GOOD PRACTICE
Tools and Information for Professional Psychologists

Understanding Military Culture
Demystifying Provider Contracts

PRACTITIONER PROFILE
Partnerships for Patient Care
Participating Successfully in the Medicare PQRS Program

PUBLIC EDUCATION RESOURCE
Living Well on Dialysis
Evaluate attention disorders and neurological functioning with the Conners Continuous Performance Tests, now with both visual and auditory attention assessments.

- A comprehensive evaluation with the introduction of an auditory attention test
- Easy interpretation with new reports offering clear visuals & summaries
- Trusted results with the most representative CPT normative samples collected
- Diagnostic confidence with a refined measurement of attention & new scores
CONTENTS

Understanding Military Culture .................................................. 2
SIDEBAR: Additional Resources ................................................. 5
Demystifying Provider Contracts .................................................. 6
SIDEBAR: Key Contract Provisions ............................................... 7
SIDEBAR: Related Resources ....................................................... 9
Partnerships for Patient Care
PRACTITIONER PROFILE: Ronald C. Fish, PhD .......................... 10
Participating Successfully in the Medicare PQRS Program ........... 12
SIDEBAR: 2016 PQRS Reporting Measures
Most Applicable to Psychologists ................................................. 13
SIDEBAR: The APAPO PQRS PRO Registry ............................... 14
SIDEBAR: Additional Resources .................................................. 15
PUBLIC EDUCATION RESOURCE
Living Well on Dialysis ............................................................. 19

Good Practice has been honored by the Association of Marketing and Communications Professionals. MarCom Award winners were selected from among more than 6,500 entries from 17 countries.
Understanding Military Culture

*With training, non-military psychologists can understand strengths and vulnerabilities that service members, veterans and their families may bring to mental health treatment.*

Military culture is like an iceberg, according to a free Veterans Affairs (VA)/Department of Defense (DoD) online training course called “Military Culture: Core Competencies for Healthcare Professionals” (see sidebar on page 5). Above the waterline are the visible aspects of the culture, such as ranks, uniforms, medals, salutes and ceremonies. At the waterline are more subtle cultural signs, including service creeds and oaths of office. Below the waterline are the hidden aspects of military culture – the values of discipline, teamwork, self-sacrifice, loyalty and fighting spirit.

Are you culturally competent when it comes to clients who are active duty service members, veterans or military family members? Even if you’re not a military psychologist, you need to be. Increasing numbers of non-military psychologists in the community are being called upon to see military and veteran clients, says psychologist Wendy Tenhula, PhD, national director for VA/DoD integrated mental health at the VA central office.

Service members and veterans may prefer to keep their mental health care and their military lives separate, either from personal preference or a desire to protect their military careers, says Tenhula. National Guards and Reservists may live too far away from military facilities to receive care there, while some veterans may not be eligible for care at VA facilities, depending on when and where they served, how long they were in the military and how long it has been since they left.

And a lack of cultural competence can mean military clients don’t get the care they need. “Concern about not being understood or respected by providers is repeatedly cited by service members and veterans as reasons for not seeking treatment or dropping out,” says Tenhula, who helped develop the “Military Culture” course. “That’s one thing military culture training tries to address – how you as a clinician can understand, respect and build on those experiences even if you’ve never served in the military yourself.”

With training, non-military psychologists can come to understand the military ethos and how it contributes to strengths as well as vulnerabilities when it comes to mental health care. They can appreciate the special needs of military subpopulations, whether it’s National Guard members, veterans or children of active duty personnel. They can also help encourage those who need mental health care by being clear that even active duty personnel enjoy the same privacy protections as other patients.
Checking your biases

Misconceptions about military clients are common among non-military mental health providers, says Tenhula.

“I’ve encountered providers who assume that people only go into the military if they have no other choices in life,” she says. Especially in today’s all-volunteer military, Tenhula points out, people join for a wide variety of reasons – for example, to further their education, learn new skills, provide for their families or travel the world.

“If you haven’t worked with service members or veterans, you might not even realize you have those perceptions,” says Tenhula, adding that such biases can affect practitioners’ work with their clients. “If you have the assumption going into your work with a veteran that people only go into the military because they are at a dead end in their lives, that’s a very different perspective than, ‘This person went through college on an ROTC scholarship and was chosen to become a leader in the military.’”

People also assume that service members returning from Iraq and Afghanistan are ticking time bombs, says Col. Rebecca I. Porter, PhD, a psychologist who directs the DiLorenzo TRICARE Health Clinic at the Pentagon. “In fact, they don’t all have post-traumatic stress disorder (PTSD),” says Porter, a past president of APA’s Div. 19 (Society for Military Psychology). “And even the ones who do may be completely capable of doing their jobs and staying on active duty.”

Understanding the military ethos

While PTSD and traumatic brain injuries have become hallmarks of the wars of the last 15 years, military individuals have unique strengths that can help them weather these and other mental health problems, says Tenhula.

“The really important message is that while military experience can put people at risk for certain difficulties, the vast majority of service members and veterans successfully navigate the challenges of post-military life and bring a lot of strengths to that and to the therapy session as well,” she says.

Key among those strengths is what Tenhula calls the “military ethos” – the values of teamwork, discipline, pride and commitment to a mission that characterize life in the military. While each of the nation’s five military branches subscribe to that ethos, she says, each also has its own slightly different ethos and values. The Army’s ethos includes never accepting defeat and never quitting,

People join for a wide variety of reasons... to further their education, learn new skills, provide for their families or travel the world.

for example, while the Navy’s ethos includes decisive leadership as a key part of success.

These values not only protect military individuals’ mental health, says Tenhula. They can also help them succeed in treatment if they do end up needing help. The military’s emphasis on commitment and follow-through can enhance treatment, for example. The military also emphasizes training, so the idea of learning new skills to be more successful in life can resonate with service members and veterans. And while veterans may feel a loss of identity now that they’re no longer part of their units, says Tenhula, psychologists can help them commit to doing what’s best for their families or whoever their social group is now.

