The Power of State and Local Engagement

The State of Medicaid

PSYPACT: A Pathway to Interstate Practice

Working for Psychologists and Psychology

30 Years Partnering with State, Provincial and Territorial Psychological Associations

Directors of Professional Affairs: Psychology’s Front Line

The Value of Political Giving at the State Level

Prescriptive Authority: Renewed Action in the States

State Beat: Psychology Leaders Address Letters on 90837 and Advocate for Testing Data
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Dr. Samuel O. Ortiz, Ph.D.

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Contents

The Power of State and Local Engagement ................. 3
The State of Medicaid ........................................... 4
PSYPACT: A Pathway to Interstate Practice ............. 6
Working for Psychologists and Psychology ............. 8
30 Years Partnering with State, Provincial and Territorial Psychological Associations ......... 11
Directors of Professional Affairs: Psychology’s Front Line 12
The Value of Political Giving at the State Level ........ 14
Sidebar: The importance of supporting state and federal PACs .................................................. 15
Sidebar: The difference between state and federal PACs ...................................................... 15
Prescriptive Authority: Renewed Action in the States .. 16
Sidebar: New Developments in RxP Training and Advocacy .................................................... 18
State Beat: Psychology Leaders Address Letters on 90837 and Advocate for Testing Data ......... 20
2017 Qualified Clinical Data Registry Committee ....... 24
With a new presidential administration taking office this year, much of the mainstream news media has focused on legislative and regulatory actions at the federal level. I’ve always maintained, however, that the practice of psychology is most impacted by policies made at the state level, where the “rubber meets the road” for practice.

States vary in how they approach implementation of regulations and programs that affect the practice of psychology. For that reason, the Practice Organization’s collaboration with state, provincial and territorial psychological associations is crucial. The Directors of Professional Affairs and other staff at the local level are our eyes and ears in the field, keeping us abreast of issues that may percolate upward and have national implications for practicing psychologists.

In this issue of Good Practice magazine, we look at state-level developments on matters that affect practice and highlight the work of some of our state psychology leaders. We examine how prescriptive authority has taken shape since psychologists were first granted the right to prescribe medication to patients 15 years ago. We also delve into how states enforce regulations related to telehealth and Medicaid coverage.

We know that Practice Organization members look to their state psychological associations for guidance. That’s why we are committed to supporting state associations and providing them with the resources needed to be successful in advocating for practicing psychologists.

I hope you enjoy Good Practice.

Sincerely,

Katherine C. Nordal, PhD

“We are committed to supporting state associations and providing them with the resources needed to be successful in advocating for practicing psychologists.”

– Katherine C. Nordal, PhD

Katherine C. Nordal, PhD
Executive Director for Professional Practice
Follow Katherine Nordal on Twitter, @drnordal
THE POWER OF STATE AND LOCAL ENGAGEMENT

Practitioners can help local leaders and policymakers transform health care practice and delivery systems.

By Arthur C. Evans, PhD
Chief Executive Officer and Executive Vice President
APA Practice Organization and the American Psychological Association

Collaboration with policymakers at the state and local levels is crucial if practicing psychologists want to play an integral role in transforming the health care systems where they live. By getting involved in state and local issues, we as psychologists have an opportunity to showcase the value of what we bring to health care in our communities.

Before coming to APA, I spent more than a decade working with community leaders in Philadelphia, as well as local psychologists and other health care professionals, to identify and implement new, innovative health care service delivery approaches to address the behavioral health needs of city residents and specifically to reduce health disparities.

It soon became clear that Philadelphia’s public behavioral health agency and local practicing psychologists needed to embrace a new way of providing health care that incorporated a recovery-based orientation to understanding mental health and substance use disorders bolstered by the latest research findings. We also needed to increase funding for mental health and addiction services and train more psychologists and other health care providers to serve this population.

By working with local and state leaders, and listening to the perspectives and experiences of Philadelphia citizens, psychologists played an important leadership role in changing the way health care services were delivered. State-level advocacy, combined with cost savings derived from the implementation of innovative and effective programs, helped us obtain additional funding to train more behavioral health providers and create new programs for prevention and mental health screening.

Psychologists across the country, like Robin Henderson, PsyD, in Oregon, are already actively engaged at the state level. In her role as a behavioral health administrator for a network of hospitals and clinics, Dr. Henderson has effectively integrated psychologists into primary care clinics where they work alongside physicians to develop and implement treatment plans for patients. Henderson is also encouraging psychologists to serve on treatment panels for Medicaid, which is the largest single payer of behavioral health services in the country.

As psychologists, we should increase our focus on community-level interventions. Practicing psychologists can help local leaders and policymakers transform health care practice and delivery systems by assessing the needs of the people living in our communities and developing a strategy to prevent, treat and rehabilitate individuals with mental health and substance use problems.
Improving Medicaid requires a multi-pronged approach to advocacy.

By Rebecca A. Clay

When it comes to removing barriers that keep psychologists and doctoral psychology interns from participating fully in Medicaid, no single strategy works in every state, says Shirley Ann Higuchi, JD, associate executive director for legal and regulatory affairs for the American Psychological Association and APA Practice Organization.

So far, staff from the APA's Practice and Education Directorates and the Practice Organization have helped 20 states tackle three advocacy goals: allowing independent practitioners to participate in Medicaid, reimbursing for services provided by supervised interns and expanding reimbursement for Health & Behavior codes for services provided to patients with medical diagnoses.

In each state, says Higuchi, the advocacy has looked a little different. In some states, the target is state psychology boards. In others, it’s state Medicaid regulators or even legislatures. And sometimes advocacy centers on working directly with Medicaid managed-care companies.

The roads to success

That tailored approach to Medicaid advocacy is paying off, says Caroline Bergner, JD, an attorney in APA's Education and Practice Directorates.

