GOOD PRACTICE
Tools and Information for Professional Psychologists

Spring/Summer 2017

Mixing Politics with Practice
Clinical Data Registries: Tools for Better Practice, Research and Public Health
Clinical Practice Guidelines Offer Important Practice Support
A New Way to Pay for Psychological Services
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Good Practice has been honored by the Association of Marketing and Communications Professionals. The 2014 MarCom Award winners were selected from among more than 6,500 entries from 17 countries.
A Message from Arthur C. Evans, PhD, New CEO of APA and the Practice Organization

It is with great excitement that I welcome this opportunity to serve as the Chief Executive Officer of the APA Practice Organization and the American Psychological Association. I love being a psychologist. The practice community is very important to me, having spent the early part of my career treating patients in the public and private sectors. Like many of you, I entered the profession to make a positive difference in people’s lives.

Over time, I recognized that improvements for my patients also required system and policy changes. So, I forged a unique career at the intersection of policy, research, and practice. I spent the past 20 years working in public health, first at the Department of Mental Health and Addiction Services in Hartford, Connecticut, and most recently as Commissioner of Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). I was also honored to serve recently on the Committee for the Advancement of Professional Practice of the APA Practice Organization.

Because many stakeholders do not fully understand the distinct skills that psychologists bring to behavioral health treatment and services, an important part of my work has been and will continue to be educating audiences – from payers to the public – about the breadth of skills psychologists contribute to our health system and communities. An example of my ongoing support for our profession, during my tenure at DBHIDS, I ensured that requests-for-proposals issued by my agency required new service programs to include licensed psychologists as a part of their staffing complement, specifying that psychologists implement evidence-based practices and conduct data collection.

My time at DBHIDS helped me realize that we need to expand options to promote mental health for more people. Ninety percent of people with addictions and 40 percent to 50 percent of those with mental health diagnoses in Philadelphia never sought treatment. This data called for urgent action. So I developed city-wide behavioral health initiatives that involved psychologists’ expertise, including an online tool at www. healthymindshilly.org that screens people for behavioral health problems in the same way that communities screen for diabetes or cardiovascular disease. Additionally, my agency addressed stigma through community participatory art projects, creating murals on a variety of behavioral health topics. These creative projects offered social support and a collective purpose that were beneficial to participants. On one such project, a psychologist conducted workshops and other activities to educate community members about suicide.

I also recognize that practitioners face legal, financial and business challenges. We need to better understand where the system is heading, build practices in ways that are compatible with emerging trends, and add insight and expertise to new models that are evolving. Most importantly, we need to be able to demonstrate how mental health care saves money by addressing problematic and unhealthy behaviors before they become medical problems, adding value and quality to the health care system.

Psychologists have a major role to play in shaping new health care systems. It is up to us to identify and seize those opportunities to influence change to promote the mental and behavioral health of those we serve.

Sincerely,

Arthur C. Evans, Jr., PhD
Chief Executive Officer and Executive Vice President
APA Practice Organization and American Psychological Association
Practice, Politics and Policy was the theme of the APA Practice Organization and American Psychological Association’s annual Practice Leadership Conference held March 4 – 7 in Washington, D.C. For more than 30 years now, several hundred psychology leaders from across the U.S. and Canada have come together in Washington, D.C., for four days of advocacy, leadership training and to examine major issues affecting professional practice.

In this latest issue of Good Practice, readers have an opportunity to benefit from the wealth of content presented at the Practice Leadership Conference and learn how the political landscape – whether federal, state or institutional – affects practitioners and influences policies relevant to psychology practice.

*Good Practice* highlights psychologists’ efforts on Capitol Hill and profiles practitioners advocating for the profession. This issue also looks at the connection between policies and payment for services; examines how emerging clinical data registries will influence payment policies; the benefits of having clinical practice guidelines; and the importance of conveying the value of psychology to lawmakers at the state and federal level, and translating that knowledge into good policy.
Mixing Politics with Practice

How psychologists can influence policy at the state and federal level

Whether managing an independent practice, working for an institution or in another setting, psychologists can get caught up in the day-to-day realities of making a living. They may be focused on treating patients, accomplishing administrative tasks and getting through the week. The idea of adding advocacy to the mix – writing letters to elected officials or donating to a political action committee – may not be a priority. However, your professional success depends on it.

“Psychologists need to know how their profession and their professional practice, regardless of where they are located, is impacted by state and federal legislation and regulation. For that reason, it’s important that advocacy be an integral part of graduate training,” says Practice Organization Executive Director for Professional Practice Katherine C. Nordal, PhD.

Professional practice is shaped by a number of political systems, Nordal says. And as a result of the 2016 elections, many of those political systems have undergone significant changes. The U.S. Congress added more than 60 new members at the start of the year. The balance of power in several state legislative chambers and governorships also shifted from one political party to the other.

“There are a lot of changes in the political landscape. There are people with new perspectives. We have to as a field understand what those perspectives are and we have to have the resources to influence those decision-makers,” says Arthur C. Evans, Jr, PhD, CEO of the American Psychological Association and APA Practice Organization.

“Now is the most important time probably in the history of psychology practice to understand the importance of stepping up and making sure that we’re engaged in the political process.”

— Arthur C. Evans, Jr, PhD

“Now is the most important time probably in the history of psychology practice to understand the importance of stepping up and making sure that we’re engaged in the political process. Otherwise, we run a very strong risk of finding ourselves shut out of the marketplace,” Evans says.

Psychologists change practice by changing policy.

Prior to the 1980s, there was no APA work unit dedicated specifically to issues that affected practicing psychologists.
and their businesses. That void was one of the main drivers for APA’s formation of the Practice Directorate—a unit serving the needs of practicing psychologists, says Practice Organization Associate Executive Director of Government Affairs Doug Walter, JD. Ultimately, the APA Practice Organization was formed in 2001 as a 501(c)(6) to advocate on reimbursement and marketplace issues for practicing psychologists.

