GOOD PRACTICE

Winter 2018

Thinking and Acting More Broadly

Celebrating a Compassionate Leader and Strong Advocate for Psychologists

Keeping Up with the Security Rule

A Psychologist’s Role in Providing Letters for Emotional Support Animals

Sequence of States: Psychologists Advocate for a Shift in Training Requirements

Making Group Therapy a Winning Part of Your Practice

Applying Psychology Skills in New Venues

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As we mark the beginning of a new year, I wrap up a decade of service as your Executive Director for Professional Practice with my retirement in March.

During my tenure, I have had the daily privilege of serving alongside an amazing team of smart, talented, enthusiastic, passionate, creative and collaborative professionals who will be a tremendous resource to our new CEO and to my successor. I am very thankful for the unwavering support from the Committee for the Advancement of Professional Practice and our Board of Directors. The Practice staff has provided valued resources to our members through some difficult economic times and in response to the challenges of an evolving health care system. We have had some great legislative and regulatory victories with parity and the expansion of mental health and addiction services. Current efforts to retain those benefits are key legislative priorities as are our efforts to have psychologists included in the Medicare “physician definition.” Today’s health care system is certainly not the same system in which I practiced, and tomorrow’s system will be different still. We look forward to serving as a valued resource for growth of your practice in the future.

Our chief executive officer, Arthur C. Evans, PhD, is a leader with transformational change in mind who will work to ensure that psychology is viewed as a strong discipline and profession with a bright future to effect meaningful change. Our value will ultimately be measured by our ability to contribute to the improved health and well-being of our nation and its citizens. We will achieve those goals if we, as Dr. Evans has said, continue to think big, take advantage of possibilities and opportunities, and stay inspired.

My 2018 wish for each of you is for good health, happiness, and having a career as a psychologist that is everything you wish it to be!

Sincerely,
Katherine C. Nordal, PhD
Executive Director for Professional Practice
Follow Katherine Nordal on Twitter, @drnordal

“Our value will ultimately be measured by our ability to contribute to the improved health and well-being of our nation and its citizens.”
— Katherine C. Nordal, PhD
THINKING AND ACTING MORE BROADLY

How psychologists can draw upon the full breadth of their psychological training

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

While it’s unclear how new models of health care financing, policy debates at the federal and state levels and other societal trends will affect the practice of psychology, psychologists’ unique training and skillset position us to take advantage of opportunities that will emerge from this rapidly changing healthcare landscape.

As a practicing psychologist, you can prepare for the future by extending your focus beyond traditional practice settings.

When you’re not seeing patients, you could schedule a time to meet with members of the local school system or a community organization. Find out how you can help develop new strategies to address some of the complex issues that children and their families experience in their daily lives, including coping with violence in their communities or the effects of a natural disaster. Boston-based psychologist Charmain Jackman, PhD, is just one clinician in private practice who is making an impact in the local school system and living up to her professional motto of “giving psychology away.” Dr. Jackman is the director of health and wellness at the Boston Arts Academy, where she works with young artists and their families to address mental health concerns that they are facing now or could encounter in the future. (See story on page 16.)

Integrated care is another area where we know practicing psychologists are employing interventions that are improving the quality of health care and changing the way it’s delivered. Psychologists are using the latest research and practice tools to serve patients who have behavioral and physical health conditions. For instance, more and more psychologists are working in pediatric clinics. Most people begin to exhibit signs of behavioral health problems at a very young age. By intervening early, and serving children in primary care, psychologists can help prevent these issues from turning into larger health problems down the road. Psychological interventions at this stage can also help to reduce health care costs.

Paul Kettlewell, PhD, witnessed this firsthand while working as the director of pediatric psychology at Geisinger Health System in Pennsylvania. In addition to providing outpatient care, psychologists built a positive reputation within Geisinger by conducting crisis evaluations in the ER. Geisinger granted hospital privileges to psychologists, which led to increased opportunities to reach more patients with comorbid mental and physical health conditions in their Children’s Hospital and in pediatric primary care sites. Since adding psychologists to their clinics, Geisinger has reported lower pharmacy expenses and reduced health care expenditures. Now, Kettlewell is extending his expertise to help our profession practice more broadly as one of the new members of the Committee for the Advancement of Professional Practice (CAPP). (See page 24 about new CAPP members.)

I could highlight many more stories of practicing psychologists who have stepped outside of the traditional psychotherapy role and found ways to improve the quality of health care in their communities. The health care industry will continue to change in significant ways. Psychologists need to play an integral role in this process, working with other providers and policymakers, to demonstrate the viability and strength of our profession. To get there, we need to both think and practice more broadly to identify and embrace the areas where we can effect meaningful change on behalf of our communities and our nation.
Ten years ago, Katherine C. Nordal, PhD, made a major career change, transitioning from a 28-year-long practice in Vicksburg, Mississippi, to Washington, DC, to become executive director for professional practice at the American Psychological Association and APA Practice Organization. As with many of her colleagues, Nordal chose a career path in psychology to help improve peoples’ lives. But throughout her career, she learned that psychologists had to advocate for themselves to effectively serve their patients.

When she started out as a practitioner, the health care system was very different, and competition from an array of mental health providers hardly existed. By the time she arrived at APA in a new role, psychologists were facing a very different marketplace. Never afraid of a challenge, Nordal was energized and eager to advocate for psychologists and sought out opportunities to help advance practicing psychology and secure a future for the profession. She cultivated relationships with key stakeholders in Congress, state legislations, federal agencies, psychology licensing boards and the insurance industry.

