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From Author
Samuel O. Ortiz, Ph.D.

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Dear Colleagues:

It is my great honor to serve as Chief of Professional Practice of the American Psychological Association (APA) and APA’s Practice Organization. As I assume this new leadership role, I want my practice and applied colleagues to know that I am in the trenches with you. I have fretted and lost sleep over billing codes, organizational and security regulations, licensing laws and more. Like all of you, I have been dismayed by the unfair funding that psychological services and science have received.

Despite these challenges, I truly believe that our future is bright. My optimism is due in no small part to the exceptional work of my predecessor, Dr. Katherine Nordal, and the talents of our APA Practice staff and governance leaders. Now we must seize the opportunity to envision the future of psychology practice – to advance the health and well-being of society and the communities we serve.

Psychology practice has touched and shaped nearly every aspect of my life. My father is a counseling psychologist in rural Ohio, and my mother is the office manager. Independent practice not only put food on our table, but also taught important life lessons about leadership, entrepreneurial spirit, community, and caring for the underserved.

In high school, I remember the Psych 101 textbook I referenced to write a paper about intelligence. I enjoyed it so much, and also my next paper on schizophrenia, that I declared psychology as my college major and have been studying or practicing ever since.

Two prior jobs have had an important impact on my leadership and commitment to psychology practice. First, I served as behavioral medicine director for the largest independent practice in the U.S. (240+ clinicians), called Pine Rest. While learning about the opportunities and challenges of independent practice, I provided presurgical psychological evaluations and psychotherapy for patients with chronic or complex medical conditions. I also led the integration with medical centers, which required me to define and explain the value of psychology to physicians and health system executives.

Second, I served as the inaugural chief of psychology for the Spectrum Health System ($5.7B enterprise; 26,000+ employees) in Grand Rapids, Michigan. I led behavioral health strategy, talent acquisition, program development, and initiatives for clinical access, quality & safety. My leadership team thrived in our large, matrixed system and grew behavioral health one thousand percent from five to 57 providers in six years, including 36 psychologists. I am proud that we successfully attained full medical staff privileges for psychologists in our 12 hospitals, as well as physician-level employment benefits.

“My vision for psychology practice is that we will become THE preeminent mental health and applied profession.”

– Jared L. Skillings, PhD, ABPP
I have been preparing for an executive position for the past several years. It was a welcome challenge to become board certified by the American Board of Professional Psychology (ABPP) in three specialties – Clinical Psychology, Clinical Health Psychology, and Behavioral & Cognitive Psychology. Further, I was able to complete Black Belt certification in Six Sigma Process Improvement, which has become a standard in industrial and organizational settings. My psychology governance leadership has included serving as chair/president of four organizations within the first 12 years of my career, including the Michigan Psychological Association and APA’s Board of Professional Affairs (BPA).

I am convinced that psychology is one of the most well-positioned professions for value-based care. As a nimble and “people first” profession, we don’t usually require million-dollar machines; much of our work can be done with minimal overhead and/or via smart technology. Along with psychological science and human factors expertise, these are the kind of professional strengths that we must build upon to provide the right services in the right place at the right time.

Finally, my vision for psychology practice is that we will become THE preeminent mental health and applied profession. When legislators, courts, or executives in health care or business think about key challenges today, psychologists should be at the top of their minds. To achieve this vision, we will develop a strategic plan for psychology practice to include diverse voices of members, governance leaders, staff, external stakeholders, and the public. We must work collaboratively to craft the future of our profession. It is up to us to seize this opportunity to improve the health and wellbeing of the communities we serve.

I look forward to working with you to lead psychology practice toward an even stronger future.

Best Regards,

Jared L. Skillings, PhD, ABPP
Chief of Professional Practice
American Psychological Association
Twitter: @JLSkillings
Psychologists have faced many challenges over the years. From unintelligible insurance contracts, to confusing billing codes and then the increasing number of steps that it takes to get reimbursed—maintaining a career as a practicing psychologist did not get easier in 2018.

Last year, I was honored to accept the position as APA’s chief executive officer. In this role, I find myself drawing upon the skills that I have developed over many years as a practitioner, which informs my ability to recognize issues that matter to practicing psychologists. For example, I know what it’s like to experience the pressures of running an efficient practice, serving your clients well, and even building a sustainable life outside of work, which often feel dependent on factors outside of your control.

I’ve experienced first-hand the obstacles that psychologists have to overcome to run a successful practice. That’s why I, supported by the indispensable APA staff, will keep advocating on issues that impact psychology practice.

This year, for example, we faced the possibility of catastrophic double-digit cuts to reimbursement rates for psychological and neuropsychological testing.

Fortunately, APA’s persistent advocacy on psychologists’ behalf prevented double-digit decreases and resulted in a 6 percent increase for a battery of outpatient testing services. If APA had not been there to fight on behalf of psychology, this result would not have been possible. On multiple occasions, APA Past President Tony Puente, PhD, and I, along with psychology advocates Joseph W. Fink, PhD, and Neil Pliskin, PhD, sat at the table with high-level officials from the Centers for Medicare and Medicaid Services to share with them why practicing psychologists and neuropsychologists are essential to the health care industry.

Psychologists possess an unmatched skillset when it comes to testing individuals for autism, dementia, surgical clearance, and a range of other issues. Tony and I presented details on every complicated aspect of testing and argued that reimbursement rates for this area of our profession should not be reduced. Members of the government relations team and the Office of Health Care Financing carried that same message to Congress and other government leaders.

CMS agreed with us, and in turn raised the 2019 reimbursement rates for most testing services to Medicare beneficiaries. This marks a major win for practice.*The CMS proposed rule released over the summer did suggest decreased payments for select groups, including neuropsychologists who gather their own test data. Therefore, our work is not finished, and we plan to continue fighting for you on this and other issues that affect your reimbursement.

Our Legal and Regulatory Affairs office is also doing exactly that. They remain committed to helping psychologists make sense of their contracts with private insurers. They’ve heard hundreds of stories from psychologists across the country voicing concerns about potential declines in payment from TRICARE, the health insurer for military personnel. The legal team continues to work with TRICARE administrators to prevent psychologists from seeing a potential 30 percent decrease in reimbursement that has been rumored.

I hope that talking about some of the difficult times we’ve faced, and our successes will reassure you that we are fighting hard for practicing psychologists. Whether it’s assisting in negotiations with private insurers, urging CMS to protect your payment rates, or lobbying for our interests in Congress, please know that our team remains committed to tackling the issues that are important to you.

*CMS detailed the changes in reimbursement rates for psychological and neuropsychological testing services in the 2019 Medicare Physician Fee Schedule proposed rule. Changes to reimbursement rates are tentative until CMS releases the final rule on the fee schedule in November 2018.
For at least a few decades, outcome measurement has been a major theme in health care reform—a pragmatic way to improve both the quality and cost of care on an individual and population level.

This same set of practices and ideas has been percolating into the behavioral and mental health domain, though more slowly—partly because mental health has operated separately from health care until recently, as well as for a range of other reasons, practical and attitudinal. While many providers endorse the concept in theory, a recent study by University of Miami psychologist Amanda Jensen-Doss, PhD, and colleagues finds that only 13.9 percent of 504 mental health clinicians surveyed used standardized progress measures at least once a month, while 61.5 percent never used them (Administration and Policy in Mental Health and Mental Health Services Research, Vol. 45, 2018).

Given that outcome measurement is the direction both health care and insurance are moving, however, more and more practitioners are incorporating these tools into their practices. And despite general concerns that embarking on this work might stifle the spontaneity of therapy or prove a bureaucratic hassle, many are finding that it really does improve clinical work by promoting patient growth and helping therapists get better at their craft.

“Using outcome measures has empowered growth in our clients and allowed both clients and providers to get a better feel for where treatment is going,” says Traci Bolander, PsyD, owner of Mid-Atlantic Behavioral Health, an outpatient behavioral health practice with four locations in Delaware who began instituting such measures in 2016. “When billed appropriately, you’re actually getting paid to do the things that are good treatment. It’s proving to insurers and others that this is a valuable service that we should be paid to do.”

What are outcomes?

Outcome measurement is the use of measures or other tools to track your progress and that of your patients over time. These instruments can be standardized measures that assess and track a patient’s depression, anxiety or social functioning; individualized or “idiographic” measures based on the client’s own stated goals toward health, mental health or well-being; or both. Some of these measures also capture so-called “common factors,” those global elements independent of model type shown to be associated with successful therapy, such as a strong therapeutic alliance and observed change within the first few sessions.