In Nevada, for example, working with the licensing board proved successful. Earlier this year, the Nevada Psychological Association (NPA) celebrated the culmination of a decade-long fight to allow Medicaid reimbursement for services provided by interns.

Almost 10 years ago, NPA began working to change the state’s Medicaid manual so interns could be included in the list of “qualified mental health professionals” eligible for Medicaid reimbursement. After years of meetings with the licensing board, state Medicaid agency and Centers for Medicare and Medicaid Services, interns can now enroll as Medicaid providers once they register with the Nevada Board of Psychological Examiners.

In Texas, a combined legislative and regulatory approach worked in 2016. With help from APA, the Texas Psychological Association (TPA) successfully persuaded the state Medicaid program to allow reimbursement for services provided by interns and postdocs. APA supported legislation TPA helped draft giving psychologists the go-ahead to supervise interns plus the administrative rule change allowing interns and postdocs to bill Medicaid.

And in 2015, Oregon celebrated a legislative success removing barriers to integrated care for Medicaid beneficiaries. In the past, state regulators said mental health services couldn’t be provided in primary care settings, even though only 10 percent of patients followed through with referrals to mental health providers, says Robin Henderson, PsyD, of the Oregon Psychological Association. And payers often rejected Health & Behavior codes.

The new law Henderson shepherded through the legislature promotes integration by allowing psychologists and other behavioral health clinicians to provide care within primary care, defines interns and postdoctoral fellows as behavioral health clinicians so their services can be reimbursed, and allows providers to use physical, mental and Health & Behavior codes regardless of setting.

Working with insurers opens doors in D.C.

The work APA and the Practice Organization are doing in Washington, D.C., exemplifies their advocacy approach.

Determined to win Medicaid reimbursement for interns’ services, the APA advocacy team
started with a regulatory approach. They first approached the D.C. Department of Behavioral Health (DBH), which referred them to the D.C. Department of Health Care Finance (DHCF). DHCF then referred the team back to DBH.

The group also considered a legislative fix, generally a much slower solution. Lawyers in and out of APA recommended against approaching the D.C. city council, the local equivalent of a state legislature. Since the licensing board hadn’t raised the issue, Bergner and colleagues laid that option aside for the time. “We try to exhaust different remedies,” says Higuchi.


The partnership with AmeriHealth began with an invitation for Karen M. Dale, RN, the company’s market president, to speak to psychologists at a 2016 summit on alternative practice models and integrated care cosponsored by the Practice Organization and the District of Columbia Psychological Association. Instead of viewing psychological services as a cost to be reduced, AmeriHealth recognizes that such services improve patient outcomes and thus reduce costs, said Dale, who called for integrating behavioral health into primary care.

“We know that collaborative practices have improved outcomes,” Dale said in remarks at the summit, noting that depression, anxiety and other psychological conditions can “derail” patients with diabetes, heart disease and other chronic illnesses. That doesn’t just mean skyrocketing costs, she said. If patients are mothers with young children, for example, entire families are destabilized. “What we need is a robust network of providers willing to see these people,” Dale says, referring to the 55,000 AmeriHealth members who live in the city’s impoverished neighborhoods, Wards 7 and 8.

APA is now helping AmeriHealth build that network. At AmeriHealth’s request, in June APA offered a training session on integrated care to psychologists and other mental health practitioners interested in collaborating with the company’s primary care offices.

This is the first time a payer rather than a state psychological association has asked for the training, says W. Douglas Tynan, PhD, who directs APA’s Office of Integrated Health Care and led the training. AmeriHealth, he says, understands “that to treat these patients more effectively, it’s not going to be medical/surgical, it’s going to be psychology where they make the most gains.”

Now APA and AmeriHealth are in the process of working out the next step. The proposed pilot program would be a win for all involved, says Gayle Norbury, PhD, who directs the consortium. For AmeriHealth, the program would help ensure beneficiaries get the help they need to improve their health. Because AmeriHealth is open to the idea of using Medicaid to reimburse for services provided by interns, the program would help support the internship program while offering a valuable training opportunity to psychology interns. And APA would get an advocacy model to use in other states.

Higuchi agrees. “This could be a direct path to a lot of issues we’re concerned about, whether it’s integrated care, independent practice or reimbursement for interns, and building all those issues that demonstrate good practice into our relationship with AmeriHealth,” she says.

To learn more about psychologists’ experiences with Medicaid, listen to our podcast episode, “Progress Notes: Practicing Psychology in the Medicaid System.” In this episode, a clinical psychologist, a behavioral health care administrator, and an attorney at APA talk about the intricacies of Medicaid and how the program can improve. Subscribe to the Progress Notes podcast on iTunes and SoundCloud, or listen on APAPracticeCentral.org.
PSYPACT: A PATHWAY TO INTERSTATE PRACTICE

When a patient relocates, a psychologist can’t simply move his or her practice. A new compact supported by the Practice Organization would establish clearer guidelines on practicing across state lines and providing telepsychological services.

By Deborah Baker, JD, and Alex Siegel, JD, PhD

Your office telephone rings, and it’s one of your patients calling you on his cell phone. Even though your patient is currently taking care of an ill family member who lives in another state, he doesn’t want to miss his weekly appointment with you. By calling you, your patient has indicated that he wants to use telehealth services for his appointments, but you’re not licensed to practice in the state where he is temporarily residing.

Situations like this are becoming more common with the growing popularity of telehealth. More patients are asking to communicate with their providers by phone, email, text or videoconferencing. But the reality is that a psychologist’s ability to provide telehealth services along with in-person services is limited to the state(s) where the provider is licensed.