Porter urges her civilian counterparts not to coddle military clients. “If they don’t do whatever homework you prescribe, for example, be firm with them about what it takes to get better,” she suggests.

Asking questions

To take advantage of those strengths, you have to know if a client is part of military culture, says psychologist Ronald S. Palomares, PhD, who provides confidential mental health services to military service members and dependents as part of the Military Family and Life Consultant program and is on the faculty at Texas Woman’s University.

Palomares suggests that all psychologists include the question, “Are you or a close family member connected to the military?” in their clinical intake. Recognizing that many patients don’t volunteer this information, the American Medical Association issued guidelines in 2015 recommending that all health-care providers ask about military history of patients and their family members.

Don’t stop there. In addition to asking about what branch of the military service your client served in, also ask what role – combat, protection or support – he or she played. A humanitarian mission is very different from counter-insurgency warfare, for example.

Other questions to ask include why a client joined a particular branch of the military and how connected he or she feels to the military.
Getting prepared

Psychologists should be prepared to respond appropriately if someone says they do have a military connection.

Start with the Center for Deployment Psychology’s self-assessment exercise, available at deploymentpsych.org/self-awareness-exercise to uncover your own biases, expectations and beliefs about members of the military. Study the VA/DoD clinical practice guidelines on evaluating and managing post-deployment health, managing PTSD and concussion and mild traumatic brain injury and other topics, available at deploymentpsych.org/content/va-dod-clinical-practice-guidelines. And take the “Military Culture” course, available at vha.train.org/DesktopShell.aspx. The course offers modules on beliefs and biases about the military, military organization and roles, stressors and their impacts, treatment resources and tools and offers continuing education credit for psychologists and other clinicians.

If your practice is close to a military base, you could also introduce yourself to providers and ask about on-base trainings and other resources available to community-based providers.

Being culturally competent in military culture won’t necessarily change how you do psychotherapy, just as it wouldn’t if you were treating someone with a different racial or ethnic background or sexual orientation from your own. What’s most important, says Tenhula, is simply respecting both military clients’ concerns and their experiences. That means knowing about the different branches, understanding rank and using correct greetings, titles and colloquialisms. To make people comfortable, you could also ensure that artwork, magazines and brochures in your office reflect military culture.

Being attuned to subpopulations

Of course, military culture isn’t homogenous. Just like any other area of cultural competency, military culture has subpopulations with their own unique vulnerabilities and strengths.

Take National Guard members and Reservists, for example. Unlike active duty service members, says Palomares, these individuals may live far from military bases and the supports they offer to both military members and their families.

“They’re coming from communities across the nation — rural, urban and everywhere else,” says Palomares.

If your practice is close to a military base, you could introduce yourself to providers and ask about on-base trainings and other resources available to community-based providers.

“When you live near a military installation, the community understands and supports the military.”

National Guards and Reservists may also struggle with identity issues, says Palomares. “They have to straddle two worlds,” he says, explaining that they must go back and forth between their normal everyday jobs and going to training or even overseas alongside full-time service members. “People sometimes struggle with making that seamless transition from one to another.”

Military families also have unique concerns, says Karen Herdzik Lopez, PhD, a psychologist whose private practice is close to Fort Bragg in Fayetteville, N.C. Deployments — especially the multiple deployments that have characterized the wars in Iraq and Afghanistan — are obviously stressful, she says. Beyond that, she says, the spouse who is left behind has the stress of having to run a household without a partner. Sometimes the left-behind spouse or children move back to their hometowns so that parents, grandparents or others can help provide support.

The stresses can continue even after the deployed spouse comes home, adds Herdzik Lopez, explaining that the military member can seem different to family members and that it can take some time for service members to re-integrate back into normal life.

“When they’re deployed, they’re working very hard under harsh conditions,” says Herdzik Lopez, noting that about 35 percent of her practice consists of veterans and military dependents. “When they come back, they’re frequently very tired and worn down, with time to process and think about the different things they’re not able to think about when they’re deployed.”

Even when military personnel aren’t deployed, says Herdzik Lopez, there can be stresses. “Service members have lots of demands placed on them beyond the typical career,” she says. “They often work long hours and get called in for special duty.”

On the plus side, the frequent moves military families typically make help give spouses and children extra flexibility, adaptability and resilience.
According to a 2014 RAND Corporation report, *Ready to Serve: Community Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families*, psychologists and other providers may not be adequately prepared to meet the needs of military clients.

While 70 percent of providers working in a Veterans Affairs (VA) or military setting had a high degree of what the report calls “military cultural competency,” the report found, only eight percent of those without VA or TRICARE affiliation did. While proximity to a VA or military facility boosted competence – with almost a quarter of practitioners within 10 miles exhibiting high military cultural competence – only 15 percent of those farther away did.

Is your practice ready? These resources can help you prepare:

**APA’s Div. 19 (Society for Military Psychology).** The division offers a newsletter, journal and other resources, including opportunities to consult with members. Visit [www.apadivisions.org/division-19/index.aspx](http://www.apadivisions.org/division-19/index.aspx).

**Center for Deployment Psychology.** Aimed at both military and civilian behavioral health professionals, the center offers information, training and other resources. Visit [deploymentpsych.org](http://deploymentpsych.org).

**Community Provider Toolkit.** This VA resource offers tools for understanding military culture, screening for military experience, treating common mental health problems and connecting with the VA. Visit [www.mentalhealth.va.gov/communityproviders/#sthash.dnscVmh7.dpbs](http://www.mentalhealth.va.gov/communityproviders/#sthash.dnscVmh7.dpbs).

**Give an Hour.** Run by a psychologist, this nonprofit organization encourages psychologists and other mental health professionals to provide volunteer services to service members, veterans and their families. Visit [giveanhour.org](http://giveanhour.org).

**Make the Connection.** This VA website showcases veterans’ stories of recovery, provides information about mental health conditions and connects users with nearby resources. Visit [maketheconnection.net](http://maketheconnection.net).