Leaders in this area say successful outcome measurement centers on two main elements. One is to use them in collaboration with your client. “Feedback to clients is an absolutely critical part of this, because [outcome-based] therapy is intended to be a collaborative process,” says psychologist Aaron R. Lyon, PhD, who directs the University of Washington’s School Mental Health Assessment, Research, and Training (SMART) Center, which supports the use of evidence-based
behavioral health practices in the schools.

The other key is using them in an ongoing, systematic way, says psychologist Kimberly A. Hepner, PhD, a senior behavioral scientist at the RAND Corporation who studies the use of these measures.

“We know that just administering an outcome measure at the beginning, the middle and the end of treatment doesn’t result in the same kinds of improvements as administering those measures in a regular, timely fashion and receiving feedback just before or during a session,” she says.

There are a few proprietary measures that are often used in this context. One is the OQ®-45.2, a 45-item instrument developed by Brigham Young University psychologist Michael Lambert, PhD, that asks about client symptoms and problems in relationships and social roles. It also includes algorithms that predict whether a patient is at high risk for dropout, deterioration or slow progress.

Another set of measures is called PCOMS, the Partners for Change Outcome Management System. Devised by psychologists Barry L. Duncan, PsyD, and Scott D. Miller, PhD, it includes the

- Tori DeAngelis

**Getting started**

If the idea of expanding your practice to include outcome measurement intrigues you, here are some tips on how to proceed:

- **Start small.** Track one or two clients or a few clients with a particular condition, experts suggest. Explain to them what you’re doing and why you’re doing it, get their consent, and use one or two measures that make sense.

- **Consider additional training.** Barry L. Duncan, PsyD, Scott D. Miller, PhD, Tony Rousmaniere, PsyD, and others provide regular trainings on outcome measurement and its companion, deliberate practice, which helps clinicians work specifically on areas of weakness identified by the data.

- **Invest in software.** Kimberly A. Hepner, PhD, who studies the use of outcome measures at the RAND Corporation, says measurement-based care is easiest if you have the support of good technology. “It helps to streamline the collection of data and track how patients are doing over time,” she says.

- **Check out relevant web-based resources.** Many of them are free. A [website](https://betteroutcomesnow.com) developed by outcome-measurement educator Rousmaniere, for example, provides links to books, chapters, articles, outcome measures and online communities and forums, as well as outcome-measuring software designed for ease of use by you and your clients.

The [website](https://www.mbhregistry.com) of Barry Duncan, PsyD, co-creator of the outcome measuring system PCOMS (Partners for Change Outcome Management System), offers the PCOMS measures for free. It also includes access to dozens of other free resources, including short webinars on using the PCOMS measures and short videos explaining the rationale of doing outcome-based treatment. Visit [betteroutcomesnow.com](https://betteroutcomesnow.com).

This review of free standardized assessment instruments includes measures for both kids and adults.

APA’s [Mental and Behavioral Health Registry](https://www.mbhregistry.com) provides a range of relevant, free outcome-measurement tools (see box). Visit [www.mbhregistry.com](https://www.mbhregistry.com).

- Tori DeAngelis

“While we’re good at many things, therapists typically have a blind spot in terms of identifying clients at risk for deterioration”

– Tony Rousmaniere, PsyD
Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), each just four items. The ORS, given at the start of each session, asks clients to rate their progress on goals related to how they are faring in four life domains: personal, interpersonal, social and overall. The SRS, given at the end, asks how clients are feeling about the therapy relationship. These instruments are intended to be transparent, allowing the client and provider to view the answers together and clients to choose their own goals and strategies with support and guidance from the therapist.

The OQ-45 and PCOMS measures have been well-researched for their effectiveness. They claim a total of 20 randomized controlled trials among them, as well as a place on the Substance Abuse and Mental Health Administration’s National Registry of Evidence-Based Programs and Practices. There are many other good measures to use as well, including well-validated measures like the PHQ-9 for depression, the GAD-7 for generalized anxiety disorder and the PLC for post-traumatic stress. Bolander, for example, initially gives the PHQ-9 to all of Mid-Atlantic’s incoming patients, and then re-administers it at least once every 60 days in addition to symptom-specific measures such as the GAD-7.

Meanwhile, APA has formally released a clinical data registry that offers access to 30 free measures that practitioners can use to capture outcomes (see box).

Really, any tool that fosters insight on a particular client’s condition at a given time is relevant, says Seattle-based practitioner Tony Rousmaniere, PsyD, who trains people in this work and uses such measures in his own practice.

“Ideally, I would have a range of different measures that I use along with my clinical judgment and the client’s self-report,” he says, “to gain a very holistic view of how treatment will proceed.”

What is their added value?

If a practitioner is thinking of exploring the use of outcome measurement, why should they do it?

One main reason, says Rousmaniere, is to help you learn about and address your blind spots. That’s important because research shows therapists tend to think they’re doing a lot better than they are, he says.

“While we’re good at many things, therapists typically have a blind spot in terms of identifying clients at risk for deterioration,” he says. A simple reason may be optimism—therapists want their clients to get better, so they’re more likely to want to believe a client’s positive report than to dig deeper if there’s a subtle red flag, he says.

Another big plus is client empowerment, says PCOMS’ co-creator Duncan. In the case of the PCOMS measures, having clients name their own goals means they take center stage in their own change process, he says. He describes a former client, a woman who reluctantly entered therapy when her children were taken away because of the woman’s drug addiction. When she first answered the ORS, she noted that her initial goal was interpersonal—reuniting with her kids. As she and Duncan worked together, they collaboratively decided she would take certain steps to get there. Over time her ORS scores went up, and a year later, she got her kids back.

“What she really liked about the work was that I always cared about what she thought, about how she thought things were going, about whether things were getting better or not and what we could do specifically to address those things,” Duncan says.

Pay for performance

Outcome measurement is also smart for insurance purposes—not to mention increasingly necessary, says Hepner, who notes that regulatory bodies are moving toward this kind of requirement. For instance, the Joint Commission—the independent accrediting organization for some 21,000 U.S. health care organizations and programs—recently began requiring accredited entities to incorporate at least one standardized outcome measure into their practices. And starting in 2019, Medicare will tie pay to performance for psychologists who take part in its Merit-based Payment System, or MIPS, and good performance includes the use of outcome measures, adds C. Vaile Wright, PhD, director of research and special projects in the APA Practice Directorate. Since private insurers tend to follow Medicare’s lead, she adds, it’s likely this trend will
MORE THAN JUST THE 50-MINUTE SESSION

Traditional forms of therapy are being challenged by developments in technology, health care, consumer desires and payer reimbursement. Here’s how to tap these trends while maintaining your clinical integrity.

By Tori DeAngelis

The 50-minute session (or more recently, the 45-minute session) has been a convenient, stable and functional way to organize one’s practice—not to mention the model many psychologists have been trained in. For a host of reasons, however, it’s becoming increasingly important to think more broadly about how to structure the parameters of your practice. Shifting trends in health care, an escalating technology boom, the movement toward integrated care and an increasingly consumer-driven market—all point to a growing need to think more creatively about parlaying your services, market and policy, analysts say. “There are all kinds of new developments beyond the traditional 50-minute hour that are changing the way psychologists are delivering psychological services,” says Lonnie Snowden, PhD, professor of health policy and management at the University of California, Berkeley. Examples include the growth in technologies designed to enhance treatment and access, short-term treatments adapted to medical settings and a greater need to provide translation services for clients with limited English proficiency, to name just a few. “All of these things are good because they expand the reach of psychological therapies and services in ways that are more usable and reach larger populations of people,” Snowden says. The catch? “Reimbursement becomes much more complicated.”

How can you incorporate new tools and ideas into your practice in ways that maintain your vision for therapy and keep you flush financially? While the answers are not always clear, here’s a look at some key areas of change and how you can expand your practice to meet them.

Tapping health care trends

Probably the biggest shift in the way some psychological care is being delivered is taking place in the larger health care system. A growing number of psychologists are working as team members in integrated care settings, or consulting with and providing services to community-based health care practices, known as co-location. Psychologists working on integrated care teams typically provide 15- to 30-minute treatment sessions delivered in the same milieu as other office-based medical services. Sessions often focus on how psychological factors influence physical conditions, as well as on preventive services—how to keep depression from escalating or a person’s high blood glucose from flowering into diabetes.