The Practice Directorate’s first task was to get services provided by clinical psychologists reimbursed by Medicare, a government insurance program established in the 1960s. In 1989, Congress changed the law to give psychologists the authority to treat Medicare beneficiaries independently in outpatient settings and bill for their services. This policy victory for practicing psychologists shifted the way psychological services were viewed and paid for not just by Medicare, but by private insurers as well.

“Medicare is the largest federal health program. Because it’s such a large insurer, it actually impacts the entire health insurance market. Getting psychologists into the program was major,” Walter says.

But Nordal stresses that getting psychologists’ services covered by Medicare didn’t happen overnight. It took grassroots advocacy and years of persistent lobbying.

Policy wins for practicing psychologists didn’t end with Medicare. The Mental Health Parity and Addiction Equity Act (MHPAEA) became law in 2008, ending decades of insurance plan discrimination against services offered by mental health providers. The APA Practice Organization worked with members of Congress and U.S. presidents to enact and implement the law that requires insurance companies to cover mental health services at parity with other health care treatments.

“There were a lot of cooks in that kitchen,” says Richard Frank, PhD, professor of health economics in the Department of Health Care Policy at Harvard Medical School. “Psychologists had strong advocates, for example, in the parity implementation coalition, that I know APA is part of. You also had a lot of parity champions in Congress,” Frank says.

“Government has a direct impact on what psychologists do as professionals, how much they are paid, and where they work. Psychologists need to think about what they need to do for themselves as a profession. When psychologists help themselves, they also help their patients.”

– Doug Walter, JD

Practicing psychologists then relied on the relationships that they’d built through years of advocacy with the “champions” of mental health care to help enact the Affordable Care Act.

“The ACA is a culmination of many separate and different advocacy efforts by the association on behalf of our profession,” Walter says. “Practicing psychologists took the lead on patient protections, consumer protections, provider protections, preexisting conditions, and provider nondiscrimination, provisions that we worked on throughout the 1990s and early 2000s with physician and non-physician groups. We wrote a lot of the provisions that ultimately ended up in the Affordable Care Act,” Walter says.

The ACA provided additional insurance protections and increased parity for psychological services, while also extending insurance coverage to independent practitioners and their family members who previously did not have access to health insurance plans.

“Government has a direct impact on what psychologists do as professionals, how much they are paid, and where they work. Psychologists need to think about what they need to do for themselves as a profession,” Walter says. “When psychologists help themselves, they also help their patients.”

Contributing to the Psychology PAC, (see PAC infographic, page 25) contacting legislators, and participating in debates on policy at all levels of government are a few
The APA Practice Organization is the only national organization promoting the professional interests of psychologists in all practice settings. It’s a legally separate companion organization to APA. Because of APA’s tax status as a charitable organization, it cannot legally advocate for practitioners’ marketplace interests.

www.apapracticecentral.org

written by Jewel Edwards-Ashman
Medical disciplines have long used clinical data registries – electronic platforms that allow providers to enter encrypted data on patients and other variables – as a valuable aid to good practice. Health care providers can use the registries to track an individual patient’s response to a given treatment and how their patients in general are faring over time. Providers can also see how their patients are doing compared with those being treated for the same condition by other doctors.

“Using these databases can inform you about whether or not your treatment is working,” says Francisca Azocar, PhD, vice president of research and evaluation for behavioral health sciences at the health management services company Optum. “And if you’re not getting optimal results, they can generate information to help you change the course of treatment for greater effectiveness” – reports and graphs that provide useful feedback, help monitor progress, and provide comparisons to benchmarks, for example.

“The APA Practice Organization is working to create a registry that will represent the needs of individual practitioners and of specific disciplines within psychology, explains Vaile Wright, PhD, APA’s director of research and special projects. To this end, the Practice Organization is gathering an advisory committee of experts who specialize in quality measurement, progress monitoring and clinical research.

The team’s job is to come up with 30 measures – a criterion set by the Centers for Medicare and Medicaid (CMS) – that cover the practice of psychology. It will be a challenge, as they’ll need to consider populations, conditions, settings and specialty areas, among other factors, says Wright.

“Ultimately, this kind of data collection is not just the way the federal government is moving, but third-party payers, as well,” says Wright. “Moreover, a lot of research suggests that collecting data and knowing how your patients are doing is simply best practice.”
The path to the QCDR

Psychologists have been participating in this type of data input for some time, so the rationale behind and methodology of the QCDR will not be completely new. In 2007, psychologists became eligible to report quality measures through Medicare’s Physician Quality Reporting System or PQRS. Medicare offered practitioners financial incentives for successful participation in PQRS. The reasons for developing PQRS were the same as the intention behind clinical data registries: to use research findings to improve patient care while saving costs.

Because many of the CMS-generated data points and measures were geared more toward physicians, many psychologists struggled to successfully report PQRS measures. In 2014, the Practice Organization partnered with Healthmonix, a health information technology company, to create the APAPO PQRS PRO, an electronic registry designed to make reporting easier for mental health providers. While an improvement, the APAPO PQRS PRO registry still posed problems because it remained aligned with the standard CMS metrics, says Healthmonix President Lauren Patrick.

Due to a major development in health care policy – the passage of the Medicare Access and CHIP Reauthorization Act, or MACRA, in April 2015 – PQRS reporting ended with the close of calendar year 2016.

MACRA mandates that eligible practitioners in Medicare participate in one of two programs: Merit-Based Incentive Payment System (MIPS) or Advanced Alternative Payment Model (APM).

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- Merit-Based Incentive Payment System (MIPS) or
- Advanced Alternative Payment Model (APM).

MIPS is a more comprehensive program that includes many of the quality measures used in PQRS. Because few psychologists are in APMs, most are expected to report MIPS quality measures, either through claims, a registry, electronic health records or through a QCDR like the one being developed by the Practice Organization. This will allow providers to report information related to their specific areas of practice.

“When the advantage of creating our own QCDR is that we’ll have more flexibility in selecting and designing the measures we feel would be most appropriate for psychologists.” — Diane M. Pedulla, JD

When the time comes, the Practice Organization will ask CMS to recognize its registry so that psychologists and other behavioral health practitioners can use it for Medicare reporting purposes.