**Military & Family Life Consultant Program.** Designed to supplement DoD services for service members and their families, this program offers short-term counseling focused on problem-solving. Visit [www.mhngs.com/app/programsandservices/mflc_program.content](http://www.mhngs.com/app/programsandservices/mflc_program.content).

**Military Cultural Awareness.** This online course from the VA explains military branches, ranks, customs, VA practices and more. Visit [learning.mycareeratva.va.gov/courses/Military-Cultural-Awareness-Course/M/wrap_menupage.htm](http://learning.mycareeratva.va.gov/courses/Military-Cultural-Awareness-Course/M/wrap_menupage.htm).


**National Center for Post-traumatic Stress Disorder (PTSD).** This VA site offers a consultation program as well as links to training and other resources. Visit [www.ptsd.va.gov/professional/consult](http://www.ptsd.va.gov/professional/consult).

**VA/DoD clinical practice guidelines.** These evidence-based guidelines explain how to evaluate and manage post-deployment health, plus how to manage PTSD, concussion and mild traumatic brain injury, depression and substance use. Visit [deploymentpsych.org/content/va-dod-clinical-practice-guidelines](http://deploymentpsych.org/content/va-dod-clinical-practice-guidelines).

“Even though from the perspective of a child in middle school or high school, it may feel like you’re ruining their lives, most military children are able to look back at the experience and the places they’ve lived, the different cultures they’ve encountered and see that as strength-producing, as giving them a flexibility or worldliness they wouldn’t trade,” says Porter, whose own children attended five or six different schools during her service. “They may become quite adept at building new support systems and friendships wherever they go.”

**Explaining confidentiality rules**

One other key part of military culture psychologists in the community need to be aware of is the stigma around seeking mental health services.

“‘We’ve made a lot of strides in decreasing stigma, but service members still worry that seeking behavioral health care is detrimental to their careers and reputations,’” says Porter. As a result of those fears, military members may not seek care or may not reveal what’s really on their minds if they do.
Demystifying Provider Contracts

When you sign a provider contract with an insurance or managed care company to deliver services to insurance plan subscribers, you agree to obligations that are enforceable by law. Some contract provisions can create difficulties and challenges for practitioners. Others are just important to be aware of to make your dealings with the company smoother.

This article begins with some general pointers for handling provider contracts, discusses how these contracts are organized, and then highlights several contract terms that may require particular attention.

Much of the advice in this article will apply to provider contracts with other entities, such as accountable care organizations or medical homes. And some of the material, particularly the general pointers, will be applicable to any contract you may sign in your practice — for example, a lease of office space, an employment contract or an independent contractor agreement.

General pointers
Consider the following general guidance:

Review the contract before you sign it. Do not assume that all provider contracts are alike. Make sure you know what the terms of a contract mean — and obligate you to do — and be certain you are willing and able to meet all of the obligations.

Reviewing provider contracts was easier decades ago when they tended to be only a few pages long. Many provider contracts now exceed 20 pages. At a minimum, you should be sure to carefully review the key provisions described in the last section.

Psychologists sometimes wonder if there is any leeway to modify a contract provision that they find objectionable. Companies typically expect health care professionals to agree to a provider contract in its entirety. As such, you may find that you have limited opportunity to negotiate terms, though some psychologists have successfully negotiated reimbursement rates. You can always ask whether a particular company is willing to modify or delete a particular provision in the contract.

Consider having a knowledgeable attorney assist you as needed with contract review. This is particularly important if you are having trouble understanding what the contract says. Based on their own knowledge and experience, your professional colleagues as well as your state psychological association may be able to provide good leads on attorneys. (Some state associations, such as those in Florida and Texas, offer members free or discounted attorney consultations as a member benefit.) For law firms not recommended by colleagues or your state association, you can check the law firm’s website to see if health care, health care contracts or provider contracts are identified as an area of expertise. If the firm’s website has a long list of specialties relative to the number of attorneys, consider whether the firm actually has in-depth expertise relevant to reviewing provider contracts. For example, you might ask how many provider contracts the firm has reviewed in the last few years.
Keep a copy of your signed contracts readily accessible, whether electronically or a photocopy, including any amendments. You need to be able to readily refer to the contract if a disagreement or other conflict with the company arises. Also keep handy any amendments to the contract that you may receive from the company. A quick review of these documents may allow you to favorably resolve problems with the company.

Be aware of state governmental entities to which you can report unfair practices by the insurance or managed care company. Your state insurance commission, or similar state agency responsible for overseeing contracts issued by insurance or managed care companies, may address health professionals' complaints about their contracts and may be willing to help you resolve these conflicts. (Some insurance commissioners only respond to consumer/patient concerns.) When you send a complaint email or letter to the company, you might want to send a copy to the state insurance agency as well (See the “10 Tips” article in the Related Resources sidebar on page 9 for further information).

Components of your provider contract
Understanding the different pieces of the provider contract will make it easier for you to review it. The typical provider contract has four basic components. Together these make up the package to which you are agreeing.

The main contract. Most of the key provisions discussed in the next section will be found in the main body of the contract, which typically ends with the signature page. While this is typically the only document that you sign, it generally contains a provision saying that you are also agreeing to abide by the terms of the other components. (Sometimes the contract uses the legalese expression that the other components are “incorporated by reference,” which means that they are considered part of the contract.)

Amendments. Often the provider contract will have amendments that change portions of the main contract. Some may only apply to particular programs, such as a Medicaid plan, while other amendments are designed to conform the contract to your state’s law. Amendments may specify what happens if there is a conflict between a provision in the main contract and a provision in the appendix or amendment. Typically, the provision in the amendment takes precedence if there is a conflict.

Amendments are the most common way for the company to change the main provisions of the contract after you have signed it. The less common alternative is for the company to send you a completely new contract to sign. Thus, in addition to any amendments that are attached to the original contract package, you may receive several amendments to the contract during its term.

Understanding the different pieces of the provider contract will make it easier for you to review it. The typical provider contract has four basic components.