During her tenure as executive director, Nordal ardently advocated for psychologists and their patients, spearheading efforts on an array of legislative, regulatory and legal issues including:

- Regulatory implementation of the Mental Health Parity and Addiction Equity Act enacted into law in 2008, including submission of comments and meetings with federal agencies that led to a stronger final parity rule
- Passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 to create a national network of electronic health records
- Class action litigation and regulatory complaints against insurers for inappropriate and non-parity reimbursement practices
- Passage and implementation of the Affordable Care Act in 2010
- Transfer of the Psychology PAC into the APA Practice Organization in 2012
- Establishment of a quality reporting registry for psychologists in 2014 and expanding it to a Qualified Clinical Data Registry in 2017
- Passage of the Medicare Access and CHIP Reauthorization Act of 2015
- Passage of Families in Mental Health Crisis Act of 2016
- Training and resources on innovative practice models to help psychologists interested in better adapting to a changing health care environment
- Relationship-building with insurance companies, resulting in the Practice Organization’s ability to rapidly solve many members’ billing and reimbursement problems, including an insurer’s dismissal of a vendor for abusive audit practices, and members’ ability to develop beneficial collaborations with insurers
- Expanding psychology’s role in Medicaid in numerous states nationwide
- Actively collaborating with APA offices including working jointly with the Science Directorate on Clinical Practice Guidelines and teaming up with the Education Directorates to develop a DC Medicaid Pilot Project using interns and post-docs to integrate care in underserved areas.

Nordal was also a compassionate boss and colleague who created a positive work environment and collegial atmosphere. As she prepares to retire in spring 2018, APA and state psychological association leaders and staff look back on her tenure as executive director for professional practice.
“I have known Katherine for years, and have seen her service to APA and the APAPO, both as a member of governance and the Executive Management Group. I have personally observed her commitment to APA, the practice of psychology and the profession in both roles. Her energy, ability to listen, kind and gentle spirit, and knowledge of the various aspects of the profession will definitely be missed. Katherine, thank you for your service to APA and the APAPO.”
– Jennifer F. Kelly, PhD, Secretary, APA Board of Directors

“Katherine Nordal, over the 35-plus years I’ve known her, has consistently elevated not only the profession of psychology, but also the psychologists within our profession. She was one of the pioneers of successful independent practice in Mississippi, and then and since, has been a treasured role model, dogged advocate, dedicated doer, uplifting motivator, bold spokesperson, and fun and enjoyable friend and colleague to many. Her strengths and successes will continue to benefit us for quite some time. As a profession we have profited mightily from who Katherine is and what she has done; as an individual, I have been blessed to learn from and to know her. Gratitude abounds.”
– Jana Martin, PhD, CEO of The Trust for the Advancement of Professional Practice

“Her best asset is that Katherine brings people together who have diverse perspectives to achieve consensus in solving problems and challenges. Despite many challenging issues, and sometimes personalities, her continued focusing on furthering professional psychology attest to her tenacity and impact.”
– Antonio E. Puente, PhD, 2017 President, American Psychological Association

“Katherine Nordal’s professional accomplishments for practice have been innumerable and can be easily seen by looking through the APA and the Practice Organization websites or her CV. As CAPP chair, what I’ve most appreciated about Katherine is her leadership style which continues to inspire, motivate and excite the diverse practice constituencies about the future vision for practicing psychologists. Katherine’s communication style not only builds relationships across a wide range of constituencies, but she also clearly articulates the message and defends and challenges ideas and strategies to assure decisions are inclusive, impactful and the best fit for practitioners.”
– Kate Brown, PhD, Chair, Committee for the Advancement of Professional Practice (CAPP) from 2015 to 2017

“Katherine’s many years as a practitioner on the front lines gave her a deeper understanding of the concerns of her constituents and fueled the passion she brought to the job every single day. Katherine was the perfect mix for the job – an unwavering champion for practice, but also someone who ‘played well with others’ and knew how to achieve her goals through collaboration.”
– Nancy Gordon Moore, PhD MBA, Executive Director, Strategic Programs, American Psychological Association

“Katherine Nordal has been the right person to guide the Practice Directorate and the Practice Organization over the past ten years. She built great collegiality amongst the staff and supported their professional development so that Practice has been able to fight for psychologists and continue to ensure that those we serve have access to quality, informed psychological services.”
– Lynn F. Bufka, PhD, Associate Executive Director, Practice Research and Policy, American Psychological Association

“Before coming to the Practice Organization Katherine was active in her state association and was an advocate for the issues faced by private practitioners. Becoming the Executive Director of the APA Practice Organization was a natural progression in Katherine’s quest to promote and advocate for psychology. She has been a fearless leader, has taken on the tough challenges of the last decade with gusto, and has always had the good of the profession, and the people psychologists serve, at the forefront of her thinking. She has been an advocate for SPTAs and the important role they play in the profession. Thank you, Katherine, for all you have done and all you have meant to psychology.”
– Sally Cameron, Executive Director, North Carolina Psychological Association

“Katherine Nordal played a key role in breaking down silos within APA and the discipline. She worked with others in the science and education sectors to strengthen the effectiveness and status of psychological practice. In doing so, she serves as a model for her colleagues and for those who will come after her.”
– Howard Kurtzman, PhD, Acting Executive Director, APA Science Directorate

“As a full-time practitioner who went on to do a Congressional Fellowship, Katherine is a role model to all psychologists who care about the future of the field. Her service in numerous APA governance roles combined with her practice background prepared her well to meet the challenge of being the Executive Director for Professional Practice for APA and the Practice Organization.”
– Dan Abrahamson, PhD, Associate Executive Director, APA

“Katherine Nordal, over the 35-plus years I’ve known her, has consistently elevated not only the profession of psychology, but also the psychologists within our profession. She was one of the pioneers of successful independent practice in Mississippi, and then and since, has been a treasured role model, dogged advocate, dedicated doer, uplifting motivator, bold spokesperson, and fun and enjoyable friend and colleague to many. Her strengths and successes will continue to benefit us for quite some time. As a profession we have profited mightily from who Katherine is and what she has done; as an individual, I have been blessed to learn from and to know her. Gratitude abounds.”
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– Sally Cameron, Executive Director, North Carolina Psychological Association
The Security Rule was designed with the recognition that technology and security threats change rapidly and that health care entities face very different risks to a patient's health information...

By Stacey Larson, PsyD, JD

The increased use of laptops, tablets and smartphones as well as electronic health records in the health care arena has many benefits for health care professionals and patients. New technology allows for greater collaboration between providers to better serve their patients’ needs. It’s essential that psychologists using technology in their practice or weighing their options for doing so have a basic understanding of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.