Psychologists who work in these settings are delivering care in non-traditional ways, says Vanessa Casillas, PsyD, director of psychology at Providence Health & Services in Portland, Oregon, part of a network of Providence-St. Joseph’s health care practices in several states. That said, these psychologists operate in a complementary fashion to longer-term care, not as the sole way of providing psychological services. “Our intention is not to be everything to everyone. We do a lot of bridging to get people connected to a more appropriate level of care when needed.”

– Vanessa Casillas, PsyD

52% delivered no online services
37.5% delivered 1-9% of their services online
everyone,” she says. “We do a lot of bridging to get people connected to a more appropriate level of care when needed.”

Psychologists are also entering the health care system through co-located practices at community-based health care organizations, where they provide an array of services at the site itself but are responsible for all aspects of their own reimbursement (some insurers allow extra payment for psychologists who bill from the address of the health care practice). An innovator in this area is Kevin D. Arnold, PhD, director of the Center for Cognitive and Behavioral Therapy in Columbus, Ohio, who has forged relationships with five such primary care offices in the Columbus area. His team provides non-traditional services like helping those practices build electronic referral systems for patients with mental health conditions; bringing therapy services to the site itself; and integrating with the office’s electronic health records to the extent allowed by law. Team members also consult with physicians on site or by phone, and offer low-cost, on-site psychoeducational trainings on topics like how parents can more effectively raise a child who has attention deficit hyperactivity disorder or oppositional defiant disorder, for example.

Both integrated and co-located care offer opportunities for independent practitioners interested in tapping into the health care arena, say experts. They recommend the following actions:

- **Think about co-locating.** If you like the idea of working part time with a health care system, consider co-location, says Arnold. Prepare a detailed plan that demonstrates how your practice could meet the setting’s behavioral health needs, then meet with the setting’s primary care physicians and lead administrative staff to structure an initial integration phase. Learn about the rhythms and processes of their office so you can best adapt your independent practice systems to theirs, he says.

- **Once you have established a relationship and a process for physicians to refer patients to your practice,** be prepared to provide feedback on how that process is going and to share your initial intake notes so physicians will better understand the kinds of services you’re providing, says Arnold. And when physicians see the tangible benefits of co-location, be ready to bring in additional providers, adds Arnold.

- **Build referral relationships with integrated care colleagues.** When a patient is referred by a psychologist working in integrated care to a provider in the community, care coordination is key, says Casillas. Some of these patients are entering traditional therapy for the first time, so it’s important they be comfortable with the transition, since the language and modalities of the two settings are different. To this end, get to know psychologists in medical settings who might refer to you, and when they do, make sure to coordinate care, she advises.

**Tapping technology trends**

Technology, too, is transforming the way that care is being structured and delivered. It’s an important area to learn about, because it’s how younger generations tend to communicate, says Dennis Morrison, PhD, an independent consultant in Bloomington, Indiana, who specializes in clinical information technology. “Clients are doing a lot of things online and with their smartphones,” he says, “and they’ll ultimately have more data about themselves than the clinician will.” Depending on the technology employed, psychologists may be fully or partly engaged in providing services—or the technology may do most of the work.

The most well-developed of these technologies is telepsychology, or therapy delivered via videoconferencing. While it has proven effective in reaching many populations in need—people in rural areas, older adults and people with disabilities, for example—it remains an underused medium. In a recent survey of 164 professional psychologists by Robert L. Glueckauf, PhD, of Florida State University, and colleagues, 52 percent said they delivered no online services at all and 37.5 percent delivered between 1 percent and 9 percent of their services online (Professional Psychology: Research and Practice, Vol. 49, No. 3).

Another emerging therapy technology is immersive 3-D...
technology, otherwise known as virtual reality (VR). It’s been successfully tested and is being used for conditions such as social anxiety and post-traumatic stress disorder, but remains relatively untapped due to its high expense. Despite that, psychologists are making forays into applying this life-like medium in creative ways. Arnold, for example, is acquiring a VR platform that uses a 3-D avatar to help people develop stress management and coping skills.

Even less studied are the burgeoning numbers of smartphone applications and online programs aimed at assessing or addressing people’s mental health conditions. According to estimates, some 10,000 mental health apps are available for download, but the area is basically unregulated, and the quality of these offerings is extremely mixed, Morrison says. He recommends vetting any products clients are thinking of using to make sure they meet clinical standards.

**Actions to consider:**

- **Get training.** Depending on the modalities you want to incorporate, make sure you get enough education to choose good products and use them properly. If you’re interested in providing remote therapy services, for example, the Telebehavioral Health Institute offers proficiency courses and certificates.

- **Own the technology.** Consider buying technology or technology services to enhance your service delivery. If you’re interested in conducting teletherapy, for example, you can purchase a monthly online service or invest in telemedicine software or hardware. Likewise, consider investing in a behavioral electronic health record (EHR), which can make patient records accessible from anywhere, facilitate at least some integration with other providers depending on HIPAA compliance and help make your office more efficient.

- **Be a tech guide.** Read up on what the current research says about use of certain technological modalities (including apps) with particular patient populations or mental health conditions. If a client wants to use an app as a supplement to treatment, offer to serve as a consultant to help him or her make the best therapeutic use of it, perhaps charging a minimum out-of-pocket fee to do this, Morrison suggests.

**Tapping consumer trends**

Intertwined with the changing health care system and the increased use of technology are growing consumer rights and desires. In the health care system, this trend is embodied in the term person-centered care, which strives to make patients a central part of their own treatment.

Taking consumer needs into account translates into better business, says Morrison. “By and large, mental health providers don’t understand that the person they’re seeing is both a patient and a customer, and that these people have far more experience in judging customer service than they do clinical quality,” he says.

**Actions to consider:**

- **Arrange your office in consumer-friendly ways.** There are many ways to do this, including hiring friendly and efficient front-office staff, investing in a high-quality referral and billing system and using it properly, and creating a pleasant-looking office environment. In addition, let clients know you are open to communicating with them by email or text, working with them to use an app, or scheduling briefer sessions when necessary, for example. Be mindful, however, that the use of certain technologies like email or text may be governed by patient privacy and security policies and telehealth reimbursement laws.

- **Make the first session count.** Data show that for most clinic-based providers, roughly half of all potential clients drop out after the first session, at least partly because that session is often consumed with bureaucratic intake questions. Assume that the first session is about the client trying to decide whether what you have to offer is what they need. Think about restructuring the initial session so at least part of it is about connecting personally with the client and addressing why he or she is there.

**Tapping reimbursement trends**

While it’s exciting (or terrifying) to consider new ways of delivering care, it’s important to think realistically about how to get paid for these services. It’s not always clear or easy: For one thing, insurers themselves are still navigating this brave new world—not just in mental and behavioral health, but in health care in general, says UC Berkeley’s Snowden. Telehealth is a good
example: Medicaid, state lawmakers and private insurers are still working out what should be covered and by how much. Currently, 48 states and the District of Columbia provide Medicaid reimbursement for some form of live video telehealth. Still fewer states allow Medicaid reimbursement for pre-taped “store-and-forward” services. Meanwhile, 35 jurisdictions have laws governing private-payer telehealth reimbursement policies, but not all mandate reimbursement and only a few require equal reimbursement to in-person therapy, according to the Center for Connected Health Policy.

Actions to consider:

• **Know your codes.** On the most basic level, get to know what’s allowable under Current Procedural Terminology (CPT) codes, advises neuropsychologist Neil Pliskin, PhD, of the University of Illinois at Chicago, who represents APA at the American Medical Association meetings related to these codes. The code structure changed in 2013, so that what was formerly framed as a 50-minute session is now a 45-minute session, with separate codes for 30-minute and extended 60-minute psychotherapy sessions. If you provide services that go beyond traditional therapy services, learn what codes are available to you, Pliskin advises.

• **Document.** Keep a record of what you’re doing, Pliskin adds. According to the U.S. Office of Inspector General’s Office of Audit Services, sufficient documentation means providing enough information to make explicit the type of treatment you are providing, the progress you have made to date and your treatment plan for the future.

“Most of the time when psychologists fail audits, it’s because of inadequate documentation,” says Pliskin. “It absolutely has to reflect the work that’s being done.”

In a related vein, think about writing your therapy notes during the session, not after—a process that can be facilitated if you have an EHR, says Morrison. You can use this process to build the therapeutic relationship by involving the client in the documentation process, he says.