The fee schedule. The schedule of various reimbursement rates by procedure code is usually a separate document. Be sure that you have reviewed and understand this schedule before you sign the contract. For example, there may be different fee schedules for different programs and it may not be immediately clear which schedule or schedules apply to your practice.

Other provider guidance incorporated by reference into the contract. Provider contracts also often have you agree to follow policies or procedures contained in resources that are not part of the provider contract package that the company sends you. The most common such resource is the provider section of the insurance company website. That section often contains important information such as recordkeeping, pre-authorization and billing requirements, as well as services the insurer does not cover. (These provider website sections replace the printed Provider Manual from a decade or two ago.)

KEY CONTRACT PROVISIONS

- Term and termination
- Ability to assign you to different company networks or products
- Payment and recoupment
- Recordkeeping policies and procedures, and audits
- Changes to contract terms
You should review these sources before you sign the contract, but be aware that the company has flexibility to change this outside guidance without formally amending your contract. The main contract or state law may limit the extent to which the company can alter the contract without proper notice. See “Changes to contract terms” in the next section for additional information.

**Key provisions**

The following provisions are the ones most likely to be central to psychologists’ disputes with, or concerns about, a company. With the exception of the recordkeeping and billing procedures, all of these provisions should be in the main contract – but they may be altered by amendments to the contract.

**Term and termination.** These provisions, or at least the termination provision, are usually found near the end of the contract. Most provider contracts are now set up to renew annually until you or the company terminates the contract.

Termination provisions control the circumstances under which you or the company can terminate the contract, and the notice required before termination. Most contracts enumerate certain reasons that will allow the company to terminate the contract, such as alleged breaches of the contract that you do not fix after being notified by the company. Commonly, providers are allowed to terminate without giving reasons, but are often required to give 90-day notice to allow for transitioning the care of patients covered by the company. Contracts often have specific provisions regarding your obligations to provide care to these patients during the transition period.

**Ability to assign you to different company networks or products.** Some contracts give the insurance or managed care company leeway to send you patients affiliated with lower paying plans and networks also operated by the company. For example, you contract to provide services for a preferred provider organization (PPO), but the company is also able to send you patients affiliated with a health maintenance organization (HMO) that has lower reimbursement rates.

Relatedly, some provider contracts have a provision saying that if you sign up for one of the company’s plans or products, for example a higher paying PPO plan, you are automatically enrolling in all of the company’s plans. Virginia prohibits such “all products” clauses.

Contracts often address circumstances under which companies may demand repayment for services, also known as recoupment or claw back.

**Payment and recoupment.** The following are important aspects of the contract regarding payment provisions. The contract should define the “covered services” for which you will get paid. It should also state how promptly the company will pay you after you have submitted a clean claim – one that contains all of the information necessary for the company to process payment. Virtually all states require insurance and managed care companies to pay claims within a certain number of days after receiving clean claims – for example 15 days for electronically submitted claims and 30 days for paper claims. The company should follow whichever time period is shorter – the one specified by state law or the provider contract.

To make sure that you are filing clean claims that the company must promptly pay, you should familiarize yourself with the company’s pre-authorization requirements and billing procedures before you provide services. These are often found in the provider section of the company website.
Payment provisions also typically govern the extent to which you can bill patients/insureds for uncovered services or services that are deemed not medically necessary. For example, the company may determine that certain services are not medically necessary, or not covered for other reasons, but the contract still prohibits you from charging more than the reimbursement rate to which you agreed for providing these services. Or you may be required to have the patient sign a document acknowledging that the patient understands that the services will not be covered by the insurer.

Finally, contracts often address circumstances under which companies may demand repayment for services, also known as recoupment or claw back. For example, the company may discover after paying you that a beneficiary was no longer an employee when you provided services, and therefore not covered by its insurance. Many states have laws that limit how far back a company can go with recoupment. Two years is common, but a few states limit recoupment to 180 days.

**Recordkeeping policies and procedures, and audits.** Your contract may specify how many years you need to keep patient records. Regardless of what the contract does or doesn’t say about the records retention period, a longer retention period may be required by your state’s law or recommended by APA’s recordkeeping guidelines.

*continued on page 18*
Partnerships for Patient Care

Practitioner Profile: Ronald C. Fish, PhD

When medical staff at Crouse Hospital in Syracuse, NY, needed help dealing with challenging interactions with patients, they turned to psychologist Ronald C. Fish, PhD, and his large mental health practice for a consultation.

Next the nurses needed help managing patients who weren’t responding to pain treatment, then more help managing patients whose rudeness, combativeness or heart-rending situations were causing nurses’ stress levels to skyrocket. Then Fish suggested screening all of the hospital’s patients for depression and anxiety, a process that has begun with chronic obstructive pulmonary disease and cardiology patients. Patients with identified mental health problems get referred to Fish and his practice.

“You have to get your foot in the door and show you’re useful,” says Fish, co-owner and clinical director of Psychological HealthCare, PLLC, headquartered in Syracuse. “It’s all about identifying needs and trying to help people.”

That has been a guiding principle for Fish and his partner, psychologist Joel Richman, PhD, as they’ve built the practice over the last 16 years. The practice now includes 70 clinicians, about half of whom are psychologists, plus social workers, licensed mental health counselors and a doctoral-level marriage and family therapist. The practice has five offices throughout the Syracuse metropolitan area. It has psychologists and other clinicians co-located in 16 medical offices, with three or four more co-location arrangements soon to come. And the practice now has a contract to provide ongoing assistance to medical staff at Crouse.

Connecting with medical practices

Fish’s practice didn’t start out big. A couple of years after earning a doctorate in clinical psychology from Loyola University Chicago in 1983, he launched a solo psychotherapy practice.

Then he got interested in joining forces with medical professionals. In the late 1990s, he and another psychologist approached a pediatric practice about co-location. “We realized that when a 15-year-old came to our offices, having suffered and failed in life for many years already, it was sad to us that we hadn’t gotten to him earlier,” says Fish. The pediatricians invited Fish to open an office in the same building and began referring patients. By 1999, Fish had seven or eight clinicians in his practice. He then joined forces with what had once been a competing practice run by Richman. Together they had about 15 providers.