The Security Rule was designed with the recognition that technology and security threats change rapidly and that health care entities face very different risks to a patient’s health information, such as inappropriate access of protected health information (PHI) by staff, or accidentally sending PHI to the wrong person.

Psychologists and other providers need to comply with the Security Rule if they electronically transmit or store protected health information related to insurance claims or other third-party reimbursement. Doing this is called “triggering HIPAA.”

HIPAA’s Security Rule applies only to electronically transmitted or stored protected health information—known as ePHI—typically kept on computers or other electronic devices.

The Security Rule recognizes that security risks to ePHI cannot realistically be eliminated. Rather, the Rule is about taking reasonable measures to manage and reduce those risks in your practice.

Is your practice in compliance with the Security Rule under HIPAA?

The Security Rule outlines the steps providers must take to manage the risks of unintended disclosures of ePHI through security breaches such as hacking or improper access or accidental loss of ePHI through a computer crash, fire or flooding.

“Some practitioners think that they can comply with the Security Rule by taking a few simple steps like encrypting emails or adding password protection to their computer files,” says Alan Nessman, senior special counsel in the APA Practice Organization’s Office of Legal & Regulatory Affairs. “Unfortunately, that is not correct.”

Many health care providers, including psychologists, have expressed confusion on how to become and remain compliant with the Security Rule. “I don’t think most folks really do understand Security Rule compliance all that well,” says Joe Scroppo, PhD, JD, in Woodmere, New York, a risk management consultant for The Trust.

To comply with the Security Rule, psychologists must conduct a formal, structured risk analysis for their practice, determine the appropriate security measures needed, and implement those measures.

The basic approach of the Security Rule

The Security Rule does not require any single method or “best practice” for responding to all types of security risks.
Instead, the rule essentially requires psychologists to come up with reasonable security measures to respond to the risks identified in a risk analysis of the technology used in their practice and document the thinking behind the selection of those measures.

The rule also recognizes that the size of the health care entity affects its risks and responses. For example, a hospital is going to have different and more complex risks than a small group practice of psychologists. An independent practitioner does not have to be concerned about a large workforce and their access to a large system of computers and protected health information. Instead the solo psychologist may have to consider the training of an administrative assistant who takes care of appointments, and the risks posed to a few computers and other devices. A smaller practice may have to consider fewer variables, but it is no less important for that small practice to maintain security rule compliance.

### Conducting a risk analysis

Psychologists must conduct a thorough assessment of potential risks and vulnerabilities to the confidentiality, integrity and availability of any protected health information held or transmitted electronically by their practice. The rule details many types of risk to consider.

Your analysis should consider risks and vulnerabilities involving:

- Computers and any other electronic devices: desktops, laptops, smartphones, tablets, etc.
- Electronic file storage: hard drives, flash drives, electronic health records, cloud storage; and
- Electronic transmissions: whether submitting ePHI through a secure portal or sending emails to patients.

You should also consider how your office is set up. For instance, can patients walking through your office or sitting in the waiting room look directly at your computer screens and potentially see another client’s health information? If you employ staff, does the entire staff have access to all client records or just those portions relevant for their respective job duties? A risk analysis should also take into consideration how you plan to manage and train your staff to ensure the security of health information or ePHI that they may access.

Some questions that you should ask yourself as you are conducting your risk analysis are:

- Have you identified the ePHI within your practice or organization? This includes protected health information that you create, receive, maintain or transmit electronically.
- What are the external sources of ePHI? For example, do vendors or consultants create, receive, maintain or transmit ePHI?
- What are the human, natural and environmental threats to information systems that contain ePHI? This includes unauthorized/inappropriate access by staff, inadvertently sending ePHI to an incorrect recipient, the accidental downloading of a virus/malware by opening an unknown hyperlink or attachment, hacking by an unknown third party or natural threats such as floods and fire.

### Securing your practice

After identifying the risks to ePHI in the risk analysis process, select appropriate security measures to manage those risks in your practice. Security measures include:

- Creating a system for backing up data and identifying data to backup
- Setting up systems and methods to limit staff access to certain data
- Determining whether to use encryption.

It is important to note that HIPAA does not require encryption. Encryption, however, does provide additional protection of health information that you store or transmit electronically. There are also encryption services available specifically for emails. As part of your risk analysis, it would be a good idea to document that you considered encryption—even if you ultimately decide encryption is not a good fit for your practice.

Additionally, if a breach occurs encryption will spare you the stress of having to alert or send breach notifications to affected patients, the Department of Health and Human Services and, if required by your state law, your state attorney general or other law enforcement.

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A service animal is defined under the ADA as a dog that has been individually trained to do work or perform tasks for someone with a disability, and the work performed must be directly related to the disability. Because ESAs are not recognized by the ADA, they can be excluded from most public places. (Note that there may be state laws that allow ESAs in public places, so it is important to check your state law.) ESAs are, however, recognized under the Fair Housing Act and the Air Carrier Access Act. Those laws recognize ESAs as a “reasonable accommodation” for a person with a disability. Because of this reasonable accommodation exception, landlords and airlines generally allow ESAs in housing and on airplanes without charge. Landlords and airlines can impose certain restrictions, however, including requirements that the owner have the means to adequately care for the animal(s). Airlines may require the ESA owner to give notice before bringing their animal onto a flight.

Therapeutic and ethical considerations

Given the positive impact on your patient, what would be the problem with writing the letter to his landlord or airline supporting the ESA request? If you are asked to do so, there are clinical and ethical questions to consider.

Does your statement/letter meet APA Ethics Code Standard 9.01, Basis for Assessments? Your examination of the person should adequately support your conclusion that an ESA is warranted. Do you have sufficient information about the patient, through direct observation or assessments,
to substantiate your findings? Would your letter be based on information and techniques sufficient to substantiate your findings? Does your examination of the person adequately support your conclusion?