What can psychologists do now?

Psychologists treating Medicare patients are not required to report under MIPS until 2019, so there is plenty of time to prepare. For the next two years, psychologists can practice submitting MIPS data and receive feedback on their performance using the current Healthmonix registry platform, now called APAPO MIPSPRO. The Practice Organization encourages practitioners to do this, as the expected financial incentives of MIPS and its complexity will only grow over the next few years.

Meanwhile, the planned launch of the QCDR is January 2018, a year before psychologists are required to report measures under MIPS. That means psychologists can transition from the APAPO MIPSPRO to the QCDR and have a year of practice before MIPS reporting begins.

The QCDR will be easier to use than the current MIPSPRO, as it will include access to technology that enables more psychologists to load data more efficiently, Patrick says. And while psychologists who work in hospitals already do this through cloud-based systems that can share their data, Healthmonix plans to work with private practitioners to simplify the mechanisms for loading data.

Given all the different options for reporting quality measures that psychologists will have come January 2019, using the APAPO QCDR makes clear sense because of its intended specificity for psychological services and ease of use, says Diane M. Pedulla, JD, director of regulatory affairs for the Practice Organization.

“The advantage of creating our own QCDR is that we’ll have more flexibility in selecting and designing the measures we feel would be most appropriate for psychologists,” she says. “Without that, psychologists would have to use what CMS is already working with, most of which comes from the old PQRS measures.”
PLANNING AHEAD FOR QCDR

What should psychologists know about the upcoming APA Practice Organization qualified clinical data registry (QCDR) and how to use it?

Know the dates. Take note of dates involving the QCDR and reporting. Getting on board at the right time could influence your payment options. The Practice Organization plans to launch the QCDR in January 2018. At that point, practitioners will be able to start using the registry to practice tracking patient care and access relevant educational tools.

Prepare. If you’re a private practitioner, consider purchasing an electronic health records program, as the new system may be able to pull your required data automatically.

Practice. Participate this year and next year in the APAPO MIPS PRO, the new version of the APAPO PQRS PRO. Doing a run-through now will help prepare you in the long run. “It’s a good opportunity to assess your performance before reaching the point where you will suffer payment cuts if you’re not reporting correctly,” says Diane M. Pedulla, JD, director of regulatory affairs in the APA Practice Organization Government Relations Office.

Don’t freak. At the same time, don’t over-worry. The new QCDR promises to be easier to use and more relevant to your practice than former platforms.

Be open to change. While current Medicare rules on using either Merit-Based Incentive Payment Systems or Advanced Alternative Payment Models are currently in effect for other clinicians, nothing in Medicare is certain for psychologists until CMS makes it official.

“Medicare continues to evolve, and it will continue to explore new payment models,” says Pedulla. “The more we can work to design measures that reflect what psychologists do, the more they and the field will benefit.”

Benefits to psychologists

When using the QCDR, psychologists can expect:

Better feedback: APAPO QCDR measures will be more specifically tailored to psychologists than previous systems, so practitioners can expect better, more accurate feedback on their practices, says Patrick.

Improved information: The QCDR will link to new research, so practitioners will receive the latest information on findings and treatments in their focus areas. The Practice Organization will be able to cull information about practice patterns and provide better data, communication, and education to psychologists, lawmakers and other relevant parties.

CE and certification credits: Healthmonix will seek educational tools to include in the QCDR that would offer credit for continuing education and/or board certification – something the company has already been doing with various medical boards.

While using the QCDR might seem like yet another bureaucratic burden that steals precious time from patient care, it promises to have great advantages for your practice, your clients and for public health, says Wright.

“Ultimately, it’s larger than, ‘Here’s the place to put your measures because you have to,’” she says. “It’s also a platform that will allow you to incorporate quality improvement initiatives into your practice and help you be the most effective therapist, assessor, consultant or treatment team member that you can be.”

Written by Tori DeAngelis

Psychologists are not required to start using the QCDR (or a related reporting option) as the official data-reporting platform for CMS until January 2019, though that date is not yet official. And while your payment won’t be impacted until 2021, you still need to submit data starting at the beginning of 2019.
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Clinical Practice Guidelines Offer Important Practice Support

APA’s first clinical practice guideline on posttraumatic stress disorder was released in February. What does this guideline and upcoming guidelines mean for practitioners, their clients and the public?

In February, APA’s Council of Representatives approved the first APA clinical practice guideline on posttraumatic stress disorder (PTSD). Two other guidelines on depression and childhood obesity are near completion as well.

Some practitioners might be concerned that these guidelines will place a heavy hand on their practice choices, but there is no cause for alarm, practice leaders say. In many respects, the guidelines will prove a valuable tool for individual practitioners, for the profession, and for the public. Not to mention that they are just that—guidelines, not requirements, they add.

In the most basic sense, these documents will make it easier for practitioners to quickly view a “synthesized summary of the most up-to-date evidence and recommendations on different treatments” in one place, says Raquel Halfond, PhD, director of the APA clinical practice guidelines initiative.

In health care settings, having APA’s own clinical guidelines will place psychologists in a stronger position to deliver the care they’ve been trained in, and to counter political resistance that may arise from other health care disciplines, adds Jared Skillings, PhD, chair of the APA Board of Professional Affairs and chief of behavioral medicine, psychology and social work at Spectrum Health Systems in Grand Rapids, Michigan.

“In medical centers historically, we’ve had to rely mainly on psychiatry guidelines rather than on psychology guidelines,” Skillings says. “Clinical practice guidelines are a way for psychology to plant our flag in the turf – to show that the work we do matters, that we’re experts in psychological care and assessment, and that we should be at the table to make decisions in health and mental health care.”

Clinical practice guidelines are standard in all other areas of medicine, including psychiatry. Clinical practice guidelines are standard in all other areas of medicine, including psychiatry. If psychologists don’t follow suit, they’ll lose their opportunity to shape health care, including reimbursement, says Vanderbilt University Professor Steven Hollon, PhD, who chaired the advisory committee for the APA guidelines from the beginning of the initiative until 2016.
Finally, clinical guidelines are intended for everyone, including policymakers and consumers. As such, they have the strong public interest mission of giving potential clients reliable information about the kind of care to seek.