The practice then began growing. “A few years ago, it became clear that the way health care was evolving, we couldn’t really be a stand-alone organization,” says Fish. “With consolidation going on in the health-care industry, we realized that we needed to ally ourselves. We looked for partners who put patient care first.”

As a result, he began intensifying his efforts to partner with medical practices seeking to deliver improved care for their patients. What started out as simple referrals has now evolved into ever-increasing interconnectivity.

Take the co-located clinicians, for example. Most of the clinicians are co-located in primary care offices. The practice also has two psychologists co-located in the office of a bariatric surgeon, who contacted the practice because he wanted to figure out why 25 percent of his surgeries failed and how to help patients succeed. The psychologists perform pre-surgical evaluations and are exploring research projects to answer the surgeon’s question. The practice will soon place a clinician in a cardiology office.

The medical practices have been appreciative, says Fish. “It makes their jobs easier,” he says. When the mental health clinicians first start at a medical practice, he adds, they tend to see the people the physicians have been trying unsuccessfully for years to send to behavioral health providers for traditional mental health problems. “These are
people who have been seeing physicians for quasi-medical complaints but who are really having problems in living,” says Fish.

The medical practices and Psychological HealthCare remain separate business entities bound by agreements covering how the practices will collaborate. Psychological HealthCare does its own billing. The behavioral health clinicians have full or limited access to a medical practice’s electronic health record system, depending on the medical practice. The clinicians and physicians work closely together.

Last year, the Health Alliance Physician Organization and IPA, a group of physicians affiliated with Crouse, approved Psychological HealthCare to join their independent practice association as a member organization. “It’s all about relationship-building and trust-building,” says Fish.

With the extension of Psychological HealthCare’s agreement with Crouse Hospital, the practice will continue to consult with hospitalized patients as well as training and supporting medical staff. Recently Fish delivered a grand-rounds presentation at Crouse about dealing with challenging patients.

“Difficult people get sick, too,” says Fish, explaining that the nurses are periodically confronted with patients who, when under stress, are loud and combative. Patients may be upset about bad medical outcomes. Or patients may be faring so poorly that nurses find themselves grieving. Fish and his colleagues help the nurses understand what’s going on with patients, how their own emotions interact with the patients’ emotions and what internal and external resources they can utilize to stop difficult situations from escalating.

In one recent case, for instance, a patient was upset about perceived mistreatment by a nurse, which in turn upset the nurse. Fish explained to the nurse how her emotional arousal interfered with her capacity to think straight, then accompanied her to the patient’s room to support and calm the nurse as well as the patient and help keep the conversation constructive.

“The chief nursing officer told me, ‘When you were called to the floor, the nurses were beside themselves and didn’t know what to do,’” says Fish. “She said, ‘When you went in, it was like a flipped switch.’”

The agreement with the hospital covers the cost of a clinician on call nine hours a day to help with crises. “The hospital is facing massive budget cuts next year, but they’re continuing our contract, because they value our services,” says Fish.

If you see a need or another opportunity, just go talk to people about it. Interested, motivated people who treasure clinical integrity will see the benefit of working with you.

Helping both patients and practitioners thrive

All this activity has helped the practice flourish.

For one thing, the practice now averages 800 new patient contacts a month. More than half of those new referrals come from the physician practices where the practice’s clinicians are co-located.

While the practice was in its biggest growth spurt a decade ago, Fish devoted himself full time to its administration. Even now, the practice is so big he spends about 70 percent of his time simply running it.

Some practices have trouble finding psychologists to work in integrated practice settings. Not Psychological HealthCare. In fact, says Fish, more and more clinicians are seeking out the practice. When Fish finds a clinician who seems like a good fit for this kind of integrated practice, he contacts medical practices to talk about possible co-location placements.

But Fish is convinced that integrating psychological and medical care is helping patients as well as his practice to thrive. And he’s hoping to eventually have the data to prove it.

That’s why he’s on the board of HealtheConnections, a nonprofit organization that aims to use health information exchanges to improve patient care and health in the region. That organization – and the data bank of medical encounters it operates – will play a key role not just in driving treatment decisions and facilitating the shift to pay-for-performance models but also in proving integrated care’s value, says Fish. As data become available, he says, he’ll be pushing for local pilot projects to demonstrate integrated care’s positive impact.

For other psychologists interested in collaborating with physicians, Fish has this advice: Just keep pushing and don’t be sensitive to rejection. “Put yourself out there and keep making proposals,” he says. “If you see a need or another opportunity, just go talk to people about it. Interested, motivated people who treasure clinical integrity will see the benefit of working with you.”
Participating Successfully in the Medicare PQRS Program

What to know and do for the 2015 and 2016 reporting years

The Physician Quality Reporting System (PQRS) is part of a broader initiative to improve quality of care in Medicare. By reporting on PQRS quality measures, individual providers and group practices can quantify how often they are meeting a particular quality metric.

The PQRS program now applies a negative adjustment to Medicare payments for eligible professionals (EPs) who did not satisfactorily report data on quality measures two years prior. Those who report satisfactorily for the 2015 reporting year will avoid the PQRS negative payment adjustment in 2017.

There are three ways to participate in PQRS: claims-based reporting; in a registry approved by the Centers for Medicare and Medicaid Services (CMS); or via certified electronic health record (EHR).

Claims-based reporting is done by adding Measures Codes and Quality Codes to the electronic or paper claim form that you currently submit to Medicare. Detailed instructions for selecting and using measures and quality codes are available in the 2015 PQRS Individual Claims Registry Measure Specification Manual at go.cms.gov/1PCM0Y]. Psychologists who are reporting through claims have until February 28, 2016 to submit their 2015 data directly to CMS. While the agency has not made changes to the claims-based reporting method for 2016, CMS has indicated that it will not support this reporting method indefinitely.