For example, a self-report from the patient may not be enough for you to justify a decision for writing such a letter. You should also consider your clinical impressions and whether there is research to support the notion that an ESA will assist the patient in dealing with an issue. For example, you may know from your treatment and the patient's self-reporting that a patient has anxiety due to fear of flying and that traveling with his dog alleviates panic attacks. Or, your patient suffers from depression, and you believe that having the dog in his apartment will comfort him and lessen the severity of his depression.

Remember, your letter is stating that the patient's diagnosis substantially impacts a life activity. Can you honestly and objectively make that determination? Does an ESA truly minimize the impact of the patient's problem, or is this just a way of allowing a beloved pet to be able to live with your patient, or allow the patient to avoid paying airline pet transport fees? If you have reservations about any of these issues, you probably shouldn't write the letter.

**Is your role changing from therapist to evaluator?** The APA Ethics Code Standard 3.05 cautions psychologists about multiple roles:

*A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person; (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship; or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.*

It further states, “A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.”

Multiple relationships are not prohibited by the APA Ethics Code, but you will want to be sure that you are being objective. By writing a letter for an ESA, you are essentially providing an evaluation for a landlord or other party for the purpose of helping him or her make a decision about your patient. Can you be objective in your assessment as a health care provider, or are you becoming an advocate?

Another consideration is whether writing the letter, or declining to do so, will adversely impact the existing therapeutic relationship you have with your patient. You would want to discuss these issues with your patient to minimize any hard feelings this may cause. You may want to then talk about alternative coping mechanisms he or she can use to deal with symptoms if you cannot justify writing a letter for an ESA.

**Requests from nonpatients**

People who wish to bring their animals to live or travel with them, and would otherwise be barred from this, often turn to psychologists for a letter of support even if they have never seen a psychologist for treatment.

If you do not have an existing therapeutic relationship with the person requesting a letter, then you probably don’t need to worry about multiple roles in these scenarios where you are acting as an evaluator, rather than a therapist. You would, however, need to be mindful about starting a therapeutic relationship with this person in the future (see APA Ethics Code Standard 3.05). Multiple relationships are not always prohibited, but you will want to be sure there is no impairment to your objectivity, competence or effectiveness in performing your function as a psychologist.

Considering the type of evaluation you would want to do, you will want to be aware of the considerations under APA Ethics Code Standard 9.01, as outlined above. You will have less firsthand clinical knowledge, so will you be able to obtain adequate information to support your conclusion?

There are some issues you’ll want to discuss with the person. First, you’ll want to make sure the client understands that the evaluation or assessment may result in a diagnosis which could impact him or her in other ways. People don’t

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SEQUENCE OF STATES: PSYCHOLOGISTS ADVOCATE FOR A SHIFT IN TRAINING REQUIREMENTS

Thanks to grassroots efforts, the postdoc is optional for licensed psychologists in 17 states. Are more to follow?

By Hannah Calkins

“But... Utah is never first at anything!”

This was the incredulous response that Nanci Klein, PhD, received when she approached Utah’s professional licensing agency about changing the required sequence of training for licensed psychologists.

It was 2006 or 2007, Klein says, and APA was revising its Model Act for State Licensure of Psychologists, which state legislators are encouraged to use when drafting licensing regulations. The psychologists working on the revision were recommending that states allow psychology graduates to count more of their predoctoral training hours toward the number required for licensure. This would relieve many graduates from having to complete supervised postdoctoral training, and make them eligible for licensure earlier in their careers.

The postdoc requirement—then on the books in every state but Alabama, which never had one—dated to a time when students accrued far fewer clinical training hours in their doctoral programs, Klein says. But the profession had evolved and so had the training programs.

Klein, who is the director of professional affairs for the Utah Psychological Association (UPA), was undaunted by the prospect of pioneering this change in the required sequence of training. Having observed every doctoral psychology program in the state, she knew that more flexibility would be good for Utah psychologists.

“Students in doctoral psychology programs in Utah complete between 4,500 and 6,000 hours of supervised training before graduating. We were really disadvantaging them by requiring more,” she says.

Klein, her colleagues at UPA, and several student and early career advocates rallied around the cause, and in 2008, Utah became the first state to pass legislation making the postdoc optional for psychologists.

“It was a no-brainer,” Klein says. “I haven’t heard a word of concern about the quality of our graduates’ training or the training requirements since we passed the bill.”

More flexibility for psychologists

Since 2008, 15 states have passed similar legislation, emboldened by APA’s adoption of the revised Model Act in 2010. Missouri is the most recent addition to this list of states, having passed a new sequence of training law in July 2017.

Supporters say that the postdoc requirement is outdated and unrealistic. Postdoctoral training opportunities are hard to come by, they argue, because employers have few incentives to offer them. Insurers generally don’t reimburse unlicensed providers, and so employers, particularly independent practices, have limited ways to bill for services provided by postdoctoral trainees. Employers also have to pay a supervisor, often making postdocs, in Klein’s words, “a cash drain.”

With limited postdoctoral prospects, many graduates are in a difficult position: unable to clear the last hurdle to licensure and therefore unable to earn an income—or to begin paying down their hefty student debts.

But economic arguments aren’t the only compelling ones, says David Lutz, PhD, professor of psychology at Missouri State University and former president of the Missouri Psychological Association (MOPA).

“In Missouri, we had psychology interns in rural areas who wanted to remain there but weren’t able to because they had to seek out postdoctoral experiences,” he says. In areas already suffering from provider shortages, this didn’t make any sense.

Jess Luzier, PhD, ABPP, who is president of the West Virginia Psychological Association,
observed similar problems there. West Virginia made the postdoc optional in 2016. “We saw changing the requirements as a way to pull in more well-trained, doctoral-level providers where there was a dearth of them,” she says.

Luzier, Lutz, Klein and other supporters are confident that changing the sequence of training requirement has virtually no effect on the quality of licensees’ training. “We wanted to make adamantly clear that we were in no way diluting the requirements,” says Lutz, who worked on the issue for years in Missouri with colleagues and students. “The required number of hours of supervised training is the same. Those hours are just in a different place.”