Developing the guidelines

For all of these reasons, APA chose an advisory steering committee to start tackling development of the guidelines in 2010.

APA is using a widely accepted process recommended by the National Academy of Medicine, formerly known as the Institute of Medicine, to develop the guidelines. The process draws upon international standards such as those developed by the United Kingdom’s National Institute for Health and Care Excellence (NICE), and incorporates “transparency, multidisciplinary panels, identification and management of all conflicts of interest, and use of a high quality systematic review,” according to the APA PTSD guideline. It’s a very similar approach to that used by the Department of Veterans Affairs and Department of Defense to develop their joint VA/DoD Evidence-based Clinical Practice Guidelines, a collaborative effort that began in the 1990s.

The process for developing APA’s PTSD guideline began with the federal Agency for Healthcare Research & Quality commissioning an independent committee of methodological experts to conduct a comprehensive literature review. The group of experts included reviewers from the nonprofit research organization RTI International and the University of North Carolina, which jointly make up one of 13 U.S. evidence-based practice centers that do this kind of work.

Next, the committee turned its findings over to a multidisciplinary guideline development panel. Besides psychology, the guideline development panel included experts from relevant disciplines like primary care, psychiatry and social work, as well as members of the public. These types of panels are tasked with discussing the findings, hashing out differences, and eventually creating recommendations based on the evidence as well as considerations related to clinical expertise and to patients’ values and preferences. Throughout the process, panel members report and address any conflicts of interest that may arise.

A finalized clinical practice guideline includes:

• A succinct executive summary;
• An in-depth explanation of the treatment recommendations and related decision-making process; and
• A section discussing treatment implementation.

Treatment recommendations use a tiered approach. The PTSD guideline, for example, “strongly recommends” four therapies: cognitive behavioral therapy, cognitive processing therapy, cognitive therapy and prolonged exposure therapy. Meanwhile, it “suggests” the use of other treatments, including specific medications, and notes “insufficient evidence” for other treatments. The panel bases all of these recommendations on the thorough, unbiased review of the literature.

Putting guidelines to use

For practitioners, the guidelines can serve as verification that you’re using a treatment or treatments with strong research support. They can also make you aware of treatments and treatment updates that you didn’t know about or that you’d like to receive additional training in. And in conjunction with APA’s professional practice guidelines (www.apa.org/practice/guidelines), they can provide guidance on how to deliver treatments that are considered best practices—for instance, how to deliver an evidence-based treatment for obesity via telemedicine, says Diana Prescott, PhD, an independent practitioner who with her husband David Prescott, PhD, runs Hampden Psychological Consultation, PLLC, in Hampden, Maine.

Clinical guidelines can also be useful in giving private practitioners a handle on best practices in different domains than their central areas of practice.”

– David Prescott, PhD
That can be important if you work with clients who have co-morbid conditions that were not apparent at the outset.

In hospitals or other large health-care settings, clinical guidelines can serve both as a guide for individual practitioners and for administrators who seek to promote high quality multidisciplinary care, notes Skillings.

“Ideally, if you’re a clinical administrator whose institution is providing interprofessional care, you should be looking at these guidelines across different disciplines and combining them” to deliver the best possible team-based care for a given patient, he says.

VA psychologist Chris Crowe, PhD, who is senior mental health consultant and liaison to the DoD’s Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, says that the similarly developed VA/DoD guidelines serve as a continuous quality improvement tool, equipping providers with the most recent evidence. Those guidelines also include treatment algorithms that assist providers in clinical decision-making so they can provide the best possible care for veterans, he notes.

What’s next?

Creating quality guidelines is expensive and time-consuming. To account for this reality, APA is considering ways to continue the process by leveraging outside resources. For example, leaders are considering endorsing high quality guidelines from other organizations in some areas instead of creating new ones from scratch, and partnering with other professional organizations to fund or otherwise participate in the creation of new guidelines.

For the new PTSD guideline and other upcoming guidelines, plans are under way to make them as accessible and user-friendly as possible, Halfond adds. APA is developing a comprehensive website that will post the PTSD guideline, as well as related resources for clinicians and consumers.

APA also plans to develop short summary versions for practitioners and the public, Halfond says. For psychologists concerned that such guidelines may neglect important clinical ingredients such as the importance of the therapeutic alliance and of clinical experience, APA is considering the development of an additional professional practice guideline that addresses the real world implications of clinical guidelines, says Skillings.

The professional practice guideline would discuss how to use a clinical practice guideline in determining care, along with delineating other components of good clinical care. In general, clinical guidelines are a way for psychologists not only to catch up with the rest of the health care system, but also to learn about research-based interventions that work – many of them developed by psychologists, Halfond says.

The PTSD guideline is available to the public on APA’s website.

Written by Tori DeAngelis
A New Way to Pay for Psychological Services

Financial incentives are increasingly rewarding quality of care instead of volume.

The rising cost of health care and other factors are causing payers to explore new models of payment, says Elena Eisman, EdD, director of the Center for Psychology and Health at APA. One key trend? Shifting from fee-for-service payment models that reward volume to payments that reward positive outcomes for patients. For psychologists, says Eisman, that means moving from “hold a session, get a payment” to getting paid for their role in keeping people healthy. The emphasis shifts from individual patients and episodes of care to populations of patients. And providers’ roles also change, with a move away from individual practitioners working alone, to team-based services designed to keep shared patients healthy. These trends are being reflected at the state and federal level as well as at the commercial insurance level. Although health care policy is unsettled at the moment, says Eisman, the U.S. Department of Health and Human Services “is expecting and hoping for a sharp decline in fee-for-service reimbursement and a sharp increase in value-based services.” Where and how mental and behavioral health services get valued in new models is evolving but still somewhat unclear.

There are several steps along the way toward changing the culture of health care providers and accustoming them to the idea that seeing more patients or providing additional services isn’t the right approach, says Delaware-based health policy consultant Alan Greenglass, MD.