In 2013, APA approved Guidelines for the Practice of Telepsychology. The last guideline – Guideline 8 – references interjurisdictional practice, cautioning the psychologist to “be familiar with and comply with all relevant laws and regulations” when providing telepsychological services across state lines or international borders. When drafting these guidelines, the task force acknowledged that “there are a number of jurisdictions without specific laws that govern the provision of psychological services utilizing telecommunication technologies” resulting in no clear legal mechanism for facilitating practice across state lines. The task force members understood that the psychology practice community and the patients served want clear guidance on how to engage in telepsychology practice across state lines.

The Association of State and Provincial Psychology Boards (ASPPB) – one of the three organizations represented on the Telepsychology Guidelines task force – began developing a regulatory proposal to facilitate interstate practice. The challenge in developing such a proposal is trying to balance the licensing board’s charge of protecting consumers against the need for flexibility for psychologists to better serve their patients.

The net result was ASPPB’s development of a multi-state licensure compact – the Psychology Interjurisdictional Compact (PSYPACT) – to provide psychologists with more clarity on practicing across state lines.

How does PSYPACT work?

PSYPACT requires that a doctoral-level psychologist be licensed in his/her own state (“Home State”) but allows a psychologist to practice telepsychology or conduct temporary in-person, face-to-face practice in another state without being licensed in that state. The psychologist’s Home State would continue to regulate the psychologist while allowing licensing boards in other states where the psychologist may be providing services to know who is practicing in their state and in what capacity. Psychologists would not be required to obtain and maintain a license in every PSYPACT state. The compact establishes minimum education and training requirements that psychologists must meet to be able to provide services.

PSYPACT is not yet in effect. It would become operational when a minimum of seven states pass legislation adopting the compact. At present, three states have approved PSYPACT – Arizona, Utah and Nevada. There are bills pending in four other states, and several other states have endorsed PSYPACT or indicated interest in pursuing PSYPACT legislation next year.

Once seven states have adopted PSYPACT, representatives from those states would form the PSYPACT Commission, the governing body of...
PSYPACT. The Commission would be responsible for overseeing PSYPACT, creating the rules and bylaws, and setting up a real-time, searchable database of psychologists practicing across state lines. Once established, licensed psychologists would have to apply to the Commission for one or both of the credentials required to participate in PSYPACT:

- the E.Passport to practice telepsychology; and/or
- the Interjurisdictional Practice Certificate (IPC) for the temporary in-person, face-to-face practice of psychology.

The psychologist would then notify the Commission and ASPPB of his/her intent to practice either through the E.Passport and/or the IPC for each PSYPACT state. Each credential must be renewed annually. And the E.Passport credential requires a certain number of additional continuing education hours related to telehealth.

Why is PSYPACT important?

There is currently no uniform legal avenue for psychologists to practice across state lines without a license. Some states have a temporary practice provision, but each provision is different. Without a multi-state licensure compact or other similar proposal, a psychologist would have to research and understand each state’s requirements for temporary practice (if such exist) across state lines. Not only is this expectation very onerous on the individual psychologist, but a temporary practice provision does not resolve any potential conflict of laws that may arise. For example, states may differ on the rules surrounding a psychologist’s duty to warn or protect if a patient expresses an intent to harm himself or herself, or an identifiable victim.

PSYPACT seeks to reconcile those conflicts of laws by requiring states participating in PSYPACT to agree to the following conditions:

- For telepsychology, the psychologist will follow the laws and rules of his or her Home State.
- For in-person temporary practice, the psychologist must adhere to the laws of the distant state where he or she is temporarily practicing in-person.
- PSYPACT states would agree that psychologists who practice under the IPC credential may do so up to 30 days in a calendar year. As a result, the obligations to practice temporarily in-person are more consistent and create less anxiety for the psychologist who seeks to engage in temporary practice in another jurisdiction.

It is important to note, however, that PSYPACT does not serve as a substitute for licensure. If a psychologist seeks to practice beyond the limits of temporary, in-person practice or telepsychological practice in another state, he or she would need to obtain licensure in that state.

Perks for patients

Most importantly, PSYPACT offers consumer protections and improved patient access through a clear regulatory mechanism. This will allow psychologists to provide continuity of care as their patients move or travel out of state. Psychologists would also be able to reach patient populations in underserved or geographically isolated areas, or areas that lack specialty health care.

PSYPACT gives licensing boards a mechanism to allow them to ascertain who may be practicing or intending to practice either temporarily in-person or via technology in their state. Through the PSYPACT Commission’s database, licensing boards will have assurance that the psychologists meet certain defined standards and criteria, have had no disciplinary sanctions, and provide regular updates on their intended practice activities into the distant states. In addition, if there is a problem, the distant state would have the authority to revoke the psychologist’s ability to practice in that state whether via technology or temporary, in-person practice. PSYPACT clarifies that the psychologist’s Home State has authority to impose discipline for any actions or omissions that occur out-of-state.

Those interested in keeping abreast of the status of PSYPACT can find information at asppb.net/page/PSYPACT.

Deborah Baker, JD, is director of legal and regulatory policy for the Practice Organization’s Office of Legal and Regulatory Affairs.

Alex Siegel, JD, PhD, is director of professional affairs for the Association of State and Provincial Psychology Boards.
For the past 36 years, Sally R. Cameron has held the distinction of being the first and only executive director of the North Carolina Psychological Association (NCPA). When she took the position in 1981, the association didn’t have an office – but they did have a box of file cards.

“They had cards for all the members, and a lot of them hadn’t paid dues in many years,” she recalls. “So if I wasn’t starting from ground zero, it was definitely ground one or two!”

From that box of file cards, she has helped grow NCPA into a robust and thriving organization of nearly a thousand members from across the state. Along the way, she’s earned a reputation as a transformational leader and brilliant advocate for practicing psychologists.

“I make sure NCPA is at every table. That way, we have a voice at every table that impacts psychology,” she says.