• **Advocate.** Extra services with no CPT codes—for example text messaging, emailing or other forms of technology use that go above and beyond the therapy session—require a longer-range strategy. Experts recommend joining forces with other relevant organizations—like your state psychological association, for example—to discuss areas that need reimbursement and how to present them to insurers, and then to advocate for those changes.

• **Create an umbrella plan.** Finally, give serious thought to the kinds of services you want to provide—including types and lengths of sessions—so you can market your practice as a cohesive whole, Snowden recommends.

“The real challenge is figuring out what you really want to do, what you think works and what makes sense,” he says, “and then to build enough flexibility into your system to do that while getting paid. A 50-minute-hour kind of billing,” he adds, “isn’t going to accommodate that all of the time.”

What was formerly framed as a 50-minute session is now a 45-minute session, with separate codes for 30-minute and extended 60-minute psychotherapy sessions.
THE “ENHANCED EPPP”: CONTEXT AND CONCERNS

Reversing an earlier decision, ASPPB will no longer require licensing boards to begin assessing practice skills with the EPPP Part 2 in January 2020. What does this mean for the future of the exam?

By Hannah Calkins

In October 2017, the Association of State and Provincial Psychology Boards (ASPPB) announced that it would make the Examination for Professional Practice in Psychology (EPPP) a two-part licensure exam called the “Enhanced EPPP” that would test both the knowledge and the skills of aspiring licensees.

At that time, it was decided that the traditional, knowledge-based EPPP would become the “EPPP Part 1,” and candidates for licensure could take it after they had completed their academic requirements. Later, after passing Part 1 and finishing their supervised training, candidates would be required to take the “EPPP Part 2,” a new component of the exam designed to measure their clinical skills. Each component would cost test-takers $600, or $1200 total—double the current cost of the exam. ASPPB was requiring that states begin administering the Enhanced EPPP in January 2020 (after initially setting a deadline of January 2019).

However, in August 2018, in response to concerns raised by its member jurisdictions, ASPPB announced that its board of directors had rescinded its decision to require licensing boards to administer the Enhanced EPPP, and that it was lifting the January 2020 deadline for implementation. Instead, Part 2 will be made available at that time to states and provinces interested in serving as “early adopters,” according to an Aug. 17, 2018, memo sent to ASPPB’s member jurisdictions.

Students and psychologists should note that this is a delay, not a cancelation, of the requirement. ASPPB’s goal is still to eventually require licensing boards to administer the Enhanced EPPP, but it is “giving its members a longer horizon to experiment” for now, said Stephen T. DeMers, EdD, former chief executive officer of ASPPB. (DeMers retired in August.)

DeMers said that the board’s decision came after they surveyed their members to ascertain their level of commitment to assessing professional skills as part of entry to practice, and using the EPPP Part 2 to do it. The results of that survey were mixed: a number of jurisdictions were strongly in favor, several voiced qualified support, and others were vehemently opposed to it. Only about half of their member jurisdictions responded, DeMers said.

According to the survey, licensing boards’ primary concerns about the Enhanced EPPP had to do with meeting the January 2020 deadline and with the “early admittance” option for students to take Part 1 after completing their academic coursework, a proposal popular with students and early career psychologists. A number of jurisdictions were also concerned about being unable to review Part 2 or obtain data about it before implementation, as it’s still under development.

While these concerns raised by their member jurisdictions’ are what ultimately prompted the ASPPB board to rescind its earlier decision, they differ somewhat from those raised by other stakeholders. Groups such as American Psychological Association of Graduate Students (APAGS), the Committee on Early Career Psychologists (CECP), and the Council of University Directors of Clinical Psychology (CUDCP) have, in various forums, questioned the validity, timing and cost of the enhanced exam.

Jennifer Callahan, PhD, ABPP, is the director of clinical training for clinical psychology at the University of North Texas. She serves on CUDCP’s board of directors, and is their liaison to ASPPB.

“DeMers said that the board’s decision came after they surveyed their members to ascertain their level of commitment to assessing professional skills as part of entry to practice, and using the EPPP Part 2 to do it. The results of that survey were mixed: a number of jurisdictions were strongly in favor, several voiced qualified support, and others were vehemently opposed to it. Only about half of their member jurisdictions responded, DeMers said.

According to the survey, licensing boards’ primary concerns about the Enhanced EPPP had to do with meeting the January 2020 deadline and with the “early admittance” option for students to take Part 1 after completing their academic coursework, a proposal popular with students and early career psychologists. A number of jurisdictions were also concerned about being unable to review Part 2 or obtain data about it before implementation, as it’s still under development.

While these concerns raised by their member jurisdictions’ are what ultimately prompted the ASPPB board to rescind its earlier decision, they differ somewhat from those raised by other stakeholders. Groups such as American Psychological Association of Graduate Students (APAGS), the Committee on Early Career Psychologists (CECP), and the Council of University Directors of Clinical Psychology (CUDCP) have, in various forums, questioned the validity, timing and cost of the enhanced exam.

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In that role, she has expressed significant concerns about the enhanced exam to ASPPB, including that many of her colleagues don’t understand why ASPPB has not consulted with them regarding its development.
The announcement that licensing boards will, temporarily, be able to decide whether to administer Part 2 does not alleviate their concerns. “As a nationwide training council with member institutions that span across all licensure jurisdictions, CUDCP remains concerned that the measure development process has not been optimal and the planned roll-out for implementation is premature,” Callahan said.

Others are more optimistic in light of the announcement. Ian Gutierrez, PhD, a recent graduate in clinical psychology at the University of Connecticut and past-chair of the American Psychological Association of Graduate Students (APAGS), said he was “pleasantly surprised” by ASPPB’s decision to make Part 2 optional for licensing jurisdictions.

“This decision reflects an increased commitment on ASPPB’s part to work in partnership with its constituent state boards, future examinees and other interested parties to implement this exam in a way that best meets the needs of the profession and the public alike,” he said.

ASPPB’s memo to member jurisdictions reflects this sentiment—and also reaffirms their commitment to competency assessment.

“We are in a culture of competency… We know that your jurisdictions have processes in place to assess competency and we are confident that unqualified people are not being awarded unearned credentials,” the memo reads. “Our goal is to provide the best possible resource to evaluate your candidates.”

Adopting a “Culture of Competency”

In development since 2010, the Enhanced EPPP is meant to provide a standardized method for assessing the skills needed for practice, and to bring psychology in closer step with its peer professions as psychologists work to assert their rightful place in health care, according to DeMers.

DeMers also says that this is the “most significant change in the psychology licensure examination program since licensure laws were first passed starting in 1945”—so it’s understandable that such a momentous change would be accompanied by a few bumps in the road.

For more than half a century, state licensing boards have relied on the EPPP to measure a candidate’s knowledge. These scores, in conjunction with a review of the candidate’s supervised training experience, have provided a holistic picture of the candidate’s fitness for licensure. But training requirements vary from state to state, training experiences vary from student to student, and their supervisors’ ratings may be too subjective to be consistently reliable, according to data shared by ASPPB on their website (asppb.net).

And, significantly, other health professions use exams to assess the competency of their licensees.

In 2010, in response to growing pressure from some psychologists, health care regulators and policymakers, ASPPB began exploring the best approaches to “obtain a standardized, objective and efficient assessment of basic professional skills that that captured the competent practice of psychology,” DeMers said.

This work continued through 2016, when they conducted a Job Task Analysis—a focused survey of practicing psychologists—to determine the critical skills psychologists needed for minimal competence to practice. The results of the survey were analyzed by an ASPPB advisory committee and its test vendor, Pearson Vue. They form the “blueprint” for EPPP Part 2.

Like Part 1, Part 2 will be a computer-based exam, which DeMers said is cost-effective and more objective than current methods for assessing competence. But while Part 1 is limited to multiple choice questions, Part 2 will utilize a variety of test item formats. Some of them are traditional, such as multiple choice, sequencing, fill-in-the-blank, and short answer questions. But other formats are innovative, and will make use of graphics, audio and video, and—interestingly—avatars that represent clients, supervisors or colleagues and prompt the test-taker to respond to a clinical scenario or interaction.

Test items are currently being written by a team of about 80 volunteers selected by ASPPB representing a cross-section of practice specialties and other demographics. More than half of them are early career psychologists, DeMers noted. 150 of the items they write will go on to beta-testing.
APA continues to develop more guidelines for treating certain conditions. In this article, psychologists give their take on how they will impact practice.