The first step is pay-for-performance or pay-for-value models, which offer financial rewards or penalties to providers according to how well they meet quality measures. “Does ‘pay-for-value’ improve the quality of care? The jury’s still out on that,” says Greenglass, pointing to a 2017 meta-analysis in the *Annals of Internal Medicine.*

The next step up is a total-cost-of-care model, says Greenglass. That can mean gains-sharing, such as the Centers for Medicare and Medicaid Services’ bundled payment program that lets providers share savings for coming in below budget for particular procedures. Medicare’s accountable care organization model is similar, allowing organizations to share in savings if they beat the budget for treating a population of Medicare beneficiaries in a geographic region.

The final step is capitation, in which an organization is paid a set price to care for each covered patient. “While other models have made incremental change, this is the only model that has been demonstrated to actually succeed at controlling the cost of care, improving patients’ experience and improving health care outcomes,” says Greenglass.

What does this mean for psychologists?

Psychologists are already moving along this continuum. Kevin D. Arnold, PhD, who directs the Center for Cognitive and Behavioral Therapy (CCBT) in Columbus, Ohio, for example, is co-locating psychologists within primary-care practices to jointly care for patients. “We aggressively pursue integration,” says Arnold of his large group practice.

Arnold now sees patients at Central Ohio Primary Care, a physician-owned medical group. “It was supposed to be four hours one day a week, but after two months, it became three days a week for 12 hours,” says Arnold, adding that CCBT has an expedited referral process for patients.
who need more ongoing care. “I hardly see patients in my own office anymore.” Arnold hopes to place one of his clinicians in each of the primary-care practice’s many clinics across Ohio.

Having more CCBT psychologists work across disciplines to keep patients healthy could eventually give Arnold’s practice access to per-member-per-month payment models. Medicaid, for example, offers a flat payment rate for each patient to networks that are integrating behavioral health and primary care. “We know we’re going to give value,” says Arnold. “We reduce the primary-care practitioner’s time in an encounter, because behavioral health issues are rolled over [to behavioral health providers].”

Arnold is already initiating value-based contracting with two large insurers. “We see payers as partners,” he says. “We want to help them save health care costs.”

Insurers know psychologists’ value, says Robin Henderson, PsyD, chief executive for behavioral health at Providence Medical Group, which has a health plan covering a quarter of Oregon’s Medicaid, Medicare and commercial populations.

The American Psychiatric Association’s Milliman report, for example, found that asthma costs 244 percent more with concurrent behavioral health conditions, cancer 172 percent and diabetes from 150 to 170 percent more, she points out. The elevated costs for comorbid conditions emphasizes the importance of treating both conditions for optimal care and likely cost savings.

Getting paid by insurers in the traditional fee-for-service system is pretty straightforward: You provide the service, then bill for it based on a per-visit basis under a Current Procedural Terminology (CPT®) code or a diagnosis-related group code used by hospitals. But contracting for bundled payments and other new models can be trickier, says Kevin J. Ryan, JD, of Epstein, Becker & Green in Chicago.

Before you sign a contract, suggests Ryan, get answers to the following questions:

- What counts as an episode of care?
- What is the price based on?
- Will payment go directly to you or go to a group that will pass it on to you?
- How does the contract account for case mix and cases that turn out to be more complex than anticipated?
- Will all your patients be subject to this payment type?
- Are there bonuses for meeting quality benchmarks?
- Are there regulatory risks, such as corporate practice of medicine prohibitions or fee-splitting laws?

“As you read a contract – or have your attorney read it – understand what you’re agreeing to do because obviously it’s not just, ‘I saw them and am going to get paid x dollars per visit,’” says Ryan.

Kevin D. Arnold, PhD, who directs the Center for Cognitive and Behavioral Therapy (CCBT) in Columbus, Ohio, is co-locating psychologists within primary-care practices to jointly care for patients.
But when it comes to contracting with hospitals, there are things holding psychologists back, says Henderson.

Privacy concerns may make psychologists in private practice reluctant to share information with medical providers, for instance. That’s out of step with today’s collaborative health care, says Henderson. “You don’t need to spill all the beans when talking with primary care, but you need to spill the beans that are pertinent,” she says.

**New ways to deliver psychological services**

Psychologists also need to be open to new ways of working, whether that means five-minute consultations about shared patients with multidisciplinary care teams or replacing traditional 50-minute sessions with new tech tools for engaging Millennials. APA is helping psychologists transition to working in integrated care teams, thanks to a Support and Alignment Network 2.0 cooperative agreement from the U.S. Centers for Medicare and Medicaid Services.

Psychologists should also reach out to physician practices to offer help on meeting their outcome measures.

Henderson encourages private practitioners to make collaborations with hospitals part of their practices. “If you’re in private practice, figure out how to engage with someone as large as Providence,” she says. “Make it easy for us.”

Written by Rebecca A. Clay

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**APA TRAINING PSYCHOLOGISTS IN INTEGRATED CARE**

The American Psychological Association’s Center for Psychology and Health has received a three-year, $2-million grant from the Center for Medicare and Medicaid Services (CMS) to help train psychologists to work within an integrated health care system.

The award comes from the CMS Transforming Clinical Practice Initiative (TCPI) Support and Alignment Network (SAN). The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely.

During the three-year award period, APA will serve as a SAN, leading an education and workforce development project that will provide 6,000 psychologists with clinical and leadership skills needed to participate as part of primary and specialty care practices that are implementing integrated care programs and alternative payment models.

For more information, contact APA’s Center for Psychology and Health at PsychologyandHealth@apa.org.

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“If you’re in private practice, figure out how to engage with someone as large as Providence. Make it easy for us.”

– Robin Henderson, PsyD
Navigating Institutional Politics

Politics are inevitable in most workplaces. Whether psychologists work in a traditional medical environment or other institutional settings, the key to success lies in developing skillsets to help you navigate organizational politics, build alliances and gain influence.

