and that staff and volunteers are physically and emotionally fit for deployment to disaster zones.

“We take a holistic approach to caring for people involved in disaster: mind, body and spirit,” says Cole. “We make sure people – whether the community affected by disaster or the disaster responders – are in good shape emotionally, physically and spiritually.”

Drawn to disaster

Cole, who earned a PhD in social and clinical psychology from the University of Iowa in 1996, was an assistant professor of psychology at St. John Fisher College in Rochester, N.Y., when she accompanied a student to meet an alumnus working at the local hospital and found her own destiny. The alum volunteered on the local Red Cross disaster mental health team and encouraged Cole to volunteer. “The student didn’t get a whole lot out of it,” admits Cole, “but I made a life-long friend who got me involved in disaster mental health as soon as I got my license.”

Cole launched her private practice in 1999, specializing in adults, couples and adolescents with depression, anxiety disorders and other problems. That same year, she began what would be an 11-year stint of volunteering with the Red Cross.

Cole began her leadership in the Red Cross by chairing her local chapter of disaster mental health volunteers in Rochester. “That’s how I got my start: showing up at single-family fires in the middle of the night and working with families who had just lost everything,” says Cole.

Soon Cole’s purview began to expand statewide. In 2008, she moved up to New York state lead for the Red Cross, coordinating disaster mental health preparedness and response across the entire state. She also helped write a curriculum and develop and implement disaster mental health training for the New York State Office of Mental Health and Department of Public Health.

In 2011, Cole joined the staff of the American Red Cross national headquarters in Washington, D.C., as the senior associate for disaster mental health. In this role, Cole provided mental health support and supervised volunteers providing services after hurricanes, floods and other large-scale national disasters, including the Joplin, Missouri, tornado.

Last summer, she moved into her new role as manager of disaster health and mental health services.

A major leadership role

These days, Cole is much more likely to be in a meeting in her office than out in the field in the aftermath of a hurricane or other disaster.

Cole directly manages the work of the senior associates responsible for health services and disaster mental health services as well as nurses and other staff responsible for wellness. The system as a whole includes about 4,000 health service volunteers, 4,000 disaster mental health volunteers and 600 disaster spiritual care volunteers.

Cole’s job is to make sure that everyone affected by a disaster gets the health and mental health services they need. But the Red Cross is now going about that task in new ways, she says.
For one thing, Red Cross Disaster Services is no longer focused almost exclusively on disaster response. Instead, the organization is expanding its focus to include the entire disaster cycle: preparedness, response and recovery. In addition, the Red Cross is doing more to address the needs of those who help survivors. As a result, one of Cole’s responsibilities is staff wellness.

“We’re making sure that their exposure to traumatic sights, sounds and experiences is limited and that we’re providing support to those who are exposed,” she says. “We want to mitigate against the possibility of compassion fatigue or anything like that.”

Cole has also helped shape the Red Cross’ overall disaster mental health vision. She helped develop a handbook that lays out what the program is all about and also helped create the network of state mental health advisors, for example. Most importantly, she says, she has had a hand in shaping the Red Cross’ holistic vision. “That’s something I’m pretty proud of,” she says.

Cole isn’t always desk-bound, however. When a big disaster strikes, she will sometimes leave her office and head back out into the field. After Hurricane Sandy in 2012, for instance, Cole managed the disaster mental health response on Long Island.

No matter what she’s doing, Cole draws on her experience and skills as a psychologist. “Psychologists have the people skills as well as the academic background in analytical and evaluative skills that are important,” she says.

Her training helps ensure that the organization’s work is based on current, valid research, for example. “We try to make sure that our programs are at least evidence-informed, if not evidence-based,” she says.

Her clinical experience has also helped shape her work at the Red Cross, says Cole, who still has a very small private practice on the side. “Transition is what interests me the most,” she says. Whether it’s in her private practice or at work, her focus is helping people deal with difficult transitions, such as getting divorced, losing a job or surviving a terrifying disaster.

Psychologists’ unique skills are also what help make the American Psychological Association’s (APA) Disaster Response Network such a valued partner, says Cole (see sidebar). The network consists of about 2,500 psychologists with special training in disaster response who volunteer to help survivors and relief workers after a disaster.

### Opportunities and challenges

Getting involved in that network is a great way to get active in disaster mental health, says Cole, adding that there are very few paid jobs in disaster mental health.

“This is not a good field to make money in,” she says. “But it’s a fabulous field to volunteer in.”

While many psychologists and others show up after a big event like Sept. 11, says Cole, they’re often not prepared to do the work that’s needed. Would-be volunteers should join their local Red Cross chapters and undergo training, says Cole, adding that the Red Cross offers periodic webinars to help train volunteers.