EPs may also satisfy the requirements for PQRS by reporting quality measures data to a participating registry, which collects and transmits data to CMS. PQRS registries must meet criteria set by CMS, such as having secure methods for data transmission and providing feedback to registry participants. More information on registry reporting is available at go.cms.gov/1wLWF8C.

The APA Practice Organization (APAPO), in collaboration with Healthmonix, launched a registry in 2014 available to all eligible mental health professionals. **Psychologists wishing to use the CMS-approved APAPO PQRSPRO registry must sign up for the 2015 reporting year by January 31, 2016 and submit their PQRS data to the registry by February 15.** For more information, see the sidebar on page 14.

Finally, individual EPs and group practices can submit quality measure data directly from their own EHR system, provided it is considered certified EHR technology (CEHRT), or through an EHR Data Submission Vendor which collects clinical quality data directly from the EP’s or group practice’s CEHRT and submits it on their behalf. More information on EHR reporting is available at go.cms.gov/1u2vPIF.
### 2016 PQRS Reporting Measures Most Applicable to Psychologists

<table>
<thead>
<tr>
<th>Measure No.</th>
<th>Measure Name</th>
<th>NQS Domain</th>
<th>Reporting Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>128</td>
<td>Preventive care and screening: Body mass index screening and follow-up</td>
<td>Community/population health</td>
<td>Claims, registry and EHR</td>
</tr>
<tr>
<td>130</td>
<td>Documentation and verification of current medication in the medical record</td>
<td>Patient safety</td>
<td>Claims, registry and EHR</td>
</tr>
<tr>
<td>131</td>
<td>Pain assessment prior to the initiation of patient therapy and follow-up</td>
<td>Communication and care coordination</td>
<td>Claims and registry</td>
</tr>
<tr>
<td>134</td>
<td>Screening for clinical depression and follow-up plan</td>
<td>Community/population health</td>
<td>Claims, registry and EHR</td>
</tr>
<tr>
<td>181</td>
<td>Elder maltreatment screen and follow-up plan</td>
<td>Patient safety</td>
<td>Claims and registry</td>
</tr>
<tr>
<td>226</td>
<td>Preventive care and screening: Tobacco use screening and cessation intervention</td>
<td>Community/population health</td>
<td>Claims, registry and EHR</td>
</tr>
<tr>
<td>325</td>
<td>Adult major depressive disorder (MDD): Coordination of care of patients with specific comorbid conditions</td>
<td>Communication and care coordination</td>
<td>Registry only</td>
</tr>
<tr>
<td>370</td>
<td>Depression remission at twelve months</td>
<td>Effective clinical care</td>
<td>Registry only</td>
</tr>
<tr>
<td>383</td>
<td>Adherence to antipsychotic medications for individuals with schizophrenia</td>
<td>Patient safety</td>
<td>Registry only</td>
</tr>
<tr>
<td>411</td>
<td>Depression remission at six months</td>
<td>Communication and care coordination</td>
<td>Registry only</td>
</tr>
<tr>
<td>414</td>
<td>Evaluation or interview for risk of opioid misuse</td>
<td>Effective clinical care</td>
<td>Registry only</td>
</tr>
<tr>
<td>431</td>
<td>Preventive care and screening: Unhealthy alcohol use and brief counseling</td>
<td>Community/population health</td>
<td>Registry and measures group reporting</td>
</tr>
</tbody>
</table>
Successful reporting

In order to successfully report for 2015 and 2016, EPs must submit data on nine measures, which must fall into at least three out of six categories called domains. There are six available domains identified by the National Quality Strategy (NQS) that represent federal priorities in the effort to improve health and the quality of health care. The six domains are patient safety, person and caregiver centered experience and outcome, communication and care coordination, effective clinical care, community/population health, and efficiency and cost reduction.

The 2016 PQRS measures most applicable to psychologists are listed in the chart on page 13.

For those participants who have face-to-face encounters with patients, one of the nine measures must be a cross-cutting measure. Cross-cutting measures are existing PQRS measures that reflect improvement in patients’ functional status. Of those listed in the chart, measures 128, 130, 131, and 226 are cross-cutting measures. CMS no longer accepts a “0 percent performance rate” for a measure, meaning the EP must perform the measure action at least once to satisfactorily report.

Those who report fewer than nine measures across three domains will be subject to Medicare’s Measure-Applicability Validation (MAV) process. The MAV process examines whether the measures reported are part of a clinically related “cluster,” meaning a group of measures applicable to a particular health problem. EPs reporting fewer than nine measures across three domains can still report successfully if the MAV process does not find other measures that the EP could have used in reporting. As stated above, an EP having face-to-face encounters with patients must report at least one cross-cutting measure or the EP will have failed, regardless of how many measures they report.

APAPO expects that many psychologists will need to go through the MAV process based on their patient populations and the limited number of services they provide to Medicare beneficiaries. More information on the MAV process is available at apapracticecentral.org/update/2014/04-24/pqrs-track.aspx.

For those participants who have face-to-face encounters with patients, one of the nine measures must be a cross-cutting measure.

APAPO, in collaboration with a leading health care data and technology company named Healthmonix, launched the APAPO PQRSPRO registry in 2014 to focus on PQRS measures used by mental and behavioral health providers. PQRS participants have a 90-percent success rate when reporting through registries and EHRs, as compared to a 56-percent success rate when reporting on claims forms. The APAPO PQRSPRO system automatically calculates and validates your data to ensure successful submission. Information about how to use the APAPO PQRSPRO registry is available on the registry website at apapo.pqrspro.com, which includes tutorials to guide participants through the reporting process. Registry staff members are available to provide support to participants.

For the 2015 reporting year, members who want to use the registry must sign up with APAPO PQRSPRO by January 31, 2016 and submit their PQRS data by February 15, 2016.