Physicians do not tend to treat people in groups. Consultations, examinations, procedures and treatments are individual patient encounters. It is not surprising then, that physician productivity in institutional settings often is measured in scheduling slots. Every slot equals one patient.

It struck Kathleen Ashton, PhD, ABPP, a health psychologist in the Cleveland Clinic’s Breast Center, that her productivity was grossly undercounted by this metric. Ashton could see several patients in a group session and it was tallied as one patient encounter. Indeed, the success of group programs was key to her department’s successful performance for the clinic and, more importantly, for its patients.

This simple observation occurred to Ashton while directing a group program at the clinic. Thanks to her attendance at administrative meetings on budgets and productivity metrics, her positive working relationship with her medical team, and some other relationships she had taken the time to forge, Ashton had the tools, institutional access, and influence she needed to fix the problem. She made a business case that the current metric was as bad for the clinic as it was for her program. She wanted to count each patient individually.

A simple observation with an easy solution, yet resolving it took a politically astute practitioner in the right place at the right time. Psychologists generally eschew politics and receive little training in the business side of practice, but in institutional settings, politics matter for patient outcomes.

As collaborative care models become more prevalent, psychologists in institutional settings are called upon more than ever to fill the types of leadership roles traditionally reserved for physician administrators.

“It is important to be savvy about financial considerations,” said Ashton in an interview. “Having that language is important for psychologists when they want to make program proposals.”

Panelists and attendees of the Navigating Institutional Politics workshop at APA’s 2017 Practice Leadership Conference shared insights and experiences to help colleagues better succeed professionally and improve patient care in institutional settings. Ashton was joined by: Kathleen S. Brown, PhD, a former interdisciplinary pain management director and psychologist at Tripler Army Medical Center in Honolulu; Jared Skillings, PhD, ABPP, chief of behavioral medicine at Spectrum Health System in Grand Rapids, Michigan; and Ryan Warner, a counseling psychology doctoral student at Marquette University in Milwaukee.
Map the landscape. Every organization’s culture, lines of communication and channels of authority are somewhat unique. Knowing the organizational chart is essential, but only scrapes the surface. Personalities drive politics. Power can aggregate in surprising places under effective leaders. Those leaders may be natural stakeholders in a project you value, and you may need their support to achieve your own goals.

Brown cited the opioid crisis as an example. She launched an interdisciplinary pain management program at Tripler, and owing to its success the program was elevated to its own department. Suddenly she held a position equal to physician department heads who did not fully understand what she was accomplishing.

“I needed to get out of my department to see who my allies were,” she recalled. Primary care physicians were operating at the front lines of the opioid crisis. They embraced the value her program offered to help them manage pain and improve functioning for their patients while decreasing the risk of addiction.

Psychologists frequently limit themselves within their own subculture in institutions dominated by physicians. Skillings suggests that psychologists break free of their silos and usual modes of speaking, and become more assertive.

“We need to stop being bashful about what we are good at,” he said, adding that physicians are unlikely to mince words when they want something done.

Acquire skills. Psychologists receive little training in budgeting, cost management and performance metrics. Fortunately, educational resources abound. The APA Practice Organization and APA offer members a menu of career-development tools to supplement the professional skills graduate programs do not provide. Management coaches and online courses are another option.

Brown’s job at Tripler involved reducing the cost burden and improving the care of chronic pain, yet she recalls, “I didn’t fully appreciate the extent to which money drove care in the current system.” She gained much of the financial training she needed from resources offered by APA Practice Organization.

Challenge biases. Negative biases and micro-aggressions complicate politics for too many practitioners. Warner shared an incident when he was working at a correctional institution. He used an expression that was culturally African American and was admonished for using “inmate language” rather than what staff deemed appropriate language.

Amplification is an effective influence-building strategy in diverse organizations that may unintentionally permit subtle biases and micro-aggressions, such as talking over or undervaluing diverse contributors. Diverse stakeholders back up each other’s opportunities to influence decisions by seconding motions, or citing and sharing their contributions. They need not agree on the desired outcome of a decision, rather they are supporting each other’s right to be heard. In less diverse environments, however, holding your ground and calmly correcting micro-aggressions may be the only option.

“Take advice from people who have been there and done the work – people who have demonstrated leadership.”
– Jared Skillings, PhD, ABPP

“Ninety-nine percent of the time,” noted Warner, “I am the only African American male in the room.”

Seek support at all levels. Thinking horizontally, as well as vertically, when seeking alliances creates political opportunities. Brown sought allies in other departments who could advocate for the interdisciplinary approach. Some of her best allies turned out to be data crunchers in the budget and finance department.

Choose mentors wisely. “Take advice from people who have been there and done the work – people who have demonstrated leadership,” Skillings said in an interview. Beware of the expert who has never demonstrated expertise, he cautioned.

The goals of good mentorships are mutually understood and focused, such as skill development. Mentors need not be top executives, although those relationships have the added benefit of developing your influence. A peer with a skill you lack may also be a helpful mentor.

Written by Sherry Delaney
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THE DEPARTMENT OF DEFENSE IS AN EQUAL OPPORTUNITY EMPLOYER.
For Shannon Edwards, PsyD, legislative advocacy is a reward and a challenge indelibly linked to her work as a clinician. But she was fiercely committed to effecting change long before becoming a psychologist. In fact, she can trace her passion for advocacy back to her childhood, when, outraged by the cancellation of the sitcom Full House, she petitioned her neighbors to bring the show back.

“I was certain that if I went door-to-door and got enough signatures, they’d put it back on the air,” she recalls.

In a way, her efforts were successful, as a sequel to the sitcom was released on Netflix recently, over 20 years later. “That feels like how long it can take for things to happen in Congress, so I suppose it was a good lesson!”

Now, Edwards is a forensic clinical psychologist and mental health reform advocate in Pittsburgh, Pennsylvania. She has a private practice, where she specializes in court-mandated services for juveniles, adults and families, and she also regularly testifies as an expert witness in family and criminal law courts. Her work gives her the opportunity to observe the effects of mental health policies on the people she serves, the public, and other practitioners. It has also motivated and empowered her to improve those policies at local, state and federal levels.