By Tori DeAngelis

In 2010, APA began a long-term process to create clinical practice guidelines for the field. Its first product was a guideline on post-traumatic stress disorder (PTSD), released in February 2017. A second guideline, on obesity in children and adolescents, was approved by APA’s Council of Representatives in March 2018, while a third guideline, on depression across all age groups, is anticipated to be finished later this year. Meanwhile, plans are under way for two more guidelines, with more to follow.

Clinical practice guidelines are one tool to facilitate decision making in the context of evidence-based practice for which APA has a policy. Evidence-based practice is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.

Creating such guidelines is essential if psychologists are to be integral players in the health care system, says Jared Skillings, PhD, APA’s new Chief of Professional Practice who previously served as chief of psychology for the Spectrum Health System in Grand Rapids, Michigan, and is a former president of the Michigan Psychological Association.

While psychology has plenty of good evidence to substantiate its treatments, “that evidence hasn’t been considered because we haven’t been at the right tables with the right science,” says Skillings, who is also former chair of the APA Board of Professional Affairs. As a consequence, health care leaders, government executives and others have used guidelines from other disciplines—notably psychiatry and even nursing—as their main source of guidance on treating mental health conditions.

“Creating our own guidelines tells these important players that psychologists matter, that our work is as good as that of medicine,” Skillings explains. “It’s a tool that allows us to explain what we do, why it works, and what the best first-line treatment options are.”

How they’ll be used

As the guidelines are released, they will have multiple uses, for providers, researchers, health care executives, policymakers, and the public.

For providers, their impact is probably most apparent for those working in structured health care environments. In essence, health care systems and leaders will use them in the same way that other clinical guidelines are used: as one part of a system’s large-scale electronic health record to help practitioners make decisions about the treatments for a given patient, Skillings explains.

Meanwhile, independent practitioners can use the guidelines to keep in touch with the latest research, both for use in practice and as a guide for continuing education choices, says Bethany Teachman, PhD, a University of Virginia professor of psychology who chairs the advisory steering committee for all of APA’s clinical practice guidelines.

“Guidelines give providers a reliable shortcut to learn about the best efficacy research evidence on a given condition,” she says.

For any provider, keeping abreast of the guidelines is also important for legal and reimbursement reasons, notes Jana N. Martin, PhD, chief executive officer of The Trust, which offers insurance, financial security, and risk management programs for psychologists and related individuals. Showing that you’re aware of the latest clinical research in your field can help waylay potential arguments that you’re not practicing in your area of competence, she says (see sidebar, page 26).

For patients and families, the guidelines can...
help them to make informed choices.

While the guidelines promise to help clinicians make good practice decisions, they are not intended to usurp one’s clinical judgment nor patient factors and preferences, Teachman underscores.

“The guidelines recognize that making good treatment decisions is not based on one criterion alone, but that using our best research is a key part of making these decisions,” she says. (To address more contextual aspects of treatment, visit the APA professional practice guidelines, which provide guidance on 19 general areas of practice such as working with transgender and gender-nonconforming people and effectively using telepsychology).

Because APA’s guidelines are just emerging, it will take a year or more for systems to incorporate them into their electronic infrastructures, says Skillings. This lag in implementation is one reason that APA is moving quickly on the issue, he notes.

**Spreading the word**

Because guidelines will play such a key role in bringing psychology to the health care table, APA is working through a number of channels to disseminate them, guidelines experts note. Some of those efforts include:

- A developing website about the clinical practice guideline development process in general, at [www.apa.org/about/offices/directorates/guidelines/clinical-practice.aspx](http://www.apa.org/about/offices/directorates/guidelines/clinical-practice.aspx). Included are meeting agendas and summaries from all related face-to-face meetings.
- A web site that provides extensive, user-friendly information about the PTSD guideline and its evidence base, as well as resources for providers, patients and families (see [www.apa.org/ptsd-guideline/index.aspx](http://www.apa.org/ptsd-guideline/index.aspx)). A similar website will be developed for each of the subsequent clinical practice guidelines.
- Articles in APA’s newsletters and magazines.
- Explanatory talks and discussions at conferences and meetings such as the Practice Leadership Conference and the APA Annual Convention.

In terms of wider outreach, the APA guidelines team is working with dissemination and implementation expert Jonathan Purtle, DrPH, of Drexel University, to design studies that evaluate the impact of the guidelines. Possible topics include assessing psychologists and other health service providers’ awareness of, attitudes toward, and use of the guidelines, as well as agency directors’ perceptions of them, Teachman says.

In a related effort, University of Virginia graduate student Alexandra Werntz is examining how messages on the APA PTSD web site influence people’s interest in learning how to access PTSD treatment. Initial results from studying the site’s “Patients and Families” page, for instance, suggests that visitors are especially likely to click on provider links if a headline emphasizes how treatment can reduce symptoms. Such findings may be used to optimize the design of the website and to guide future work on explaining the value of evidence-based treatments to the public, Teachman says.

**An evolving process**

Finally, the APA clinical practice guideline development process is still young. As the APA team continues this work, its members are learning more about how to improve the process,

Teachman notes.

“We are committed to ensuring that our guidelines focus sufficiently on the importance of clinical judgment and patients’ values,” she says. “We are also considering how to address potentially beneficial treatments that have not yet been well studied, for example.”

To this end, anyone interested in sharing thoughts, relevant research, or other input on the guidelines is encouraged to email the team at cpg@apa.org. In addition, all draft guidelines undergo a 60-day comment period, and the advisory committee strives to get the word out electronically to all APA members, boards, committees, divisions, and the Council of Representatives, as well as state, provincial and territorial psychological associations, the ethnic minority psychological associations, other professional associations, subject matter experts, and more. Members of each guideline panel—the entities responsible for reviewing the literature and making recommendations—review the comments and revise draft documents accordingly.

For even greater involvement in the process, consider applying to join either the guidelines’ advisory steering committee, or a panel on a particular guideline topic. In both cases, calls for nominations are distributed via listserv and online newsletters whenever there are openings, says Teachman. “A key priority is ensuring that a diversity of perspectives is included,” she says.

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With data breaches occurring more frequently both nationally and internationally, there has been a growing trend toward more stringent protections of personal data. As a result, the European Union (EU) updated its data protection laws with the General Data Protection Regulation (GDPR) which took effect on May 25, 2018, to harmonize data privacy protections across the EU. This regulation has implications for U.S. organizations, including practicing psychologists who treat patients from any of the EU member nations temporarily residing in the U.S.

This EU regulation may have an impact on psychologists’ patient privacy data practices. If you are a consultant or provider who works with any patients from the EU (or have contacts with companies in the EU), you should familiarize yourself with this law. Psychologists who treat EU citizens who are temporarily residing in the U.S. should also read up on the GDPR (See Sidebar).

Here in the U.S. health care providers must be familiar with the Health Insurance Portability and Accountability Act (HIPAA) and its patient privacy protections as well as any relevant state privacy laws. However, two states are at the forefront in broadening privacy protections and control for patients beyond what HIPAA already requires: Colorado and California.

Colorado
On May 29, 2018, Colorado enacted legislation that will require covered entities, including health care facilities and private practices, to:
• Implement and maintain reasonable security procedures;
• Dispose of documents containing confidential information properly;
• Ensure that confidential information is protected when transferred to third parties; and
• Notify affected individuals of data breaches in the shortest time frame in the country (within 30 days).

The law took effect Sept. 1, 2018. The Colorado law is similar to the GDPR because it uses the term personal identifying information (PII) which is broader than how HIPAA defines “protected health information” (PHI). PII includes social security numbers; personal identification numbers, passwords, pass codes; driver’s license or ID card numbers; passport number; biometric data (i.e. fingerprints, DNA); and employer, student or military ID information.

Psychologists who maintain electronic or paper files that contain PII (which includes PHI) will need to develop a written policy that details how that information will be destroyed once it is no longer needed. A Colorado psychologist who transfers personal identifying information to a “third-party service provider” will need to ensure additional security protections for the information being transferred.

A Colorado psychologist who transfers personal identifying information to a “third-party service provider” will need to ensure additional security protections for the information being transferred.
protections for the transferred information or require the third-party service provider to implement reasonable security procedures to help protect the PII from unauthorized access, use, modification, disclosure or destruction.