Psychologists who treat patients with dementia also have the option of reporting the Dementia Measures Group. Psychologists choosing this option must report each measure in the group on 20 patients, at least 11 of whom must be Medicare Part B fee-for-service (not Medicare Advantage) patients. Measures groups cannot be reported through claims; a psychologist who wants to report the Dementia Measures Group must use a registry or EHR reporting. The 2016 Dementia Measures Group consists of the following measures:

#47  Care Plan
#134  Screening for Clinical Depression and Follow-up Plan
#280  Staging of Dementia
#281  Cognitive Assessment
#282  Functional Status Assessment
#283  Neuropsychiatric Symptom Assessment
#284  Management of Neuropsychiatric Symptoms
#286  Counseling Regarding Neuropsychiatric Symptoms
#287  Counseling Regarding Risks of Driving
#288  Caregiver Education and Support
The Quality Improvement Programs section of the APA Practice Organization’s Practice Central website contains the latest information for 2015 and 2016 for both new participants and those who are already reporting in the program. Resources include a list of measures available for 2015 and 2016, a quick reference guide that links applicable codes to each measure, frequently asked questions and video tutorials on participating in PQRS.

The Centers for Medicare and Medicaid Services page on the Physician Quality Reporting System provides quick links to a variety of topics, including eligibility, how to get started in PQRS reporting, PQRS measures codes, group practice reporting information, electronic reporting and more.

Certified Health IT Product list (CERHT)
A comprehensive list of certified health information technology products maintained by the Office of the National Coordinator for Health Information Technology. Psychologists interested in PQRS reporting via an electronic health record (EHR) system should check this list.

QualityNet Help Desk
The QualityNet Help Desk provides answers to common PQRS support questions, including reporting requirements, negative payment adjustments and feedback reports.

GET CREDENTIALED SHOW YOUR PROFICIENCY

Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders
A nationally recognized professional credential from the APA Practice Organization offered exclusively to licensed psychologists who treat patients with alcohol and other psychoactive substance use disorders.

Effective with third-party payers, referral sources and regulators.

Contact the APA Practice Organization
College of Professional Psychology
Phone: (202) 336-6100 • TDD: (202) 336-6123 • Fax: (202) 336-5797
Email: apapcollege@apa.org
But while a military psychologist works for the military and abides by different rules, psychologists in the community can offer the same privacy and confidentiality to military individuals that they would to anyone else — something that psychologists should emphasize with military clients.

“Some people … assume that service members don’t have any confidentiality, when in fact the limits to confidentiality are almost identical to what you see in the civilian sector,” says Porter, explaining that psychologists working in the community are duty-bound to report threats to self or others.

A psychologist working with an active-duty client should also probe into the nature of the person’s work, Palomares adds. “Are we talking about someone who is just entering data or someone walking around with an M16 guarding a top-secret facility or someone who’s actually working in a top-secret facility?” he says. “If they’re working in a highly sensitive or very volatile area yet struggling with mental health issues, when do those issues impact their jobs?”

Psychologists could also ask permission to discuss concerns with the client’s commander, says Porter. If a person’s job involves driving tanks and a psychotropic medicine can make users drowsy, for example, the psychologist could ask for permission to alert the person’s commander that he or she shouldn’t be driving.

No matter how you handle confidentiality concerns, it’s important to acknowledge the strength a military client is demonstrating just by his or her presence in your office, says Porter, explaining that military culture encourages stoicism.

“They tend to think that they need to be strong and need to handle issues on their own,” she says. “It takes a great deal of courage to reach out and ask for help.”

---

**Civilian Psychology Careers**

Care for military personnel, beneficiaries and their families at Army hospitals and clinics worldwide.

» Exceptional Benefits  
» Opportunities Worldwide  
» Rewarding Careers  
» Flexible Work Schedules

Search jobs online today at CivilianMedicalJobs.com
We’re ahead of the curve. And we help you get there, too.

Visit apapracticecentral.org for the latest on the topics that matter most:

• Psychotherapy codes
• HIPAA compliance
• Medicare reimbursement
• Telepsychology
• And much more

Want to hear about it when it happens? Follow us on Twitter at twitter.com/APApractice
Demystifying Provider Contracts  continued from page 9

The details of what content should be in your records is usually not covered in the provider contract, but more likely in the provider section of the company website. In some cases, the company’s recordkeeping guidance is not well tailored to mental health recordkeeping. If so contact the company to clarify what recordkeeping it expects from you as a psychologist. Document your inquiry and any response.

The reason that companies may tell you how long and how to keep records is that most provider contracts give the company the right to audit your patient records. A company may conduct audits for a variety of reasons, including quality of care, medical necessity, quality of recordkeeping, fraud and abuse, and the annual Risk Adjustment Audits that started in 2015 as required by the Affordable Care Act. (See the sidebar on page 9 for articles on preparing for and responding to various insurance and managed care audits.)

Changes to contract terms. Most provider contracts have what might be called a “take it or get out” provision for contract changes. In other words, contracts often require the company to give you 60 days’ notice of significant changes to the contract. But if you don’t like the change, the only option the contract gives you is to terminate your contract. If you find yourself in this circumstance and you have bargaining power with the company, it may be worth asking whether the company will make an exception for your practice.

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.

It’s not too late.
There’s still time to report PQRS measures for 2015 if you register online by January 31, 2016.

apapo.pqrspro.com
If you receive dialysis treatments for kidney disease, you probably spend a lot of time focused on your physical health. That’s important — but so, too, is your mental and emotional well-being.

Dialysis is life-saving, but it’s also life-changing. Still, by taking charge of your emotional health — and accepting help when you need it — you can live a rewarding life on dialysis.

Rollercoaster Emotions

Dialysis requires significant time and effort. In addition to the considerable time spent traveling to and from appointments and undergoing treatment itself, people receiving dialysis must carefully monitor their diet and fluid intake. It’s a lot of work, and it takes time to adapt to the changes.

When people learn they need to begin dialysis, they typically experience a flurry of emotions. Often, the first reaction is shock or denial. People may feel numb or fail to accept the reality of the situation. Anger, sadness, worry, and guilt are also common. People may dwell on the past, wondering what they could have done differently.