The early Full House campaign aside, Edwards says her advocacy took shape while she was working as an intern at Torrance State Hospital in southwestern Pennsylvania. There, she observed that patients at the hospital — who were not only very ill, but often disenfranchised, without family support or state resources — were receiving substandard care.

“Psychologists and other licensed professionals weren’t drawn to working in this environment, so as with other state institutions, the hospital was staffed by well-intentioned but unlicensed individuals,” she says. “Furthermore, patients would cycle through treatment, jail and back, without continued care resolutions available. I wanted to get involved and help change those conditions.”

So she did. Edwards helped pass Pennsylvania’s Psychological Practice Modernization Act of 2016, which — among other things — amended existing laws permitting unlicensed professionals working in county, state and federal institutions to do work of a psychological nature, such as testing or supervision. These individuals are now required to be licensed.

But bridging gaps in services is an ongoing challenge, Edwards says. “We need more psychologists to work in state hospitals, jails and prisons to fill the employment void.”

As her career moved forward, Edwards learned how to problem-solve at the institutions where she worked. “While funding was always an issue, many problems stemmed from simple gaps in communication between agencies, organizations, patients and families. I’ve found that a lot of problems can be solved just by sitting people down and talking.”

This “sit down and talk” approach has served her well in forming strategic partnerships and helping to pass legislation that expands mental health services.

“I see advocacy as relationship-building,” she says. “Psychologists are uniquely positioned to do this — it’s what we do in our work as clinicians. We understand how to bridge gaps in communication between lawmakers, organizations, and the public. And we are especially qualified to convey to lawmakers how policies will affect the people we serve.”

One of Edwards’ most significant advocacy successes was with the Helping Families in Mental Health Crisis Act of 2016, which was sponsored by Rep. Tim Murphy,
R-Pa. The law, originally introduced in the aftermath of the shooting at Sandy Hook Elementary School, contains many provisions reforming the nation’s approach to mental health, including expanded support for the education and training of psychologists.

Edwards first learned about Murphy’s bill from a family she was working with at Torrance, whom she credits with changing the course of her advocacy work. Inspired, she reached out to the Congressman’s D.C. staff, and from there continued to work with him and others on the bill as it stalled, was reintroduced, and finally became law in 2016. She did this work in partnership with Doug Walter, JD, the associate executive director of the APA Practice Organization’s government relations department.

“Dr. Edwards is a great advocate for the profession of psychology,” Walter says. “She built a great relationship with a member of Congress, has acted as a good resource on mental health issues and has been persistent about requesting support for those issues.”

When Edwards first began advocating for national mental health reform, she was frustrated with the process—she felt that lawmakers didn’t understand mental health. But then she realized that this dynamic was similar to her work-related interactions.

“When I’m in court giving expert testimony, and the judge has questions about psychological testing, for example, I’m not defensive. I just use the opportunity to explain things like the reliability and validity of my evaluations.”

Talking with lawmakers presents that same educational opportunity, she says.

“If we don’t educate them, then they won’t know, and they’ll make many of their decisions based on economics. We just have to go to them with an open mind and talk, face-to-face, about how policies affect our patients and our practice.”

Now, Edwards is focusing her advocacy efforts on the Medicare Mental Health Access Act (MMHAA) (S.2597, H.R.4277), which would include psychologists in Medicare’s physician definition and remove barriers to care.

The MMHAA has support on both sides of the aisle, because “mental health knows no partisanship,” she says.

Psychologists have a significant professional stake in policy outcomes. However, Edwards understands that psychologists have historically been hesitant to get involved in politics. To counter that reluctance, she would encourage colleagues to take advantage of the current swell of locally-focused activism and robust civic engagement in the U.S.

“There is a movement happening in our country right now. This is great time to get involved and effect positive change for mental health, psychology and human well-being in general.”

Psychologists’ part in the movement doesn’t need to be resistant; it just needs to be constructive, she says.

“Simply calling your senators and representatives is a great start, and really important. If you want to do more, join a regional network of psychologists—or start one! Come together in a way that’s beneficial to your community.”

Edwards acknowledges that committing to this kind of work is easier said than done. “If you can’t give your time, donate,” she advises. “Join the Practice Organization and give to the Psychology PAC; they’re pushing for changes on a national level that will affect us all.”

Written by Hannah Calkins
Psychology’s Next Generation of Advocates

For early-career psychologists and members of the American Psychological Association of Graduate Students (APAGS), coming to Washington, D.C., in March to advocate for professional psychology on Capitol Hill can be life-changing. Good Practice spoke to four attendees at this year’s Practice Leadership Conference (PLC) about how the experience influenced their advocacy efforts on behalf of psychology:

Opening up possibilities
Sydney Morgan, a counseling psychology graduate student at the University of Missouri-Kansas City (UMKC), was so energized by PLC that when she spotted Rep. Emanuel Cleaver, D-Mo, on the plane ride home, she was eager to make contact.

Cleaver deplaned too fast for Morgan to catch him, but she’s not going to let that stop her. Says Morgan, “I plan to give his local office a call so I can chat with him.”

That sense of being able to act at the national level was prompted by Morgan’s participation in PLC, she says. But Morgan has been an advocate since starting graduate school. She began as a campus representative for APAGS, then moved up this year to become the southeast regional advocacy coordinator – helping to organize grassroots advocacy activities. In addition, Morgan and other UMKC counseling psychology students are active on campus, pushing for gender-neutral bathrooms and urging the counseling center to fill openings with staff who reflect the university’s diversity.

Meeting legislative staff at the D.C. offices of her representative and senators was eye-opening, says Morgan, who was surprised by how open and supportive they were. She plans to use her newfound confidence to engage with legislators at the Missouri Psychological Association’s upcoming advocacy day. She also plans to stay engaged at the national level. “Legislative advocacy seemed a lot more manageable than I thought,” she says. “There was a feeling that we could make a difference.”

Learning new tactics
Even before attending the PLC, Elyse Mowle was intent upon a career in advocacy.