The new law also changes Colorado’s data breach notification law by shortening the amount of time providers must notify individuals of a data breach to 30 days and by expanding the types of information that will trigger a breach notification. Personal information that may trigger a breach notification obligation includes a Colorado resident's first name or first initial and last name in combination with any of the following data elements:
- Social Security number;
- Student, military or passport ID number;
- Driver’s license or ID card number;
- Medical information;
- Health insurance identification number; or
- Biometric data.

Similar to HIPAA, notice of a breach will not be necessary if the information was encrypted, unless the encryption key was also compromised.

As is already required by HIPAA, covered entities in Colorado are required to implement and maintain reasonable security procedures and practices that are “appropriate to the nature” of the identifying information and the size of the business (or health care practice). At this time, there has been no further guidance as to whether Colorado may require more stringent “reasonable security procedure/practices” than what HIPAA already requires.

California

California already has strong health care data protection laws in place. Current state law requires that all licensed health care professionals post a privacy policy detailing what personal information may be collected as well as giving consumers a way to “opt-out” of sharing personal information for direct marketing purposes. Any professionals who maintain a website that may collect personal information must also “conspicuously” post the privacy policy on the website.

On June 28, 2018, the California Consumer Privacy Act of 2018 was passed, and the new legislation will more broadly define personal information (similar to Colorado and GDPR) and will require disclosure of personal information that is collected or shared for any reason.

The Consumer Privacy Act, which will go into effect on January 1, 2020, is unlikely to affect many California psychologists as it will only apply to businesses that have annual gross revenues over $25 million and excludes protected health information of a “covered entity” under HIPAA, or medical information governed by the California Confidentiality of Medical Information Act (CMIA). However, this measure may be an initial step toward broader trend of stricter personal data protections. So, it is essential that practicing psychologists stay abreast of these changes. The Consumer Privacy Act

THE GDPR

The General Data Protection Regulation (GDPR) establishes protections for the privacy and security of personal data related to individuals in the European Union and potentially has implications for the clinical activities of health care providers in the United States. In the U.S., providers are very aware of HIPAA and the protections that it affords patient data.

But the GDPR has a broader definition of personal data than HIPAA and covers any information associated with an “identified or identifiable” person. It includes computer IP addresses, photos, credit card data and more. While HIPAA focuses on the health care data and what can be done with it, the GDPR is concerned with the individual’s personal rights and the opportunity to control his or her personal data.

GDPR requires companies to gain the affirmative consent of any individual who resides in the EU for which data may have been collected. The law also requires that organizations process data requests from EU patients much more quickly than with U.S. standards. And U.S. providers will also need clear permission from the individual to even use EU resident information.

Generally, GDPR may affect only a small subset of psychologists—those who provide services to individuals who are EU residents, to companies that are based in the EU or those who work closely with companies that may obtain EU resident personal data. Most psychologists are not going to need to meet GDPR. However, it is necessary to examine your practice to ensure that you are not potentially triggering the law. For example, are you a psychologist working with foreign exchange students? Working with an Employee Assistance Program here in the U.S. but the employee you are counseling is an EU resident?

Additionally, psychologists who maintain a website may trigger GDPR. Having a website for your practice that could be viewed or accessed by an EU resident may not subject you to GDPR. However, if you are actively advertising or offering your services overseas to EU residents (e.g., telehealth), you will want to take steps to be in compliance with GDPR.

If you believe you or the organization, employer or hospital that you work with may trigger GDPR, it is recommended that you apply for Privacy Shield Certification to protect any data exchanges. This certification was developed to provide companies in the U.S. and the European Union a way to comply with the data protection requirements of GDPR when transferring data from the EU to the U.S. and will give providers a safe harbor.

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CONSIDERATIONS WHEN USING MENTAL HEALTH APPS

Our top five tips for finding effective cell phone apps to use with your patients

By Stacey Larson, JD, PsyD

Smartphones have become a fixture in our society. It’s not unusual to see someone using his or her cell phone for multiple tasks throughout the day for something as simple as communication to more complicated work or financial matters. As smartphones become ubiquitous, more and more mobile applications (“apps”) are being developed daily. There are numerous smartphone apps that venture into the mental health arena. These apps can offer resources which make therapeutic techniques accessible, portable and cost-effective for consumers. However, there are so many different apps in multiple formats, operating systems (Apple, Google, etc.) and designs that it can be overwhelming for psychologists who want to utilize this technology in practice. There are several things that should be considered when looking at mental health apps to use in conjunction with your practice.

Efficacy

Research does exist about the use of mobile apps in conjunction with therapy, however, the information is generally limited about how the apps are developed. Additionally, few apps have been evaluated to determine if they have a positive effect on the condition for which they are supposedly developed. Because it is possible for anyone to develop an app, with or without specialized expertise in mental health, it’s not unusual to find an app that is not based on any research or evidence-based practices. Therefore, it’s important for psychologists to be knowledgeable about different apps they may recommend.

TIP: Look for apps that include input from mental health practitioners. If it isn’t clear from the description on the app store, reach out to the developer with your questions. You may want to ask them if they’ve done any research or if the app has gone through clinical trials to demonstrate clinical effectiveness. It may also be helpful to look for apps that were developed by a governmental body. For instance, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Veterans Affairs have been developing well-researched apps for mental health issues such as depression and PTSD.

The reviews of apps may be useful for information on ease of use and functionality but it is best not to rely on them for research or efficacy of the app. There are apps out there that are not good resources for consumers so it’s important to dig a little deeper. You should try the app yourself and make sure that you agree with the information presented and if not, that you are able to explain why the information may not be useful to your client.

Availability

There can also be an issue with availability of apps. As quickly as apps can be developed and uploaded to the app store, they can be removed. It is not unusual for apps to disappear from an app store after just a few months.

TIP: In light of this, look for apps that have shown longevity,
or have been available through the app store for longer periods of time. There is less chance of a well-established app disappearing suddenly from the marketplace and it is more likely that a well-established app will also have some research to back it up—to address the efficacy issue discussed above.

App updates
If you use a computer or any other digital device, you’re probably familiar with seemingly frequent system updates to most of the programs you use. Just like Windows may release an update or your smartphone may download an update, apps can be updated and changed as well. This may pose a problem for providers who use mental health apps if the update is significantly different from the original product. The change could be as simple as a new look or as complex as a complete overhaul of the app.

**TIP:** If you use apps in your practice, it’s important that you stay on top of any updates and be prepared to assist your clients in learning how the new app may work. Alternatively, you must be willing to stop using an app if it is no longer useful for your practice.

Operating systems
There are multiple online “stores” through which apps can be downloaded—Apple, Google, Windows. Some apps may be developed on several different platforms, whereas others may only be available for use on one platform. Given that it is possible you may have a different type of phone than your clients, you will want to research any apps that you are considering using in your practice to determine if there are multiple versions available. Another concern is whether the apps look and function similarly across the different platforms. And sometimes apps are developed based on a certain version of an operating system. The app may not work on your or your client’s device anymore if the operating system is changed or updated.

People are using apps in multiple ways, and this presents exciting new opportunities for psychologists to connect with patients. Mental health apps can supplement the therapeutic relationship as well as provide additional support to patients in between sessions or during times when the psychologist may be unavailable. At the same time, technology advances also require that providers be educated and aware of the rewards and potential problems with using apps.

**TIP:** Try out several apps yourself. You should familiarize yourself with any apps that you may want to recommend to patients. If possible, try to utilize your favorite apps on different operating systems to familiarize yourself with each and to compare them for any significant differences. If your favorite is not available on all operating systems, be prepared to recommend alternatives.

- In addition to the issues mentioned above, it’s always a good idea to remember the other standards that should be considered when using any technology in your practice.
- **HIPAA Compliance:** Consider and suggest the use of apps that are compliant with the Health Insurance Portability and Accountability Act.
- Determine the appropriateness of using apps with patients on a case-by-case basis.
- **Consult with colleagues** who have used mobile apps in practice. Find out what apps they recommend or avoid.
- **Take advantage of free resources:** The IMS Institute for Health Care Informatics, Pew Research Center, SAMHSA and the Veteran’s Administration are all good resources that maintain information on apps as well as do research on them.
PSYCHOLOGISTS ADAPTING TO A CHANGING MARKETPLACE

How two psychologists, trained as clinicians, are adapting their practices to a changing marketplace.