Most volunteer opportunities are at the local level rather than at big, national disasters, she adds. “It’s not particularly fun, exciting or glamorous, but that’s where the need is,” she says. “Even just giving a few hours a month is so valuable to the local community and makes you ready for when the big disaster hits.”

Volunteering puts psychologists into contact with an amazing group of fellow volunteers, adds Cole, who says that working with volunteers is the best part of her job. “They’re an extremely dedicated, creative group with great experience, great ideas and incredible heart,” she says.

Plus, volunteering is its own reward, according to Cole. “Being part of the community is a good thing!”

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**INTERESTED IN DISASTER RESPONSE?**

The American Psychological Association (APA) Disaster Response Network (DRN) consists of licensed psychologists with American Red Cross training in disaster response who offer volunteer assistance to relief workers and survivors in the aftermath of disaster. DRN members also engage in disaster preparedness and recovery activities such as teaching disaster courses, participating in planning meetings and educating the public about common reactions to disasters. The DRN office, housed in the APA Practice Directorate, tracks disaster mental health trends, research and resources and shares that information with DRN members. For more information about how you can participate in the DRN program, visit [www.apa.org/practice/programs/drn/index.aspx](http://www.apa.org/practice/programs/drn/index.aspx).
Thriving as a Forensic Psychologist

Practitioner Profile: William E. Foote, PhD

Back when William E. Foote, PhD, was in training, much of what is now known as forensic psychology didn’t exist yet.

“There were no textbooks and no major test instruments,” says Foote, who earned his psychology doctorate from the University of New Mexico in 1978. “We had some authorities in the field doing good work, but they hadn’t published widely at that point…. It just really wasn’t a field.”

Fast-forward three decades, and both the field and Foote are thriving. For the last 34 years, Foote has had a forensic psychology practice in Albuquerque, N.M., specializing in both criminal and civil cases.

“It has been one of the greatest joys of my life to see the field of forensic psychology happen,” says Foote.

An “information-gathering machine”

Foote got his first taste of forensic work as a psychological counselor at the Penitentiary of New Mexico in Santa Fe, his first clinical placement while he was in graduate school back in the mid-1970s. An internship at California’s Atascadero State Hospital confirmed his fascination with forensic work. “I like trying to understand how people end up doing what they do,” says Foote.

When Foote launched his private practice in 1979, he decided to focus on forensic work. The work hasn’t changed much over the years, although standards and the complexity of cases have.

“We now do more comprehensive, thoughtful, thorough evaluations,” he says, explaining that while three-page evaluations used to be acceptable, he now writes 15 or 20 pages. “And we used to be shooting in the dark, since we didn’t know much about violence prevention or post-traumatic stress disorder. Science has moved along and given us a lot more to deal with than before.”

Although it varies from year to year, Foote’s practice is evenly divided between civil and criminal cases.

On the civil side, Foote has developed a specialty in employment discrimination cases, writing reports and testifying in depositions or in court about the impact of hostile work environments or harassment on workers. He has also shared his expertise with others in two volumes co-authored with Jane Goodman-Delahunty: Evaluation for Workplace Discrimination and Harassment: Best Practices for Forensic Mental Health Assessment (Oxford, 2010) and Evaluating Sexual Harassment: Psychological, Social, and Legal Considerations in Forensic Examinations (APA, 2004). Foote also evaluates plaintiffs involved in car accidents and other personal injury cases.

On the criminal side, Foote conducts pre-trial evaluations. He may be assessing criminals’ state of mind – whether legally insane or criminally responsible – when they committed their offenses. He also assesses their competence to stand trial. Post-conviction, Foote helps the court decide whether an individual should be on probation or in jail or what should happen once they’re released. He also consults in death penalty cases.

Foote also consults occasionally with the state and local police department and sheriff’s department, working with officers whose fitness for duty has been questioned.

Another of Foote’s specialties is sexual abuse by clergy and teachers, a specialty that resulted in his evaluating 85 Inuit men sexually abused by a teacher in Canada’s arctic region and then helping to create a treatment program for them once the case was settled. “I’ve also done a lot of work with Pueblo, Navajo and Apache folks here in New Mexico,” says Foote, who served as a diagnostic consultant to the Indian Health Service for more than a decade early in his career.

No matter what kind of case he’s working on, Foote’s role is typically the same. “You’re an information-gathering machine,” he says. “For us to be able to get into people’s
lives, understand their lives and be able to communicate what they’ve been through is the essence of the art of forensic psychology.”