That ethos has put Cameron at “tables” everywhere from the state legislature to negotiations with insurance companies to meetings of the Council of Executives of State, Provincial (and Territorial) Psychological Associations, or CESPPA, where she is widely respected for her wisdom and leadership.

Cameron’s colleagues describe her in superlatives – Charles Cooper, PhD, NCPA’s director of professional affairs, called her a “phenomenon” – but Cameron is humble when reflecting on her accomplishments. She emphasizes not what she’s done, but what motivates her to do it.

“One reason I’ve loved working with NCPA is that the second most important thing, and sometimes the most important thing, is advocating for the people psychologists serve,” she says. “In this role, I can do both: care about the profession and about the people, too.”

A track record of success

In March 2017, at the Practice Leadership Conference in Washington, D.C., Cameron’s contributions and support for professional psychology were recognized with a prestigious Presidential Citation by APA President Antonio Puente, PhD.

“Ms. Cameron is an exemplar of innovation, collaborative leadership, coalition-building and genuine caring for her fellow human beings. She has been a mentor to many and collaborator to all... [Her] quiet effectiveness in demonstrating new directions for the work of state associations and APA has advanced our field,” Puente wrote in the citation.

One way to trace the evidence of this is to appreciate Cameron’s long history of organization-building.

For example, more than 25 years ago, she helped found the North Carolina Psychological Foundation, and she serves as its executive director in addition to running NCPA. She has also assembled multidisciplinary coalitions like the Joint Insurance Task Force, a team of psychologists and other mental health professionals who work on members’ reimbursement issues.

In addition, she has extended her dedication beyond North Carolina to the wider community of practicing psychologists and state associations.
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Advocating on issues affecting psychologists and their patients:
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• Including psychologists in Medicare
Meet four psychologists working to improve psychology practice in their states.

By Hannah Calkins

Sixteen state, territorial and provincial psychological associations (SPTAs) employ a Director of Professional Affairs, or a DPA. A DPA is a psychologist who serves as an advocate and informational resource about professional practice issues for the SPTA and its members. DPAs also work closely with APA Practice Directorate and Practice Organization staff on professional psychology advocacy at the national level. They help advance the dialogue on a wide range of important professional issues affecting practitioners and their patients, including: mental health parity; health care financing; billing and reimbursement; licensure; psychological testing; and prescriptive authority.

Though the responsibilities of the DPA vary from state to state, they share the same broad goal: to improve the professional lives of practicing psychologists. They do this through consultations with members, legislative advocacy, coalition-building and sharing information and strategies with each other.

We spoke with four DPAs from across the country to highlight their work and demonstrate their value for all practicing psychologists.

Paul C. Berman, PhD
Maryland Psychological Association (MPA)
DPA since 1993

Berman is a licensed psychologist in Baltimore County, Maryland. He runs a forensic psychology practice with his wife, Katie Killeen, PhD, as well as the Towson Addiction Center.

In addition to this work, he spends about 12 hours a week carrying out his responsibilities as DPA, but that number can be as high as 20 or 30 hours a week during Maryland’s legislative session, which runs from January through April.

In Maryland, the DPA has a different title – Professional Affairs Officer – but it’s essentially the same position, Berman says. He has held the post for almost 25 years.

When people ask what this work entails, he tells them that he is “a liaison between psychology and the outside world.”

In practical terms, that means that he meets and negotiates with insurers, legislators and other mental health professionals to advocate for psychologists, shape policies and form multidisciplinary coalitions.

“It’s probably the most enjoyable part of what I do as a psychologist: reaching out to people in different worlds and making contact with people across associations and professions,” he says.

Berman is also very involved in MPA’s legislative activities, and spends some of his time consulting with MPA members and helping them solve problems in their practice – mostly related to insurance.

“My view of insurance and managed care companies has really changed during my time in this position,” he says. “They aren’t trying to deny mental health benefits; they’re trying to ensure that people have these benefits within reasonable budgetary frameworks. Our perspectives are just different.”

Charles Cooper, PhD
North Carolina Psychological Association (NCPA)
DPA since the late 1980s

Cooper describes a “marvelous synergy” between his work as a DPA and his broader professional life, where he is the executive director of a multidisciplinary practice in Chapel Hill and Raleigh.

“As DPA, I get to understand what’s happening in practice settings all over North Carolina, and I’m wired in with my DPA colleagues around the country,” he says. “Conversely, I do a better job as DPA because I direct a practice and am a clinician myself.”

Because the executive director of NCPA, Sally Cameron, is a registered lobbyist (and “a
phenomenon!” according to Cooper), Cooper leaves legislative activities to her and focuses on other areas.

“My job has been to work on insurance issues, and a lot of that has to do with advocating with decision-makers,” he says. He also either chairs or attends several regular committee meetings as DPA, such as the Long-Range Planning Task Force, which aims to help psychologists prepare for the future of the profession, and the Division of Independent Psychology Practice, which he compares to the Practice Organization.

“My major goal right now is to help North Carolina psychologists shift from a fee-for-service world into a pay-for-performance world, and to increase the integration of behavioral health into general health,” he says.

Cooper says the highlight of his year as DPA is the annual Practice Leadership Conference, where all the DPAs from across the country meet to exchange news and ideas. “It’s a rich, meaningful bond that we share,” he says.

Elizabeth Winkelman, JD, PhD
California Psychological Association (CPA)
DPA since January 2016

Although Winkelman has been in the DPA role for a comparatively short time, she has a uniquely valuable background to draw from. She is a psychologist who has trained and worked in a variety of clinical settings, and she also has a legal background – which means that she not only understands the needs of practitioners, but she is also equipped with the skills to analyze the ways laws and regulations impact them.

Compounding that experience is her work in the APA and Practice Organization from 2005 to 2013.