In 2014, Lutz coauthored an article on the perceptions and anticipated impacts of eliminating the postdoc requirement. He and his coauthors found that some of the psychologists and students surveyed had significant concerns, mostly related to license mobility and to the possibility of inconsistencies in the quality of training programs. However, they also found that the more well-informed respondents were about APA’s Model Act, the more likely they were to support making the postdoc optional. “We used the data in the article to gain the support of our colleagues at MOPA, the state psychology board, and finally, the state legislature,” Lutz says.

Like Lutz, Luzier has a long history of engagement on the issue. As a graduate student in Ohio, she was involved in changing the requirements there in 2010, and she drew on that experience a few years later as a licensed psychologist in West Virginia. Also like Lutz, she knew what she needed to do in order to encourage her colleagues. “I did what a psychologist does best: gather data,” she says.

Luzier contacted the psychology boards of nearby states that had made the postdoc optional, and talked with them about the effects of the change. One thing was clear: more flexible sequence of training requirements drew psychologists to the state. “It was a dramatic increase,” she says. “At the same time, there were no increases in ethics complaints or disciplinary actions against newly licensed psychologists due to this change. So, from a public safety perspective, there’s no compelling reason to argue against changing the law.”

Others urge caution—and await hard data.

But some psychologists see it differently, particularly those associated with state licensure boards. “There has been no empirical data to demonstrate that psychologists don’t need to complete a postdoc,” says Alex Siegel, JD, PhD, the director of professional affairs at the Association of State and Provincial Psychology Boards (ASPPB).

However, he said that Part Two of the Examination for Professional Practice of Psychology (known as EPPP Part Two), which tests skills, may

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Group therapy is generally not the go-to modality for psychologists. It’s not typically taught in graduate school, so students’ first experience may be learning it on the fly during internship, without sufficient training or practice.

That said, the medium is gaining serious traction, thanks to new research showing its effectiveness, along with new tools to aid its success and a systemic call for more efficient, cost-effective treatments, says APA Div. 49 (Group Psychology and Group Psychotherapy) President-elect Martyn Whittingham, PhD.

“There’s increasingly strong evidence that group therapy is not only about as effective as individual therapy, but it’s more efficient,” he says.

A landmark 2016 meta-analysis by Brigham Young University Professor Gary Burlingame, PhD, and colleagues, underscores the point. The study, reported in Psychotherapy (Vol. 53, No. 4), pooled the results only of studies that compared group and individual therapy within the same study. Each study used identical treatment types, patients and doses. The team found no differences between the modalities in rates of treatment acceptance, dropout, remission or improvement. Meanwhile, other recent reviews show that group therapy can effectively address conditions including depression, anxiety, social anxiety, eating disorders and addictions.

If the idea of running a group intrigues you—or if you’ve had some experience running groups but feel you need more—how should you go about it? After receiving the appropriate training, you can maximize group attendance, retention, success and reimbursement using a range of practical and evidence-based strategies. Here are the basics.

Make a plan. First, get clear on the goals of your group, advises Brigham Young’s Burlingame. Groups run the gamut from support groups to psychoeducational groups to psychotherapy process groups, each with their own structures and goals. Decide which type you want to pursue, and get training in that particular modality.

Schedule for good attendance. Once you know the type of group you want to run, make sure you have enough clients to make it a success, says Doug Tynan, PhD, director of APA’s Office of Integrated Care. “You can’t do group therapy if you can’t get the group together,” as he puts it. Gather more referrals than you think you need, adds Div. 49 President Giorgio Tasca, PhD. For every 16 referrals he gets, he ends up with about eight clients who join the group, he says.

Use creative means to find group members, other experts say. For example, start a list of people in your own caseload you think might benefit from some form of group therapy, or consider starting groups with people on your own wait list or that of your clinic.

Using educational tools like brochures or links on your website can further increase your uptake by helping referral sources and clients better understand group therapy and its benefits, adds Leann Diederich, PhD, a clinical psychologist who runs groups in State College, Pennsylvania. The American Group Psychotherapy Association, for example, has a handout called “Group Works” that contains excellent information about the purpose and goals of group. You can also create your own brochures that highlight your background, the type of group you’re running, and the group’s structure and goals, she says.

Prep potential members. Before starting a group, hold individual sessions with people interested in taking part. It can mean the difference between someone staying or dropping out, Tasca says. He holds one or two such sessions with each group candidate, developing a case formulation and treatment goals and assessing his or her thoughts.
and concerns about joining. If a client is avoidant or anxious, for example, Tasca might explain that it’s normal at times to feel like leaving a group, but that he’ll help them process those feelings if and when they arise.

Screening tools can aid this preparation process, Whittingham adds. Empirically validated measures like the Group Readiness Questionnaire and the Group Therapy Questionnaire-Short Form can help assess risk factors for dropout and help therapists prepare clients for group dynamics, he notes.

**Make it easy for clients to attend.** Once you have a solid group of potential members, set times and conditions that are convenient for them, advises APA’s Tynan.

When Tynan ran hospital-based groups for children with attention deficit hyperactivity disorder and their parents, for example, he held them shortly before dinnertime so people could get a quick meal in the cafeteria and come to group right after. He also assessed which nights parents took kids to religious instruction and he didn’t hold group on those nights or during Halloween week.

“You have to be really patient-centered and family-centered and ask your patient population, ‘What would be a good time for you?’” he says.

Depending on your population, you can also spur attendance by arranging for childcare, elder care or transportation, adds C. Vaile Wright, PhD, the APA Practice Directorate’s director of research and special projects. Some Medicaid programs, for example, allow patients to use Uber and Lyft; you can also help patients obtain bus vouchers, for example.

**Facilitate group process.** Once you’ve launched your group, set the stage for a safe and structured environment, Tasca recommends. He spends the first two sessions developing an alliance with the group, which includes communicating the idea of universality—that the issues they face are similar to those that others are facing—and making sure he acknowledges everyone, even those who aren’t saying anything.