“It’s the way to have the most impact on as many people as possible,” says Mowle, a clinical psychology graduate student at Texas A&M University and state advocacy coordinator for APAGS. While researchers help psychologists learn how to treat people and practitioners put that knowledge to use, she says, none of that matters without the policy component. “That’s all out the window if there’s no access to health care,” she says.

“Legislative advocacy seemed a lot more manageable than I thought. There was a feeling that we could make a difference.”

– Sydney Morgan
Mowle first took interest in psychology advocacy after attending a legislative day sponsored by the Society for the Psychological Study of Social Issues about a year and a half ago. Then she got involved with APAGS. Now she’s helping the Texas Psychological Association fight against a move to consolidate all mental health practitioners – including master’s level practitioners – under a single licensing board.

A PLC session called “The Deregulation Movement: Strategies for Policy Advocacy” offered useful tips for fighting that battle, says Mowle, noting that the session featured the story of how the Rhode Island Psychological Association successfully fought a consolidation battle.

The most important lesson she’ll take back to Texas? Building a coalition with a broad array of mental health practitioners in the state. “Psychologists, psychiatrists and the master’s level providers often disagree on things,” Mowle admits, noting a history of “bad blood.” Mowle now plans to find ways to engage these professionals in the fight to keep their separate licensing boards.

Renewing a commitment to advocacy

Annie Derthick, PhD, almost didn’t come to the PLC, because she was so disheartened by the current socio-political climate in Washington. “There’s so much negative energy wrapped around Washington and our government,” says Derthick, a psychologist at Providence Family Medicine Center in Anchorage. Now she’s glad she did. Derthick has always been an advocate in her personal life, focusing most recently on lesbian/gay/bisexual/transgender health care and religious freedom for immigrant and refugee populations. For Derthick, that kind of advocacy is an extension of her role as a clinician. “If I have a patient in my office who’s experiencing depression or anxiety as a result of being in an oppressive system, part of my clinical work is to fix that system, not just to ‘fix’ that person,” she says.

Derthick was struggling with her role as an advocate on behalf of psychology itself, however. “I have had to find a way to reconcile that agenda with my own personal agenda, which is fighting oppression,” she says. That happened
over the course of the PLC, thanks to the opportunity to spend time with other early-career psychologists and diversity delegates facing similar identity crises. She has started to reframe professional advocacy as championing the cause of access for the underserved. Derthick is now planning to create a continuing education program just for early-career psychologists and students in her state—a kind of advocacy primer with the association’s state advocacy and federal advocacy coordinators, which will be held in September 2017.

“I hope 20 years from now, we’ll be able to look back and say, ‘Remember our first PLC? Wow, look how far we’ve come!’”

– Dawn Huber, PhD

Preparing for leadership

Dawn Huber, PhD, was always a reluctant leader, more inclined to take a behind-the-scenes approach to advocacy. But when she met APA Practice Organization head Katherine C. Nordal, PhD, at a Practice Organization event, Nordal encouraged her to come to PLC for a thorough grounding in everything she needed to know.

“I went back to my state association and made a deal: If they would get me to PLC, I would finally step up and be the president-elect-elect,” says Huber, an assistant clinical professor of health psychology at the University of Missouri School of Health Professions. The association’s president-elect-elect system is a mentorship model that allows for a seat at the table for a few cycles before assuming power, explains Huber, who will take on the role in June.

Huber has long been active in advocacy at the state level, whether testifying at the state house or meeting with state legislators. PLC represents “a big stepping stone” toward feeling comfortable with federal-level advocacy, says Huber, noting that she was “raised in a family that really valued the idea of using your voice to speak up for others.”

In addition to the skills training at the PLC, Huber appreciated the opportunity to network with the pipeline of psychology’s future leaders. “I hope 20 years from now, we’ll be able to look back and say, ‘Remember our first PLC? Wow, look how far we’ve come!’” she says.

Written by Rebecca A. Clay

The Practice Leadership Conference (PLC), previously called the State Leadership Conference, is an annual conference for psychology leaders representing state, provincial and territorial psychological associations. Hosted jointly by the APA and the Practice Organization, the conference dates back to the mid-1980s.

PLC equips practicing psychologists to be effective advocates for the profession and for their patients. Conference attendees are briefed on federal legislative issues affecting professional psychology and learn how to become vigilant, organized and proactive advocates to ensure policy outcomes that benefit psychologists, psychology and patients. The conference culminates with visits to congressional representatives. To learn more about PLC, visit apaprinnticentral.org/advocacy/state/leadership.

Sydney Morgan and Dawn Huber, PhD
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Advocating for the Profession

Three hundred psychologists hit the halls of Congress to lobby for practitioners and the patients they serve.

Every March, psychology’s leaders from across the United States and Canada convene in Washington, D.C., for what is now called the Practice Leadership Conference, or PLC (formerly known as the State Leadership Conference). After three intense days of training, education and networking, delegates from each state association take part in the conference’s culminating event: going to Capitol Hill to meet with their Senators and Representatives to lobby for the interests of psychology and psychologists. During the conference, the Practice Organization’s Government Relations staff held multiple briefing sessions for the delegates, where they went over talking points, shared communication strategies and coached them on Capitol Hill etiquette.

This year, delegates had two advocacy messages:

• Preserve and extend Affordable Care Act coverage for mental health and substance use treatment.

• Request their members of Congress to co-sponsor the Medicare Mental Health Access Act (S.2587/H.R.4277), which would add psychologists to Medicare’s “physician definition” and remove barriers to care.

Psychologists took those messages to the Hill on March 7—the day after Congressional Republicans released their long-awaited bill detailing plans to repeal and replace the Affordable Care Act (ACA). That bill was later withdrawn, but on the morning of the 7th, politicians and Congressional staffers were scrambling to respond. Despite the chaos, it was a great day for psychologists to assert their place in health care.
Representative Scott Taylor (R-Va.) poses with members of the delegation from the Virginia Psychological Association.

Senator Mike Enzi (R-Wyo.) speaks with the delegates from the Wyoming Psychological Association.

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