“I worked on many of the same issues in the Practice Organization’s “Legal and Regulatory Affairs Department as I do in my current role as DPA,” she says. “There is a lot of overlap in the key issues that affect psychologists on the state and national level, so collaboration between the DPAs and the Practice Organization staff can be extremely useful.”

Now, Winkelman works closely with CPA’s leadership to promote psychologists’ interests in the legislature, at psychology board meetings and at meetings with regulators, she says.

She also provides individual consultations to members on issues such as HIPAA compliance, insurance and billing and telehealth.

“Psychologists do a tremendous amount of important and challenging work to benefit their clients and society. I strive to make it easier for them to do that work,” she says.

Winkelman’s goals include continuing to work with insurance company administrators and regulators to improve policies and procedures that affect psychologists and their clients; disseminating CPA’s End of Life Option Act guidance document, which is intended for psychologists providing services under California’s aid-in-dying law (available at www.cpapsych.org/endoflifeoptionact); and expanding the practice tools and information available to members on the CPA website.
THE VALUE OF POLITICAL GIVING AT THE STATE LEVEL

By Luana Bosolo

State political action committees (PACs) can be just as significant as federal PACs when it comes to political giving. According to an analysis by the Sunlight Foundation, a nonpartisan nonprofit advocating for open government, PACs spent more money on state-level candidates in 23 states during the 2012 election cycle than they did on federal candidates in all 50 states. The analysis, reported by The Washington Post (Sept. 16, 2013), showed that state-level PACs contributed $1.4 billion to candidates running for governor, attorney general, state legislative and other state-level offices.

Money talks, and active state PACs can be influential in filling the pipeline of elected officials at every level of state and local government. “State association PACs play a critical role in recruiting and supporting candidates who support issues relevant to psychologists and their patients,” says Jennifer Johnson, director of Psychology PAC (www.supportpsychologypac.org) in the APA Practice Organization.

PACs provide a vehicle for psychologists to advocate for their profession with legislators. “The purpose of a PAC is to establish relationships with candidates and have them get to know us,” says Jo Linder-Crow, PhD, chief executive officer of the California Psychological Association (CPA). “We take seriously psychologist candidates running for public office and work to support them, even at a very local level, like a school board position.”

There is also value in showing up for campaign events and delivering a contribution in person. “When you contribute to a legislator’s campaign, you create an opportunity to begin a dialogue and develop an important relationship,” says Connie Galietti, JD, director of legal and professional affairs in the APA Practice Organization.

Galietti, a former executive director of the Florida Psychological Association, managed the state association’s PAC. “In Florida, the state psychological association got appointments with legislators to discuss important issues because they knew us from fundraising activities,” says Galietti. “Showing up to political fundraisers helped us establish a foundation for building a relationship. In some instances, that relationship helped in advocating with legislators to be open to amendments to legislation or softening language in a bill relevant to psychologists.”

“Face time is critical with candidates because it puts a human face on the issues relevant to psychologists,” says Johnson. “Personal stories shared by psychologists directly with candidates are compelling. When a psychologist speaks in person to legislators and candidates, they hear directly from one of their constituents.”

“It helps to have a check delivered by a constituent, instead of a lobbyist,” says Galietti. “Candidates and legislators listen to their constituents. Psychologists need to show up and shake hands, so the candidates associate you with the envelope and conversation.”

How to start and manage a state PAC

Eighteen state psychological associations have a PAC. Many of those associations understand that running a PAC involves year-round activities, not just sending a fundraising letter to your members once a year. Whether your state association currently has a PAC or is considering establishing one, Linder-Crow and Galietti offer the following tips on starting and managing a PAC.

• Understand fully why your state psychological association wants to start a PAC, advises Galietti. There are costs to establishing and operating PACs including administrative and set-up fees.
• Make sure your membership can support a PAC. The reality is that members’ pockets aren’t deep. If you have a small association with few members and a tight budget, then you may be limited by how much money you can raise.
• Hire an attorney familiar with campaign finance laws in your state who can help your association file the required paperwork with the state division of elections.
• Retain an accountant experienced with campaign finances. Most states have reporting and disclosure requirements to track contributions to a PAC and money distributed to candidates. The National Conference of State Legislatures (www.ncsl.org) has information on campaign contribution limits for all 50 states. Another helpful resource is www.FollowTheMoney.org which tracks state-by-state contributions to state and federal candidates by election year.
• Keep bylaws for a PAC separate from your state association bylaws and establish an independent board (which may be called board of directors or board of trustees). Linder-Crow says her state association’s PAC, known as CPA-PAC, is managed out of the California Psychological Association’s office but has a separate board of trustees.
• Appoint members to the PAC board who are active political givers. Linder-Crow and Galletti recommend that all members of the PAC’s board of trustees be required to contribute to the state association PAC.
• Set goals and determine a PAC contribution strategy, advises Linder-Crow. Identify doable fundraising target levels and activities. CPA-PAC gives to legislators on key committees or who hold influential positions in the state legislature that could have an impact on issues affecting psychologists.

The importance of supporting state and federal PACs

Since legislation occurs both at the state and federal levels, it’s important to make sure that psychologists are heard at both levels. Sometimes there may be an overlap at the federal and state levels on some legislative issues, but there are often legislative issues unique to each level of government that are relevant to psychologists, such as federal laws about Medicare reimbursement or state licensing laws.

Says Johnson, “Since the Psychology PAC only contributes to candidates at the federal level, it is important that state associations develop state PACs to ensure the profession is protected at the state level.”

The difference between state and federal PACs

PAC laws vary from state to state with each state having their own unique campaign finance laws that govern the activities of a state PAC. Most of the time, the secretary of state’s office oversees the filings and activities of state PACs. State PACs are limited to contributing to campaigns for governor, state house and senate seats as well as county level political offices; whereas, federal PACs support federal level candidates running for Congress.