Avoid being confrontational or

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**Finding the Right Group Training**

Running an effective therapy group doesn’t mean abandoning your knowledge base in individual therapy, but it does require extra training in at least two main areas, says Div. 49 President Giorgio Tasca, PhD. One is understanding the multiple dyadic relationships that take place in groups; the other is understanding group-level processes—the phenomenon in which groups take on a life of their own.

“You’re taking care of eight individual patients,” says Tasca, “but you’re also taking care of the group.”

There are many types of groups to get training in—everything from support and psychoeducational groups for specific mental health and physical conditions to process-oriented groups that address people’s general problems in relating to others. Groups may be short-term and limited to certain members, or ongoing and open to new patients.

To find the right training for you, group therapy experts recommend connecting with two organizations: the American Group Psychotherapy Association, or AGPA (agpa.org), and APA’s Div. 49 (Society of Group Psychology and Group Psychotherapy).

AGPA, the main professional association devoted to the field of group psychotherapy, hosts conferences and workshops, provides educational resources, and oversees a certification process designed to help you gain competency in key group therapy constructs and leader behaviors. Div. 49 is devoted to educating and connecting group therapy researchers and practitioners. Div. 49 also hosts workshops and conferences on different aspects of group therapy and best practices.

In tapping these organizations and resources, seek information on best practices for the types of groups you’re planning to run, adds Div. 49 President-elect Martyn Whittingham, PhD. That includes not just best practices on specific groups for specific conditions, but best practices related to the group process itself—on pre-group preparation, for example, or developing group cohesion. Such group-level practices “apply to all kinds of groups and settings, and can make the difference between group programs that falter and those that thrive,” he says.

At the internship level, college counseling centers can likewise provide excellent group-based training, adds Div. 49 2016 Membership Committee Leader Leann Diederich, PhD, who received her initial training in group training at The Pennsylvania State University’s counseling center and became its group therapy coordinator before going into private practice.

“College counseling centers know how group works and they know it’s an effective treatment for working on interpersonal issues,” she says.

Further expand your knowledge by connecting with like-minded colleagues, Diederich recommends. Opportunities include Div. 49 community conversation hours and AGPA-sponsored consultation groups for example. Meanwhile, Div. 49 student members can join a mentorship program if their universities lack training in the area. Many states also have local group psychotherapy associations.

Finally, be diligent in your quest for good training and information, experts say.

No one source can provide everything you need, and you have to be creative in obtaining the knowledge and guidance you need to meet your goals.

The rewards for your labors will be worth it, he adds: “If you become informed, it can really make a difference in the success of your group.”

- Tori DeAngelis
Psychologists in the Stockton, California, offices of the integrated care organization Kaiser Permanente are engaged in a wide variety of treatment groups for patients with medical conditions, including a pulmonary wellness workshop, a fibromyalgia coping workshop, bariatric support groups, a group to treat patients with anxiety-related bladder problems, and a workshop to help people self-manage migraines and other headaches.

Psychologists’ growing involvement in such groups signals a greater appreciation and acceptance by medical providers for what psychologists can bring to the health care table, not to mention the power of group formats to save costs and increase efficiency, says Sean Woodland, PhD, an embedded psychologist there.

“The medical community is opening its eyes to the fact that people’s lack of motivation for losing weight or eating healthily, for example, is something that we can treat intentionally,” he says.

More and more data support the promise of group formats to help medical patients adhere to treatment, adopt healthy lifestyle choices, set realistic goals and manage pain, adds APA Div. 49 (Group Psychology and Group Psychotherapy) President-elect Martyn Whittingham, PhD.

To take part in this work—whether you are already employed in a health care system or practice independently—take a few key steps, group therapy experts recommend.

• First, get training. Health-related groups tend to be relatively structured and focused, and employ cognitive behavioral techniques that many psychologists are familiar with. In some ways, therefore, they may be easier modalities to learn than more psychodynamically oriented groups, for example. Find out more by contacting the American Group Psychotherapy Association, which has numerous training resources in all areas of group therapy, including for medical conditions.

• Next, market yourself, even if you’re employed in a medical setting. Ask physicians, nurses and others about caseloads they’re having difficulty handling—patients with diabetes who have trouble controlling their diets, for instance, or patients who can’t quit smoking. Explain how your skills can help with such patients, and provide brochures or other materials that describe what you do and how your treatment can help.

• If payment isn’t covered in your salary—for example, if you’re an independent practitioner who is consulting with a medical office—learn the right billing codes and how to use them, says Randy Phelps, PhD, senior advisor in APA’s Office of Health Care Financing. There are several Health and Behavior Codes that cover the behavioral, cognitive and biopsychosocial aspects of treatment for patients with medical conditions.

At best, these groups confer benefits beyond the stated goals for the group, says Doug Tynan, PhD, director of APA’s Center for Psychology and Health. For example, they give patients a chance to share thoughts on managing their condition, which would never happen in an individual medical appointment.

“They often have great ideas I never would have thought of,” Tynan says.

- Tori DeAngelis

stoking conflict in those first sessions, adds Diederich, using such strategies only when a group has built sufficient cohesion and trust. “You need the background to be able to say, when necessary, ‘That isn’t appropriate at this stage,’ and to block and redirect a person accordingly,” she says. “Without that knowledge, you can get into situations where a client feels scapegoated or makes disclosures that they’re not ready to make.”

It’s also helpful to have a co-leader, Wright adds. “If one of you is leading a discussion or introducing a new idea,” she says, “the other can be paying attention to group dynamics on more of a process level.

Use outcomes measures. Outcome measures are becoming a big deal, not just for individual therapy, but for group therapy as well. In fact, using these tools is good for group process and for the health of your practice, says Whittingham. Health care regulators and insurers are already requiring practitioners to use such tools to help demonstrate the quality of care they’re delivering.