By Nicole Owings-Fonner, MA

Derek Phillips, PsyD, Psychologist
Sarah Bush Lincoln Health Center

After completing both his internship and post-doctoral fellowship in neuropsychology at Psychological and Neurobehavioral Services of the Centerstone Consortium in Lakeland, Florida, Derek Phillips, PsyD, decided it was time to return to his roots in rural Illinois. The first step would be to find a job where he can use his education and training. Sarah Bush Lincoln Health Center (SBLHC), a 145-bed regional hospital system with 2,500 employees, seemed like a logical choice. Phillips knew a health system would be a good fit for him due to his strong appreciation for the hospital environment. He believes that the integrated care structure and team of professionals with varying perspectives strongly enhance the care that patients receive. Phillips reviewed the services offered at SBLHC and identified potential gaps in the mental health services. Despite having a psychiatry and counseling department with both inpatient and outpatient services, there were no psychologists on staff. Seeing a potential opportunity, he emailed the medical staff recruiter and explained what he could do for them. Over the next 18 months, a position was created specifically for him housed within the neurology department.

Phillips now spends his days conducting neuropsychological testing to identify cognitive deficits for a variety of patients mainly through outpatient services. Almost 100 percent of his time is spent on direct patient care. He’s finding fulfillment being able to close a gap in services. Previously when individuals were referred for assessment, they would have to travel long distances, with many patients choosing not to go because of lengthy travel times or potential time away from work. Unfortunately, a different service gap still exists due to a lack of mental health providers. After conducting his assessments, he frequently refers patients for therapy or to a psychiatrist for medication, but it can be six months or more before they are able to get an appointment.

“It’s a really good time to be in psychology despite the changes driven by insurance and reimbursement,” says Phillips. He sees psychologists as an integral part of care teams and believes that while psychology’s future is increasingly moving toward the integrated health care model, there is also still a place for private practitioners. One step he hopes the profession takes is to come together and present a united front so that psychologists are at the table when new health care policy is being created.

Phillips advises new psychologists to collaborate with colleagues and explore nontraditional roles. “Reach out to mentors and friends when you are looking at contracts or negotiating positions or salaries. Identify gaps in services, build alliances with others in the areas you are looking to join, expand your skills,” he says. It seems that he has no trouble taking his own advice. Phillips is currently working on his master’s in clinical psychopharmacology.
As an early career psychologist, Derek Phillips, PsyD, offers the following tips to other clinicians who are either just starting out or ready to make a change:

• **Identify opportunities.**
  Determine where you want to be, what your interests and skill sets are, and look for gaps in services or business needs. Phillips identified that he wanted to be near family in rural Illinois, that a health system would be a good fit with his interests, and that there was a lack of psychologists in the local hospital system.

• **Know your value.**
  Be prepared to demonstrate how you will fill the gap or opportunity you’ve identified through your clinical training, education and previous experience. By cold emailing the medical staff recruiter and explaining what he could do for them, Phillips was able to pique their interest and have a position created specifically for himself. Sometimes it can help to contact physician leaders who you have worked with previously.

• **Get involved.**
  Join your state psychological association or relevant APA Division(s), keep in touch with classmates, and continue to look to mentors both in psychology and in other professional fields. Phillips was recently elected secretary of APA’s Division 42 (Independent Practice) and represents APA Division 55 (Pharmacotherapy) on the APA Council of Representatives.

Tips for adapting to change

After participating in the grassroots effort to get prescription privileges for psychologists in Illinois while he was in graduate school. He sees an astronomical need for mental health and psychiatric medication with the shortage of psychiatrists and other behavioral health service providers in his rural area. In the near future, his patients won’t have to wait an extended amount of time for an appointment with a psychiatrist for necessary medication management. “I’ll be a one-stop-shop for patients,” says Phillips. “It is the interface of medicine and psychology.”

**Nita Tewari, PhD,**
Independent Consultant

Dr. Nita Tewari began her professional life by working as a staff psychologist at the University of California, Irvine (UCI) in the student counseling center and teaching in the psychology department, a path familiar to many psychologists with degrees in clinical or counseling psychology. She found providing clinical services, working with students, and publishing her textbook *Asian American Psychology: Current Perspectives* to be rewarding, but was looking to create a career that would allow her greater flexibility while raising her family.

Valuing life balance, Tewari began providing diversity workshops and mental health trainings which led to writing, speaking and consulting opportunities with women’s lifestyle magazines, Hollywood studios, county agencies and psychology conferences. Evolving with the changing times of America, and her family, her presentation topics shifted to providing trainings focusing on the impact of technology on sleep and mental health. When her talks, “Get Your ZZZ’s to Get Your A’s” and “Connected, but Still Feeling Disconnected?,” were well received, she began thinking about the growing attachment to devices used by her own children and by society as a whole. She dug deep into the studies documenting the significant impact electronic devices and social media have on the cognitive and emotional functioning, physical health, and social development of children and teens.

Attending the California Psychological Association convention, which focused on psychology and technology, further confirmed the relevance of her career direction, personally and professionally.

Today, Tewari is a coach and consultant for parents, helping them manage family technology and screen time for happier kids and a more fulfilling family life. Rather than providing traditional psychological and behavioral health services, Tewari helps her clients find solution-oriented strategies around specific goals. Her mission is to educate and empower parents on technology use and its impact on mental health, communication skills, building relationships, well-being and living with intention and finding purpose while disconnecting from devices. Using the metaphor of youth
become more common for those who do not bill Medicare as well.

Still hesitant?

Rationales aside, it may still feel like a lot to consider incorporating this new set of tools into your practice. A 2013 article in Psychotherapy Research (Vol. 25, No. 1), by James F. Boswell, PhD, and colleagues highlights several practical and philosophical reasons that providers might balk at involvement, including the financial and time burdens of buying into these systems and concern that insurers could use the data against them.

Others are concerned that outcome measures might not sufficiently capture cultural factors or symptom severity—that the main measures used in this context have been tested mostly on white, relatively healthy samples and overlook people from different cultures or ethnicities or who are more seriously mentally ill or traumatized, for example.

“I think any sort of tracking measure or psychological assessment measure—whether it’s a symptom inventory or an outcome measure—needs to consider people from different groups and how they might respond to it,” says Tyson Bailey, PsyD, a provider at Spectrum Psychological Associates in Lynnwood, Washington, which sees many clients who are ethnically diverse and have histories of complex trauma.

In fact, outcome measures are by their nature limited, Rousmaniere says. For example, most measures don’t capture aspects of change that aren’t based on clinical symptomatology, such as a client’s growth in self-identity. So an outcome measure is a helpful addition that rounds out other information you already have, he says.

Admittedly, incorporating these tools takes effort and education, Duncan adds. But eventually, it will save you time, improve outcomes—and lead to some exciting clinical work.

“The cool thing about this work is that change is contagious,” he says. “Once a client has mastered something that’s been really troubling to them, one change kind of begets another. It can really accelerate.”

A new platform to measure outcomes

As you’re getting on board with outcome measurement, APA’s Mental and Behavioral Health Registry, www.mbhregistry.com, can help. For an annual fee, the database offers 30 free standardized process and outcome measures, both for mental health conditions and for transdisciplinary issues such as tobacco use and anti-depressant medication management. The registry is the only database of its kind to include anxiety measures geared specifically for this purpose; other useful measures will be added over time, including measures on sleep, functional impairment and quality of life, says C. Vaile Wright, PhD, director of research and special projects in the APA Practice Directorate and co-manager of the registry project.

Using the platform, clinicians can enter anonymous data on patients, see whether patients are improving or getting worse, and compare their data with that of other providers, says Wright. Over time the registry will also include access to relevant training and continuing education opportunities and links to resources such as best practices, and clinical and professional guidelines.

“Our goal is to be a resource or tool,” she says. “So, if psychologists want to participate in value-based payment models, they will have the technical database to do so.”

APA created the registry in response to upcoming requirements of Medicare’s Merit-based Payment System, or MIPS. Starting in 2019, MIPS will allow psychologists who treat 200 or more Medicare beneficiaries a year or who bill Medicare for more than $90,000 a year to earn bonus pay for superior performance in reporting quality measures (or get penalties for poor performance). The registry is also useful for psychologists who don’t need to report to Medicare at this time but who want to track their clients’ progress and see how they are performing compared to other providers.

APAs intent in creating the registry was to provide a psychology-friendly toolkit that uses measures psychologists are familiar with, versus those imposed from outside, Wright adds.