Federal PACs are highly regulated and required to follow the rules and regulations under the purview of the Federal Election Commission. Psychology PAC, housed in the APA Practice Organization, concentrates on political candidates at the federal level who support legislative issues important to psychologists.
Five states now allow psychologists the right to prescribe psychotropic medications – three of them since 2014. What does this momentum mean for the future of this expanding proficiency?

By Tori DeAngelis

At the annual Hawaii Psychological Association meeting in 1984, the late Sen. Daniel Inouye (D-Hawaii) urged psychologists to seek prescriptive authority so they could better serve populations in need. Over the next 33 years, psychologists helped pass bills in seven states, and five of those bills became laws.

The first two states to pass laws—New Mexico in 2002 and Louisiana in 2004—now have approximately 160 psychologists who can write prescriptions. In 2014 Illinois passed a bill in record time, and Iowa and Idaho went on to score victories in 2016 and 2017, respectively.

“We now have five states that have passed prescriptive authority legislation, and there are other states that are very close and working very energetically towards passing their legislation,” says Beth Rom-Rymer, PhD, a Chicago-based practitioner who spearheaded the Illinois win. “There has certainly been a renewal of energy in this direction.”

Still a matter of debate

Prescription privileges for psychologists have been slow to materialize. Opposition from both psychiatrists and psychologists have made prescriptive authority a hot-button issue, and moving bills through state legislatures can take years.

Still, there remains a strong current of support for the movement—not only among those seeking privileges per se, but among other psychologists, physicians and psychiatrists who support the movement’s rationale. Advocates believe prescriptive training can help fill the huge service gaps in rural and other underserved areas.

Due to the shortage of psychiatrists in rural areas and elsewhere, “most psychotropic drug prescriptions are written by general physicians who know very little about either psychiatric mental health diagnosis or treatment,” says retired anesthesiologist Robert M. Julien, MD, PhD, who has provided psychopharmacology training to psychologists and supports their right to prescribe. Advocates also believe trained psychologists have advantages over other providers, thanks to their extensive knowledge of psychosocial factors and their detailed training in medications’ chemistry and biology.

“Prescribing psychologists look at the whole person and try to determine the underlying causes of their difficulty—and then how they can address those issues through psychotherapy, other kinds of supports and, if necessary, the appropriate use of medication,” says medical psychologist Joseph E. Comaty, PhD, past chair of the APA RxP Designation Committee, which oversees the designation process for psychopharmachology programs.

Some psychologists remain skeptical about prescriptive authority, expressing concern that it could turn psychologists into “mini psychiatrists.” Psychologists in this group think the field would be better served by building on existing strengths, such as evidence-based psychological treatments, for example.

“I feel that we should put our efforts into doing what we do well, even better,” says Maryland practitioner Mary K. Alvord, PhD, who adds she feels prescribing is a poor fit for psychology’s “brand.” The first recipient of APA’s Presidential Innovative Practice Citation in 2009 for her work in promulgating telepsychology in practice, Alvord notes that she is strongly in favor of progress—just not this kind.

“I love the idea of enhancing treatment,” she says, “but I worry that [the prescriptive agenda] is going to take the profession in a different direction.”
That said, gaining prescriptive authority is not just an ideological matter, it’s a practical one, too, supporters say. The health care industry is changing, and providers with far less training in psychological and behavioral issues than psychologists—nurse practitioners and physician’s assistants, for example—are working to secure these privileges so they can stay competitive and adequately address their patients’ needs. Interested psychologists should do the same, advocates argue.

“Not everybody needs or wants to do this,” as Rom-Rymer puts it, “but for our field to grow and provide opportunities for our young psychologists, I think this is certainly one avenue to pursue.”

**Status in the states**

States with prescriptive authority laws have different training criteria and are in different stages of rule development.

However, the laws—which are also the basis for rule creation—share several features. Most:

- Require that psychologists train in an APA-designated program or its equivalent. Programs at four institutions – Fairleigh Dickenson University, Alliant International University, New Mexico State University and the Southwestern Institute for the Advancement of Psychotherapy, and the University of Hawai’i, Hilo – currently meet APA standards.
- Limit the programs to only licensed psychologists.
- Require that psychologists pass the Psychopharmacology Examination for Psychologists (PEP).

All states with prescriptive authority require that, at least at the beginning of practice, psychologists work with a patient’s physical health care provider, says Deborah C. Baker, JD, director of legal and regulatory policy for the APA Practice Directorate. “It’s a safety-net issue, so that [prescribing psychologists] are not working in a vacuum,” she explains.

The main areas of difference pertain to the types of patients that psychologists can see and the range of drugs they can prescribe, Comaty adds. Louisiana, for example, has no restrictions on patient type and allows psychologists to prescribe any psychotropic drug, except narcotics that are used on- or off-label for treating any behavioral health disorder. Illinois, meanwhile, is more restrictive in both of these areas, not allowing prescriptions for pregnant women, children, adolescents and adults older than 65, or the use of narcotics or benzodiazepines.

Also, Louisiana’s law uses the term “medical psychologist” exclusively to describe psychologists with prescriptive authority. Other states have opted to describe this practice area with the terms “prescribing psychologist” or “psychologist certified to prescribe.”

**Innovative training in Illinois**

Illinois is taking a different tack from other states in a key area: The law allows graduate students the option of gaining didactic training in clinical psychopharmacology at the predoctoral level, compared with APA designation criteria, which only allow such training after licensure.

Illinois leaders believe that predoctoral training could greatly increase the number of prescribing psychologists available to provide services to the state’s underserved communities, Rom-Rymer says. Aspiring psychologists would have the opportunity to earn a joint degree in psychology and clinical psychopharmacology, she adds.