Fortunately, there are many well-validated outcome measures for individual

RESOURCES

The American Group Psychotherapy Association has a wealth of resources for evidence-based practice in group psychotherapy as well as group practice guidelines: www.agpa.org

The Association for Specialists in Group Work’s list of best practices for a range of group areas, including multicultural guidelines: www.asgw.org

The Substance Abuse and Mental Health Administration’s National Registry of Evidence-based Programs and Practices, which includes many evidence-based practices that use group therapy: www.samhsa.gov/nrepp

The University of Texas clearinghouse for group therapy workshops: cmhc.utexas.edu/clearinghouse/

therapy that can be tailored for group therapy, including questionnaires you can provide at the beginning and end of each session, adds Whittingham. Quality-of-life measures like the OQ45.2, and the Outcome Rating Scale are examples. Also available are instruments that measure specific outcomes like depression. That said, not all measures are sensitive to change, says Whittingham, so use care when selecting them, he advises.

**Get reimbursed.** Finally, educate yourself on the codes you need to get properly reimbursed, says Randy Phelps, PhD, senior advisor in APA’s Office of Health Care Financing. Understand the differences between the codes and how to use them. For example, there are separate codes for groups involving groups of families and those that focus on people with medical conditions, and codes differ in the ways that you can bill chunks of time.

Using these strategies will help ensure that your group provides maximum gains for your patients, Wright notes.

“Once you have a group established and it starts to gain a reputation, it can really take off,” she says. “You end up getting wait lists for your group therapy.”

**Group therapy codes: the basics**

Here are the codes used to reimburse psychologists for group therapy and other group interventions:

- **Code 90849: Multiple family group psychotherapy.** This code is for treating families with relatives who have similar mental health issues, such as schizophrenia. The methodology aims to help families learn how to handle common issues and situations that arise. To bill, treat each family like an individual patient, and bill each family for the session.

- **Code 90853: Group psychotherapy for groups other than multi-family groups.** For groups of patients with similar mental health conditions or diagnoses. Bill each patient separately for the length of each session. Can be billed in conjunction with Code 90785 (see below).

- **Code 90785: This code is for so-called interactive complexity, which refers to highly intense communication that complicates the delivery of a group therapy session. Examples include facilitating extremely difficult communication with discordant or emotional family members, and engaging young or verbally undeveloped or impaired patients. It is not used often. It is important to note that interactive complexity is considered an “add-on” service; therefore, 90785 cannot be billed as a stand-alone service. It must be billed in addition to another code for the primary service.

- **Code 96127, Brief behavioral assessment.** Designed to reimburse providers for assessments that are used as part of prevention and screening. Reimbursement rates are low, and most carriers won’t pay for use of these instruments. Hence, pre-approval is advised.

- **Health and Behavior, or H&B Codes:** These codes apply to intervention services that address behavioral, cognitive and biopsychosocial factors in treating patients diagnosed with a medical condition, like diabetes or heart disease. They are not used for mental health conditions. Each service is billed in 15-minute units.

  **Use H&B Code 96153** when two or more patients are in a group and the payment amount is per person. The total group fee equals the amount for one unit (15 minutes), multiplied by the number of people in the group.

  **Use H&B Code 96154** when an intervention service is provided to a family with the patient present for the session. An example is teaching relaxation techniques to reduce a patient’s fear of receiving diabetic injections and the parents’ fear of administering them.

  **Use H&B Code 96155** for an intervention service provided to a family without the patient present. An example is working with parents and siblings to help shape a diabetic child’s behavior. However, Medicare and many private insurers don’t cover this code because the patient isn’t present, so be sure to seek pre-approval.

For more questions on these codes, contact APA’s Office of Health Care Financing at ohcf@apa.org. 📞
APPLYING PSYCHOLOGY SKILLS IN NEW VENUES

Practitioner Profile: Charmain F. Jackman, PhD

By Rebecca A. Clay

Psychology graduate education pushes what Charmain F. Jackman, PhD, calls the “dream of private practice.” That was never enough for Jackman, who comes from a long line of female entrepreneurs and sees herself as a therapist-entrepreneur. Her grandmother, aunt and mother taught her that businesses fare better when they rely on multiple revenue streams, and Jackman has put that belief into practice.

Today Jackman is the full-time director of health and wellness at Boston Arts Academy, a public high school for visual and performing artists. But she also has a part-time private practice called Innovative Psychological Services, where she provides individual therapy and conducts forensic assessments in termination of parental rights cases. She serves as a consultant for academic summer programs for high school students. And she runs a coaching business aimed at other clinicians. (See sidebar for Jackman’s tips for applying clinical skills in new ways.)

“As psychologists, we should be thinking about how we can use our skills to reach untapped markets,” says Jackman, who earned her doctorate from the University of Southern Mississippi in Hattiesburg in 2001. “There’s a certain segment of the community that will find us, but we have to actively seek out others.”

Working with young artists

As a teenager in Barbados, Jackman dreamed of being a psychologist and working in schools. Now she does both, with a twist. “It’s very unusual to have a counseling psychologist doing clinical work at a school,” she says, noting that school psychologists specializing in educational testing are the norm in the district. The school’s only clinical psychologist, Jackman leads a nine-member team made up of social workers, a nurse, health educators and clinical interns.

Arts training, by design, stirs up deep feelings, says Jackman. “The arts curriculum pushes students to dig deep into their emotions,” she says, explaining that students have to engage in self-exploration and reflect on their personal histories to develop their artistic voices. However, these activities can also trigger memories of past trauma. “That’s why having clinicians on-site is crucial,” says Jackman. “We are available to provide on-site support immediately, which is a great benefit for students experiencing emotional crises.”

Jackman and her team provide individual therapy, group counseling, health education and crisis assessments to students, most of whom self-refer or are brought in by friends. In response to a spike in crisis assessments and subsequent psychiatric hospitalizations a few years ago, she launched a program called “Bridge” to help students transition back to school after hospitalizations. “Diving back into a full academic and arts course load is overwhelming if you have been out of school for an extended period, and it can trigger a relapse,” she says, explaining that the program gives students access to clinical and academic support as they stabilize and transition back to their regular schedule.

“I am always amazed to see students perform at high levels, despite difficult personal circumstances,” says Jackman.