**Opportunities and challenges**

For Foote, forensic psychology is incredibly rewarding. “You do a job that helps the system function more effectively and helps justice happen,” he says.

It’s also rewarding financially, especially since forensic psychologists work outside the traditional third-party insurance reimbursement system. Foote is paid directly by lawyers, courts and public defender systems or sometimes even clients or their families.

But forensic psychology isn’t entirely immune from the same kind of market forces that other practitioners face, says Foote. Over the last decade, he says, brokers acting as middle-men have sprung up and act almost like insurance companies.

“Some are high-quality organizations that don’t really trample on you,” says Foote. Others, however, have such a fixed format for what they want in an evaluation that ethical issues can arise. “You have to be careful with such a restricted format that you’re not asked to do an inadequate evaluation for the purpose intended,” he says.

There’s plenty of work out there for forensic psychologists, adds Foote. And psychologists are well-suited for forensic work, given their background in assessment and knowledge of such areas as family dynamics or rehabilitation psychology.

But the field isn’t for everyone, he warns.

“For one thing, you have to be able to get into thinking much more linearly and much more like lawyers than most psychologists are comfortable doing,” he says, explaining that forensic psychologists must deal in facts rather than delve into the unconscious and other psychological concepts. Forensic psychologists are also constrained by the rules of law and rules of evidence, he says, which means it’s a much less free and intuitive process than psychotherapy.

Forensic psychology is also much more confrontational. “You’re often in an adversarial position, with people who want to leave you dead on the witness stand,” he says.

Plus, the work can be very stressful, says Foote, who has declared a hiatus on working on certain kinds of emotionally difficult cases.

“Trauma — to victims or to the people we evaluate — is a central part of what we do,” says Foote, who manages his own stress by spending time with his history professor wife and two adult children, fly-fishing and singing with a men’s a cappella group. “You’ve got to be tough to do forensic work. If you’re not tough, you drop out.”

What’s more, a background in clinical psychology or related fields isn’t enough, says Foote. “You can’t just step out of a clinical therapy office and into the courtroom without a lot of preparation,” he says. “It’s not something people can take on as a hobby or a sideline.”

Forensic psychology has what Foote calls a “more particular” set of ethical standards, for instance. Forensic psychologists also need to know a lot about the law in the area where they propose to work and how to handle such cases.

That’s why would-be forensic psychologists need specialized training and supervision. Both APA’s Div. 41 (American Psychology-Law Society) and the American Academy of Forensic Psychology offer high-quality training, he says.

Foote is personally committed to ensuring that psychologists get the training they need to do forensic work.

As Div. 41’s president in 2012 and 2013, he launched an initiative called the Forensic Practitioner’s Toolbox. A joint project between Div. 41 and Div. 42 (Psychologists in Independent Practice), this web-based educational resource is expected to feature monthly programs and other resources on forensic practice once the material is available online early in 2014.

Thorough preparation is necessary because of the very high stakes involved, says Foote. “There’s not a single case we take on where there isn’t some substantial amount of money or degree of liberty or danger to the public at stake,” he says.
More than Two People in the Room continued from page 5

of confidentiality... and 2) the foreseeable uses of the information generated through their psychological activities.”

Several sample informed consent agreements that may be useful in developing your own forms and policies for working with multiple parties are available from The Trust (www.apait.org/apait/download.aspx) and the Center for Ethical Practice (www.centerforethicalpractice.org/ethical-legal-resources/practice-resources/sample-handouts/).

Implementing thorough informed consent procedures and being knowledgeable about relevant laws, rules and standards are critical for the practitioner. So are maintaining a focus on the best interests of your patients and obtaining clinical and/or legal consultation when needed to help you smoothly navigate the difficult situations that can arise when there are multiple participants in treatment.

If you have further questions about working with couples, families, groups or collaterals, please contact the APA Practice Directorate’s Legal and Regulatory Affairs Department at praclegal@apa.org or 800-374-2723.

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**


apparently are not eligible for reimbursement under the Louisiana telemedicine coverage mandate.

**Medicare reimbursement**

Over the past decade, the Centers for Medicare and Medicaid Services (CMS) has provided reimbursement for certain health care services delivered to Medicare beneficiaries using telehealth. Clinical psychologists are among the categories of health care providers participating in Medicare who are eligible to furnish services via telehealth covered by the federal program.

The federal agency has approved the use of telehealth in lieu of an in-person encounter for professional consultations, office visits, office psychiatry visits and several other types of services. However, CMS specifies certain conditions that must be met for telehealth services to be reimbursed under Medicare.