Illinois candidates are required to:

- Take several basic science undergraduate courses for prescribing psychology licensure—similar to those taken by pre-med or pre-nursing students.
- Pass master’s level courses in clinical psychopharmacology that are the equivalent of earning a master’s degree, though a master’s degree is not required.
- Take 14 months of clinical rotations in nine medical settings.
- Pass the PEP.

Psychology students and psychologists can meet the law’s requirements any time during their schooling or once they are practitioners, Rom-Rymer emphasizes.

Several Illinois graduate students
are already working on joint master’s and doctoral degrees in clinical psychopharmacology and psychology, respectively, and more than 150 practicing psychologists are working toward prescriptive authority under the terms of the 2014 law. The University of Illinois, Champaign-Urbana and Southern Illinois University have also designed an undergraduate curriculum that combines traditional undergraduate psychology prep classes and the seven basic science courses required under the law. Rom-Rymer will mentor 75 psychology undergraduates at Champaign-Urbana who will take this curriculum.

Meanwhile, a number of psychologists in Iowa have expressed interest in starting training as soon as state prescribing rules are finalized, says Bethe Lonning, PsyD, who helped pass that state’s law. “As our ability to prescribe evolves and more psychologists get training in our state, I think psychologists will become better distributed in rural areas where people need the care,” Lonning comments. The law, she adds, also promises benefits to those who currently travel from rural areas to cities for care: “People will only have to come for one appointment, rather than two,” she says.

Louisiana practitioner Glenn Ally, PhD, who has been prescribing psychotropic medications for 12 years, believes that prescription privileges are an individual choice—but it’s important that psychologists have access to that choice.

“In much the same manner that many of our colleagues make choices about pursuing specialties in neuropsychology, forensics or rehabilitation psychology,” he says, “medical psychology is a choice that should be available to us.

“In my view,” he adds, “we must use the right tool to fit patients’ needs, rather than trying to force their needs into the only tool we may have.”

Coinciding with recent prescriptive wins in the states are these developments that seek to update and refresh the movement:

• The launch of an eight-member task force to revise the APA model curriculum and model legislation on prescriptive authority, developed in 2009. The task force—headed by the APA Board of Educational Affairs, the Board of Professional Affairs and the Committee for the Advancement of Professional Practice—is expected to revamp those documents based on the changing knowledge base in psychopharmacology, as well as consider the varying requirements across state laws and federal systems for credentialing psychologists to prescribe, says Deborah C. Baker, JD, director of legal and regulatory policy for the APA Practice Directorate.

Nominations for the task force closed in May 2017, and the APA Board of Directors approved the slate in August.

• A revised and updated PEP (Psychopharmacology Examination for Psychologists), one of the requirements for all states with prescription privilege laws. Originally overseen by the APA Practice Organization, the PEP is now under the auspices of the Association of State and Provincial Psychology Boards (ASPPB), which is hiring a firm to help recraft the test so it meets the dual purposes of appropriately demonstrating and testing the knowledge and skills of individuals who have gone through the appropriate training, and making sure the exam is clearly worded and accessible to takers, says Matthew D. Turner, PhD, director of the PEP and the Examination for Professional Practice in Psychology.

“ASPPB is working closely with experts in the field to ensure that the final product represents the knowledge needed to practice and is a fair and valid measure,” says Turner.

The new exam will be up and running in January 2018, and will not be available until the revision is complete, he notes.

• APA advocacy that aims to win entry for prescribing psychologists in the U.S. Department of Veterans Affairs. APA’s director of military and Veterans health policy, Heather O’Beirne Kelly, PhD, and staff have been campaigning on Capitol Hill to make policymakers more aware of the advantages of allowing properly trained psychologists to prescribe in the VA system.

“If that hurdle is crossed, it will provide better services for our veterans in the system and foster the further development of the prescriptive authority movement across the country,” predicts medical psychologist Joseph E. Comaty, PhD, past chair of the APA RxP Designation Committee.
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Psychologists in Maine, Pennsylvania and New Hampshire take a stand on legal and regulatory issues that impact the profession.

By Hannah Calkins

**Maine**

A Maine trial court judge has ruled to uphold a statute that protects neuropsychological and psychological test data, according to Sheila Comerford, executive director of the Maine Psychological Association (MePA).

The victory came on May 19, about a month after a Maine psychologist informed MePA that opposing counsel had requested the judge to compel him to turn over a patient’s record, including raw test data, to the court. (The judge would then decide whether to release the record to opposing counsel.)

The request was a challenge to a 2013 law MePA championed that prohibits the disclosure of raw neuropsychological or psychological test data and materials to anyone but another psychologist.

In response, MePA contacted APA Practice Organization’s Legal and Regulatory Affairs (LRA) staff, who supplied MePA and the psychologist with support and materials to oppose the request.

MePA was successful: The judge ultimately denied the request, citing that the 2013 law was sound and allowed for no exceptions. The opposing counsel also decided not to appeal this decision, Comerford reports.

**Pennsylvania**

Leaders from the Pennsylvania Psychological Association (PPA) are collaborating with Highmark – a large insurer based in Pittsburgh – to address concerns regarding Highmark’s monitoring of the use of current procedural terminology (CPT) code 90837 (psychotherapy, 60 minutes with patient).

Rachael Baturin, MPH, JD, who is director of legal and regulatory affairs at PPA, reports that in the summer of 2016, some members began receiving letters from Highmark that seemed to be attempting to deter them from using CPT 90837. These letters were addressed to psychologists who allegedly used 90837 at a high rate compared to other psychologists in the network.

Some psychologists feared they would be targeted for an audit, though Highmark maintains that the letters were meant to be “educational” rather than threatening, Baturin says.

In response, PPA and the Practice Organization’s LRA staff contacted Highmark, which confirmed that the letters were truly intended to be educational, not punitive. They also said they do not presume that a more frequent use of 90837 involves inappropriate billing, according to Connie Gallietti, JD, LRA’s director of legal and professional affairs.