“This is an opportunity for psychology and psychologists to take a leadership role in determining quality mental and behavioral health care,” she says.

For more information on the registry, visit apapracticecentral.org. To sign up for the registry itself, visit www.mbhregistry.com.
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“Item-writing will be ongoing until we have enough validated items across the test specifications to offer multiple validated forms of the exam,” he said.

Questions remain
On their website, ASPPB defines “competence” as the “integrated and habitual use of knowledge, skills, attitudes, and values in psychology” and concludes that the “evaluation and establishment of competence is necessary to ensure the protection of the public.”

But some of those most affected by this change find that conclusion difficult to accept.

Callahan, for instance, has serious doubts about the impetus for ASPPB’s push for competency assessment.

“We’ve been told that a high percentage of people who pass Part 1 will pass Part 2. That doesn’t sound reassuring to us,” she said. “Why do this if there’s no discriminant purpose?”

“Obviously, I think competency as a concept is a good thing,” said Tyson Bailey, PsyD, a Seattle-area private practitioner and chair of CECP. But, similarly to Callahan, he isn’t convinced that Part 2 will “serve a gatekeeping function,” and wonders whether the enhanced exam will create more problems than it solves.

For example, he is concerned about license mobility issues, particularly for early career psychologists.

“This is something we need to contend with, because psychologists trying to start their careers already have mobility issues” independent of this additional requirement, Bailey said.

Gutierrez shares these concerns, and hopes ASPPB will provide further clarification about the portability of licensure across state lines. “If some states require Part 2 for licensure and others do not, psychologists will want to know if they will be required to take Part 2 should they seek licensure in another state,” he said.

Finally, another resonant concern—perhaps the most important to some—endures: the cost.

“[CECP remains] concerned about the how this may impact the decision to come into the field, as well as the continued difficulties associated with another cost for someone transitioning from student to early career psychologist,” said Bailey.

DeMers says that ASPPB is sensitive to this issue, and is well aware that graduate students and early career psychologists are struggling with debt, rising living expenses and lack of income before licensure. In fact, he said, costs of development, validation and ongoing operation would justify a much higher fee than $600 for Part 2, but “the ASPPB board chose a longer horizon to recoup development costs and operate at a breakeven position in order to lower the burden on candidates,” he said.

Looking ahead
DeMers said that six or seven jurisdictions are likely to sign on as early adopters of the enhanced exam, which will continue to be developed on its current timeline. In the meantime, he urges students and other stakeholders to review the wealth of information on ASPPB’s website, which offers the latest information on timelines, rollout, validation studies, exam content, sample items and preparation.

He acknowledges the fears and anxieties that many psychologists and future psychologists may have about the exam and their ability to practice. But he maintains that competency assessment is a necessary step forward for the profession.

“All of professional health care regulation has adopted multi-step assessment of professional competence, and psychology has fallen behind,” he said. “We must have the will to deal with the challenges of change in order to keep the profession credible and independent in a challenging health care environment.”
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As the guideline process continues, it’s important for practitioners to remember that the goal is to benefit the profession, not impede it, adds The Trust’s Jana Martin. “The guidelines can do a great deal for the profession if they’re used properly and not restrictively,” she says. To this end, practitioners’ best move—in addition to providing input on them—is to educate themselves about how to best use them in the context of their practice and experience, and in the wider context of the changing health care landscape, she says.

Clinical practice guidelines are part of the future, but it may not be clear how to use them in practice. While the guidelines are intended as guidance—not as mandates—clinicians may be concerned that if they don’t follow them to the letter, they may face legal, practice-related or reimbursement challenges.

To counter these concerns and to help you use the guidelines in ways that minimize your risk but don’t unnecessarily cramp your practice, Jana N. Martin, PhD, chief executive officer of the psychology insurance and risk-management organization The Trust, offers this advice:

1. **Familiarize yourself with the guidelines.** Keeping up to date with the guidelines—even if you don’t use them in a given case—shows that you are an informed practitioner who understands and considers the latest developments in your field, Martin says. Demonstrating this knowledge can protect you in cases of complaints or depositions: Pleading that you weren’t aware of the guidelines “can jeopardize even good clinical decisions you may have made,” she says.

2. **Use them in context.** While it’s good practice to use guidelines to help steer therapy, adds Martin, use your clinical judgment, too. Even patients with the same diagnosis vary considerably in individual characteristics, presenting problems and life contexts, for example, and cases assume added complexity with children, people with physical or cognitive disabilities, and those with co-occurring disorders. On top of that, Martin notes, therapy is a collaborative venture, and you and your patient must mutually determine the best treatment direction. Hence, take the guidelines seriously—but don’t let them overtake you, she advises.

3. **Document your treatment rationale.** That said, no matter what approach you take—but especially if you choose a treatment that isn’t within the guidelines—keep notes on why you selected the approach that you did, Martin recommends. A few sentences are fine, though it’s wise to elaborate a bit further if you choose a treatment not cited in a guideline.

Documenting your choice “supports the notion that you have truly developed a treatment plan with that particular patient’s needs in mind,” she says, rather than blindly following a set of guidelines.

4. **Consult with colleagues.** Another good risk-management strategy: When in doubt, consult with a colleague about your treatment direction. Doing so aligns with the definition of the standard of care, namely what a reasonably prudent psychologist would do in a similar situation. Again, document your conversation with your colleague and your chosen direction, whether you use a treatment noted in a guideline or not, Martin advises.

“When you consult with someone or you consult a resource, you demonstrate that you’re choosing an appropriate intervention that your peers might use as well,” she explains.

5. **Obtain informed consent.** Finally, getting patient consent for a treatment direction is yet another smart way to protect yourself from legal or other harm, Martin says.

“If I’m going to modify an intervention with a patient, I want to make sure I discuss with them why I’ve chosen that approach, and get their consent that it’s an approach they are comfortable with,” Martin says.

While there’s no crystal ball to foresee how insurance companies and the courts will interpret practitioners’ use of these guidelines, the best defense is a good offense, Martin underscores.

“If an insurer or other entity tries to use the guidelines in an overly restrictive way,” she says, “using good risk-management strategies will increase your protection and reduce your risk.”

- Tori DeAngelis
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**What’s next: privacy considerations for psychologists**

In light of the increasing awareness for greater security protections for personal data, many clinicians may find that they need to consider compliance issues beyond HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). Psychologists should familiarize themselves with state data privacy and breach notification laws as all 50 states and the District of Columbia have policies about who must comply with the law, different definitions of personal information, what constitutes a breach and the requirements that must be followed should a breach occur.

It’s important for psychologists to consider not just the data they hold and what they may share, but also the implications for patients and how to discuss with their patients about what steps are taken to protect personal information. As more states consider ways to strengthen an individual’s right to control his/her personal data, psychologists must keep abreast of proposed legislation. Psychologists ought to consult with colleagues, their state licensing board, state psychological association and APA about how changing policies about personal data protections may impact their practices.

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**Psychologists Adapting to a Changing Marketplace**

as digital natives and parents as digital immigrants, she uses her education and experience to help her clients bridge the digital gap. Parents, she explains, need practical information on social media platforms, apps, video games and parental monitoring software in establishing clear boundaries and rules for technology use and developing effective communication strategies for engaging with their children and optimizing their growth.

As an involved member in her community, her children’s Parent Teacher Association (PTA) and the Dean’s Leadership Circle at UCI, she was able to market herself by word of mouth and has appeared live on Angel Radio air waves through the Anaheim Angels radio network, creating engaging and easy to remember psychology and technology tag lines such as “Disconnect to Connect” and describing social media behavior as “Scrolling and Trolling” while viewing images and newsfeeds.

As for the future of psychology, Tewari feels strongly that all psychologists need to be comfortable with technology since we are living in the digital era with an ever-changing digital landscape. She expects technology to be a critical force in shaping human behavior and psychology’s future in navigating self-marketing on social media, seeing virtual clients and utilizing facial recognition software.

Tewari views developing new approaches to educating clients through nontraditional ways while taking the appropriate measures to ensure confidentiality and other legal/ethical requirements as important to the practice of psychology. “Embrace the reality that technology is a daily part of human life and take steps to learn the language of a new generation,” Tewari advises.

She believes it’s time for psychologists to stray from traditional careers and be open to using their training and skills in new ways such as in coaching, entertainment, government, providing media training, and working in tech companies on application and software development. She encourages psychologists to expand their networks, be willing to test out new ideas, and to think from a business perspective.
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