Managing Stress and Negative Feelings

Maintain the activities in life that bring you pleasure. Don’t let dialysis prevent you from doing things you love to do. As much as possible, keep up the hobbies and interests you had before dialysis, even if you have to adapt them somewhat to your dialysis schedule or health condition. If you can, continue working. Socialize with friends. People who make a point to go on with life as usual, despite dialysis, tend to be happier and healthier.

Educate yourself. Gather information and ask questions to help you understand the dialysis treatment and the lifestyle changes that go along with it. Your healthcare providers are learning from you, too. Keep a list of your questions and bring them to your doctor appointments and keep a notebook of important information so you have all your medical information in one place. Having all the necessary details will help you maintain a sense of control over your health.

Stay connected to other people. Reach out for support from your spouse/partner, family, and friends. Be open with them about what you’re experiencing and how you’re feeling, and don’t be afraid to ask for help. Explain to others what you need; your loved ones probably want to help, but they may not know how unless you tell them.

Seek additional support. No matter how helpful your friends and family are, it can be hard for you to experience something they don’t fully understand. Talk to your doctor about joining a support group for people with kidney disease so you can connect with others who are going through the same things you are.
**Take a deep breath.** Relaxation exercises such as meditation and gentle forms of yoga, as well as prayer can help lower stress levels. Exercise has also been shown to boost mood in people undergoing dialysis. Consult with your physician about what forms of exercise are safe and appropriate for you.

**Give back.** Continuing to be helpful to those you love, volunteering your time or doing charitable work can help remind you that you have valuable skills to offer, even if you can no longer work or take on as many commitments as you once did.

**Seek professional help.** When dealing with a chronic illness, it’s easy to get stuck in negative thought patterns. Psychologists, social workers and other mental health professionals can help you take control of those negative thoughts and adjust to the unique challenges of dialysis.

### Signs You May Need Help

It’s normal to feel sad while adjusting to the changes that dialysis brings. But for some people, the sadness lingers. Studies suggest that approximately 1 in 5 patients with chronic kidney disease suffer from depression. Anxiety is also common in people with chronic illness. A 2008 study found that 45 percent of people receiving dialysis for end-stage renal disease experienced some type of anxiety disorder.

You might need extra help managing your emotions if you notice you are:

- Feeling hopeless
- Often very stressed or worried
- Sleeping more or less than you used to
- Frequently irritable with friends and family
- Withdrawing from people or activities you used to enjoy
- Doing things you know aren’t healthy, like skipping medications
- Making excuses for not following doctor’s recommendations

If you’re concerned about your emotional state or your stress levels, there are people who can help. The doctors and mental health professionals at your dialysis clinic are trained to discuss these concerns with you and help you manage them. They can also provide you with resources and referrals of local mental health providers in your community that can help.

People undergoing dialysis can safely take some antidepressant medications. However, non-drug options may also be effective, either alone or in combination with medications. Studies have found that exercise therapy and cognitive behavioral therapy (CBT), for instance, can successfully treat depression in people with chronic kidney disease. With CBT, a mental health professional can help you identify ways that you are stuck and help you gain control over negative thoughts and unhelpful behaviors. Many people with kidney disease find that therapy can help them begin to feel like their old selves again.

### MOVING FORWARD

Establishing new, healthy habits takes time. When you make a mistake, don’t beat yourself up — or give up. Instead of dwelling on what you did wrong, think about how you might better handle that situation in the future, and then move on.

Chronic kidney disease is serious, but it is manageable. With the right tools and the right support, you can take control of your emotional and physical health to live a full and rewarding life.

---

**Special thanks to Joanne Smith, R.N., Education Manager for DPC Education Center, and qualified professionals Teri Bourdeau, PhD, Josephine Johnson, PhD, Maureen O’Reilly-Landry, PhD, Kathryn Sawyer, PhD, and Cortney J. Taylor, PhD, who contributed to this article.**

---

This resource was developed jointly by the American Psychological Association (APA) and Dialysis Patient Citizens Education Center as part of a partnership to educate dialysis patients and their families on the psychological and emotional aspects of managing kidney disease.
TherapyNotes
Online Practice Management for Psychologists and Mental Health Professionals

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
Easily submit claims electronically with TherapyNotes EDI! Track balances, view revenue reports, and generate CMS forms, superbills, and patient statements all from within TherapyNotes.

…and Many More Features!
- Appointment Reminders: Automatic text, phone, and email reminders
- Reduce no shows and decrease expenses
- Fully Integrated Credit Card Processing: Swipe or enter patient credit cards
- New Patient Portal: Customers can request appointment times

Special Offer!
Sign Up And Receive Your First 2 Months Free!
Use Promo Code: GPW15
Offer Expires: 3/1/2016

View Features and Sign Up Today at www.TherapyNotes.com

My experience with TherapyNotes this past month has been fantastic!
Firstly, the system is easy to navigate, thorough, flexible, and extremely clinically intuitive. Secondly, technical and customer support has been efficient, fast, and very personal. I am leaving another EHR system for TherapyNotes... gladly. I’m very happy that you’ve created such a quality product. Thank you!
-Dr. Christina Zampella, FT, Licensed Clinical Psychologist

Just want to say that I truly love the system!
It takes all the guesswork out of tracking paperwork. Being able to schedule appointments and then have the system take over and track what is due for each client is wonderful.
-Kathleen Bierman, PCC 5

Many more stories on TherapyNotes.com
Websites for Therapists MADE EASY

$0 Set-Up Fee/$59 per Month.
NO EXTRA CHARGES. 30-DAY MONEY-BACK GUARANTEE

BUILD YOUR WEBSITE FOR FREE AT www.TherapySites.com
CALL TODAY | 866.288.2771

• Basic Search Engine Optimization Included
• Free Online Appointment Requesting
• Unlimited, Easily Customized Pages
• Unlimited Number of Email Addresses
• Unlimited Customer Support
• Plus 6 months free online listing through Psychology Today

“TherapySites was the most effective way to launch my practice, which is booming, even in these hard times.” – B.C., San Diego, CA