Since then, PPA has been working with Highmark to change their practices regarding CPT 90837. Highmark has asked for input in how to change the tone of their letters and how to better understand the practice settings in which the code might apply.

Baturin says that PPA is communicating this update to members, and will continue to monitor the letters that Highmark sends regarding CPT 90837.

**New Hampshire**

People in New Hampshire who wish to change how their gender is listed on their identification cards must file a “Change of Gender Designation” (PDF, 49KB) form with the Department of Motor Vehicles (DMV). A health care provider’s signature is required to certify the form and the provider must check a box indicating the kind of provider they are – and there is no box for psychologists, according Leisl Bryant, PhD, ABPP, the executive director of the New Hampshire Psychological Association (NHPA). The form only recognizes physicians, APRNs, clinical social workers and clinical mental health counselors.

continued on page 22
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Working for Psychologists  continued from page 8

“That’s one of the values of CESPPA: connections and sharing,” she says. “Having a big network keeping us informed about updates and challenges is crucial, as is the support of APA and the Practice Organization.”

Cameron is also widely regarded as a seasoned advocate who already had nearly a decade of lobbying and advocacy experience before she came on board at NCPA.

“Ms. Cameron is respected throughout the state for her expertise in public policy surrounding professional practice and behavioral health services,” Puente wrote. “Her reputation among state officials and legislators is impeccable, and she is trusted to give them the straight story.”

A registered lobbyist, Cameron has had a hand in passing strong scope-of-practice and mental health parity laws in North Carolina; getting psychologists recognized as primary care providers in the state health plan; and enrolling psychologists as Medicaid providers, among other successes.

More recently, she helped strategize NCPA’s opposition to North Carolina House Bill 2 (also known as HB2 or the “bathroom bill”).

“I’m so proud of our leadership,” Cameron says of NCPA’s support of protections for transgender people in the state. “We took a stand. Our response was based on research, but we were thoughtful about it and unafraid to speak up.”

It’s clear that Cameron views her role as just one link in a strong, interdependent chain made up of NCPA’s board, volunteers, members, the network of state associations and – critically – the public.

“I feel very fortunate to have staff, members and leadership who care about their profession and give an amazing amount of time to it,” she says. “I love the variety of this work, and that I’m part of an organization that allows me to advocate for things that don’t necessarily just put dollars in psychologists’ pockets, but also helps the people they serve.”

State Beat: Psychology leaders address letters on 90837 and advocate for testing data  continued from page 20

Bryant says that this was brought to NHPA’s attention over a year ago when a member reported he was unable to complete the form for his patients. Since then, leaders and members of NHPA have been engaged in an effort to add psychologists to the form by writing letters, sending emails and repeatedly contacting the director of the DMV. NHPA has been told by the director’s office that their communications have been received, and that “someone” will be in touch.

“The response from the DMV has been disappointing so far, but we continue to see this as an important issue and are committed to finding resolution,” Bryant says. She is working with the Practice Organization’s LRA staff to coordinate an approach.

This article is part of State Beat, a monthly column published in the PracticeUpdate newsletter, reporting news, issues and advocacy efforts impacting practitioners in specific state, provincial and territorial psychological associations (SPTAs). The article was originally published in the June 15, 2017 issue of PracticeUpdate. To read other State Beat columns, visit www.apapracticecentral.org/practiceupdate.
Progress Notes is a podcast produced especially for practicing psychologists by the APA Practice Organization. Episodes cover a range of topics, including the financial and legal aspects of running a practice. Hear expert analysis on developments in health care policy along with stories that highlight the work of fellow psychologists.

To access Progress Notes, visit the APA Practice Organization online: apapracticecentral.org/business/podcasts

**WHY THE NAME PROGRESS NOTES?**

Ian Gutierrez, MS, MA (left), a clinical psychology graduate student, is the creative mind behind the name of the podcast. The idea came to him when, after just signing off on a progress note, he received the email announcing the APA Practice Organization’s podcast-naming contest. “All practicing psychologists write progress notes, so ‘progress notes’ are familiar to the practice community,” he says. The name of the podcast is also aspirational. “In promoting the mutual professional interests of practicing psychologists at a national level, the APA Practice Organization facilitates progress for our professional practice by providing resources to its members and through its advocacy on Capitol Hill,” says Gutierrez. “So, the new podcast will take note of the progress that we are making as a profession.” Gutierrez is the 2017 graduate student member of the APA and APA Practice Organization Board of Directors, and he is chair of the American Psychological Association of Graduate Students.
The APA Practice Organization appointed an advisory committee to develop a new qualified clinical data registry (QCDR) for psychologists and other behavioral health practitioners to track patient outcomes and compare new treatments and research. This is an opportunity for the Practice Organization to take a leadership role in identifying gaps in quality measurement and propose new measures that cover the practice of psychology. The QCDR will also prove valuable for psychologists who aren’t Medicare providers as the entire health care industry shifts away from its fee-for-service payment model.

The QCDR advisory committee is composed of seven experts specializing in quality measurement, progress monitoring and clinical research.

Chair: Carol Goodheart, EdD, independent practice in New Jersey

David Bard, PhD, University of Oklahoma Health Sciences Center

Bruce Bobbitt, PhD, LP, retired from Optum (United Health Group)

Zeeshan Butt, PhD, Northwestern University Feinberg School of Medicine

Kathleen Lysell, PsyD, VA Central Office

Dean McKay, PhD, ABPP, Fordham University

Kari Stephens, PhD, University of Washington

Additional information on the APA Practice Organization’s QCDR registry is available in the June 15, 2017 issue of the PracticeUpdate newsletter and the Spring/Summer 2017 issue of Good Practice magazine available at www.apapracticecentral.org.
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