First, the Medicare beneficiary receiving services via telehealth must be at an eligible originating site located in a rural Health Professional Shortage area or in a county outside of a Metropolitan Statistical Area (as defined by federal law). An originating site is the site where the Medicare patient is receiving services via telehealth. Examples of an originating site may include a provider’s office, hospital, federally qualified health center, community mental health center, or skilled nursing facility.

It is important to note that a patient’s home or other non-medical sites (such as a coffee shop) are not included in the list of eligible originating sites. So a psychotherapy session conducted via Skype to a patient at home would be ineligible for reimbursement under Medicare.

Currently, Medicare only reimburses for real-time, interactive audio-video telecommunications used to furnish services by the provider at the distant site and the patient at the originating site. Reimbursement for services using asynchronous technology is only permitted for federal telemedicine demonstration projects in Alaska and Hawaii.

It appears that reimbursement for eligible telehealth services is on par with that for in-person services. For billing purposes, the provider at the distant site would submit a claim for telehealth services using the appropriate procedural billing code identifying the professional service furnished along with an appropriate billing modifier. The "GT" modifier indicates that the service identified by the appropriate CPT code was provided “via interactive audio and video telecommunications systems.” This confirms that the telehealth service was provided consistent with CMS requirements – that is, the Medicare patient received services at an eligible originating site in an HPSA or non-MSA area.

**It is important to note that a patient’s home or other non-medical sites... are not included in the list of eligible originating sites.**
Approved Medicare telehealth services include a wide array of services. Each year, as part of the process whereby CMS updates the Medicare fee schedule, stakeholders may propose changes to the list of approved Medicare telehealth services. So the number of services eligible for telehealth reimbursement expands nearly every year. With regard to services provided by psychologists, the following are approved telehealth services for Medicare: individual psychotherapy, neurobehavioral status exam, psychiatric diagnostic interview exam, health and behavioral assessment and intervention (HBAI) services, brief face-to-face counseling for alcohol misuse, behavioral counseling for obesity, alcohol/substance abuse structured assessment and smoking cessation.

**Medicaid reimbursement**

To date, approximately 44 Medicaid programs, including the District of Columbia, allow for at least some reimbursement of telehealth services. Connecticut, Iowa, Massachusetts, New Hampshire, New Jersey and Rhode Island do not cover services provided via telehealth under Medicaid. Most Medicaid programs limit reimbursement to live videoconferencing. A few state Medicaid programs allow for store-and-forward but typically limit services to teleradiology or teledermatology.

Of the 44 programs allowing for Medicaid coverage of telehealth services, approximately 36 programs appear to cover telemental health services. However, that does not necessarily mean that psychologists can bill Medicaid for telepsychology. Only about a dozen of these states specifically include psychologists in the list of providers eligible for telehealth reimbursement under Medicaid. The majority of those states appear to either limit coverage of telemental health services to psychiatric services (for example, pharmacological medication management), or do not include psychologists among approved Medicaid providers.

Even where psychologists are eligible to receive reimbursement for telepsychological services, Medicaid programs may apply certain requirements. For example, a patient’s home is generally not considered an eligible originating (patient) site for telehealth services. Typically, patients would need to receive services at a provider’s office, a hospital, a federally qualified health center or community mental health center, or other similar facility. Some states require preauthorization for telehealth services while a few states only allow telehealth services if there are no available providers within a reasonable proximity for a patient to see in person. There may also be billing requirements for telehealth reimbursement under Medicaid.

It is important to contact your state’s Medicaid office to determine whether psychologists are eligible providers for telehealth services under Medicaid and if so, what restrictions or requirements need to be followed for coverage under Medicaid.

MANAGING CHRONIC PAIN

HOW PSYCHOLOGISTS HELP WITH PAIN MANAGEMENT

Pain is an all-too-familiar problem and the most common reason that people see a physician. Unfortunately, alleviating pain isn’t always straightforward. At least 100 million adults in the United States suffer from chronic pain, according to the Institute of Medicine. The American Academy of Pain Medicine reports that chronic pain affects more Americans than diabetes, heart disease and cancer combined.

The Nature of Pain

Pain serves an important purpose by alerting you to injuries such as a sprained ankle or burned hand. Chronic pain, however, is often more complex. Although people often think of pain as a purely physical sensation, pain has biological, psychological and emotional factors. Furthermore, chronic pain can cause feelings such as anger, hopelessness, sadness and anxiety. To treat pain effectively, you must address its physical, emotional and psychological aspects.

Medical treatments, including medication, surgery, rehabilitation and physical therapy, may be helpful for treating chronic pain. Psychological treatments are also an important part of pain management. Understanding and managing the thoughts, emotions and behaviors that accompany the discomfort can help you cope more effectively with your pain — and can actually reduce the intensity of your pain.

Psychological Treatments for Pain

Psychologists are experts in helping people cope with the thoughts, feelings and behaviors that accompany chronic pain. They may work with individuals and families through an independent private practice or as part of a health care team in a clinical setting. Patients with chronic pain may be referred to psychologists by other health care providers. Psychologists may collaborate with other health care professionals to address both the physical and emotional aspects of patients’ pain.

When working with a psychologist, you can expect to discuss your physical and emotional health. The psychologist will ask about the pain you experience, where and when it occurs, and what factors may affect it. In addition, he or she will likely

STRESS AND CHRONIC PAIN

Having a painful condition is stressful. Unfortunately, stress can contribute to a range of health problems, including high blood pressure, heart disease, obesity, diabetes, depression and anxiety. In addition, stress can trigger muscle tension or muscle spasms that may increase pain. Managing your emotions can directly affect the intensity of your pain.

Psychologists can help you manage the stresses in your life related to your chronic pain.

Psychologists can help you learn relaxation techniques, such as meditation or breathing exercises, to keep stress levels under control. Some psychologists and other health care providers use an approach called biofeedback, which teaches you how to control certain body functions.

In biofeedback, sensors attached to your skin measure your stress response by tracking processes like heart rate, blood pressure and even brain waves. As you learn strategies to relax your muscles and your mind, you can watch on a computer screen as your body’s stress response decreases. In this way, you can determine which relaxation strategies are most effective and practice using them to control your body’s response to tension.

Stress is an unavoidable part of life, but managing your stress will help your body and your mind and lessen your pain.
ask you to discuss any worries or stresses, including those related to your pain. You also may be asked to complete a questionnaire that allows you to record your thoughts and feelings about your pain.

Having a comprehensive understanding of your concerns will help the psychologist begin to develop a treatment plan.

For patients dealing with chronic pain, treatment plans are designed for that particular patient. The plan often involves teaching relaxation techniques, changing old beliefs about pain, building new coping skills and addressing any anxiety or depression that may accompany your pain.

One way to do this is by helping you learn to challenge any unhelpful thoughts you have about pain. A psychologist can help you develop new ways to think about problems and find solutions. In some cases, distracting yourself from pain is helpful. In other cases, a psychologist can help you develop new ways to think about your pain. Studies have found that some psychotherapy can be as effective as surgery for relieving chronic pain because psychological treatments for pain can alter how your brain processes pain sensations.

A psychologist can also help you make lifestyle changes that will allow you to continue participating in work and recreational activities. And because pain often contributes to insomnia, a psychologist may also help you learn new ways to sleep better.

Progress and Improvement

Most patients find they can better manage their pain after just a few sessions with a psychologist. Those who are experiencing depression or dealing with a long-term degenerative medical condition may benefit from a longer course of treatment. Together with your psychologist, you will determine how long treatment should last. The goal is to help you develop skills to cope with your pain and live a full life.

Tips for Coping with Pain

Consider the following steps that can be helpful in changing habits and improving your sleep:

**Stay active.** Pain — or the fear of pain — can lead people to stop doing the things they enjoy. It’s important not to let pain take over your life.

**Know your limits.** Continue to be active in a way that acknowledges your physical limitations. Make a plan about how to manage your pain and don’t push yourself to do more than you can handle.

**Exercise.** Stay healthy with low-impact exercise, such as stretching, yoga, walking and swimming.

**Make social connections.** Call a family member, invite a friend to lunch or make a date for coffee with a pal you haven’t seen in a while. Research shows that people with greater social support are more resilient and experience less depression and anxiety. Ask for help when you need it.

**Distract yourself.** When pain flares, find ways to distract your mind from it. Watch a movie, take a walk, engage in a hobby or visit a museum. Pleasant experiences can help you cope with pain.

**Don’t lose hope.** With the right kind of psychological treatments, many people learn to manage their pain and think of it in a different way.

**Follow prescriptions carefully.** If medications are part of your treatment plan, be sure to use them as prescribed by your doctor to avoid possible dangerous side effects. In addition to helping you develop better ways to cope with and manage pain, psychologists can help you develop a routine to stay on track with your treatment.
Scheduling & To Do Lists
Streamline your practice management and workflow. Past appointments are automatically added to your To Do List. Sync your calendar to your iPhone. Great multi-clinician scheduling features.

Patient Notes & EMR
Our form-based system makes it easy to keep up with your notes. Templates were designed specifically for mental health and therapists. Also upload any files to your patient records.

Electronic Billing
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My experience with TherapyNotes this past month has been fantastic!
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