Jackman also works with teachers. At the beginning of each school year, for instance, she leads a professional development workshop on the warning signs of mental health issues.
health issues in adolescents. She sits in on classes to observe problematic behaviors flagged by teachers, then suggests ways to address the behaviors. She also conducts mediations between students and teachers if they’re experiencing conflict. “Our school has a social justice orientation,” says Jackman, explaining that the school encourages students to be artist/activists who will advocate for improvements in their communities and society as a whole. “We encourage students to speak to power.” Engaging families and educating them about adolescent mental health are also important parts of Jackman’s school-based services.

**School’s out, but opportunities remain.**

One advantage of working at a school is summers off, says Jackman. And that means extra time to take advantage of additional income opportunities. As a consultant for two Massachusetts Institute of Technology summer programs, she provides clinical support to students and is on call to guide program staff in addressing student concerns.

“It’s an interesting contrast to working with artists,” Jackman says. While the artists are comfortable with their feelings and seeking help, she says, the high school students in these Science, Technology, Engineering, and Math (STEM) programs are often reluctant to reach out when they’re struggling. “These are students who can typically solve complex equations or build intricate contraptions on their own,” says Jackman. “They often perceive asking for help as a flaw and often minimize their struggles or think that they should be able to handle any problems on their own.”

Jackman is also busy helping other psychologists thrive. She offers business development coaching to clinicians who want to launch or grow their own private practices, plus workshops on such topics as personal branding for therapists. “We know how to do the clinical work, but not how to market ourselves,” says Jackman. “We rarely get that training in graduate school, but clinicians need these business skills to run lucrative practices.”

Jackman’s own brand is based on the idea of giving psychology away—getting the word out and increasing access to care for underserved communities.

On a recent trip to Barbados, for example, Jackman led a professional development workshop on mental health for counselors at the Barbados Community College and spoke to a group of adolescents about topics the country’s young people typically don’t discuss with adults.

In addition to all her other roles, Jackman also serves on the Diversity Council of Big Sister Association of Greater Boston, having been a mentor herself for nearly a decade. She was the psychological consultant for a movie called *Knockaround Kids*, a 2013 film about three children in Massachusetts’ child welfare system. She has also become a source for journalists from the *Boston Globe* and local television stations.

“We need to think about nontraditional ways we can contribute and put our services to use,” says Jackman. “That’s the new model—to go where we haven’t gone before and find new territory to explore.”

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**Moving beyond Private Practice**

When Charmain F. Jackman, PhD, works with psychologists interested in launching private practices, one of her key messages is to not put all their eggs in the practice basket. “It’s important to look at diversified streams of income and not be overly reliant on reimbursement from insurance,” says Jackman. Fortunately, she says, psychology training—which includes clinical work, research and writing—prepares psychologists to take on multiple roles. And, she adds, “psychology can be applied to any field.”

Jackman offers these tips to psychologists interested in bringing their skills into innovative new venues:

- **Create your niche.** “Be open to new ideas and think about how you can use your special skills,” says Jackman. Many psychologists have careers in other fields before becoming psychologists, for example, which could lead to opportunities to apply psychology in new ways. Also think about what interests you outside of work, such as a running club or creative hobbies, and how you might bring psychology to bear on those areas.

- **Promote your brand.** Get out of your office, meet a wide variety of people and follow up with people you meet, says Jackman, noting that some of the connections she has made have approached her with opportunities years later. “I would never have anticipated where they would lead,” she says. “Networking may seem terrifying to some psychologists, but it is a necessary part of your business strategy.”

- **Set goals.** Do what you tell your clients to do, says Jackman. That means setting a goal, creating action steps toward reaching that goal and enlisted accountability partners who will keep you on track. “Post the goal where you’ll see it every day,” she says.

- **Be persistent.** New opportunities often take time to materialize, says Jackman. But don’t be discouraged, she says. “Don’t take the first or second no; keep pursuing it,” she says. “If there’s something you’re interested in, just go after it.”

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About 600,000 veterans die in the United States each year, amounting to one in four American deaths, according to Scott T. Shreve, DO, the Department of Veterans Affairs (VA) National Director of Hospice and Palliative Care. One-third of veterans are enrolled in the VA medical system and, Shreve adds, more veterans die in VA hospice beds each year than in all VA intensive and acute care beds combined.

Under Shreve’s direction, the VA has dramatically increased its investment in hospice and palliative care. Palliative care can begin at the time of diagnosis and treatment for the illness. Hospice care begins when treatment has stopped, and the patient is typically told they have about six months left to live.

Importantly, the VA’s investment in end-of-life care includes mental health. There is a mental health provider—often a psychologist—on every hospice and palliative care team in the country. “These are interdisciplinary teams. Mental health providers in general are so needed in the VA system, but psychologists in particular are our go-to people in helping, for instance, to treat post-traumatic stress symptoms manifesting at the end of life,” Shreve says.

Shreve’s example is just one of the many important clinical and interprofessional roles psychologists play on hospice and palliative care teams. Psychologists also address veterans’ often-complex comorbidities, provide evaluations and consultations on an array of mental health concerns, and facilitate conversations with veterans and family members about goals of care and end-of-life decision-making.

Outside the VA, in the fee-for-service world, it can be difficult for psychologists to participate in this type of integrated, holistic care, says Michele Karel, PhD, a board-certified clinical geropsychologist who serves as Psychogeriatrics Coordinator in the Office of Mental Health and Suicide Prevention in VA Central Office.

That holistic care necessarily extends to the end of a veteran’s life. “We owe our veterans a dignified, comfortable end-of-life experience consistent with their goals and values,” Karel says.

**Life and death in the day-to-day**

Veronica Shead, PhD, is a clinical psychologist in hospice and palliative care in the VA St. Louis Health Care System. She treats veterans with advanced illnesses in inpatient and outpatient settings on a team that includes two physicians, a nurse practitioner, a social worker and a chaplain.

“Our primary goal is symptom management. That can entail non-pharmacological, behavioral and other psychological interventions to help veterans cope with a range of symptoms, from pain and nausea to anxiety and depression,” Shead says. “We take a bio-psycho-social-spiritual approach to care.”

As a psychologist, a significant amount of Shead’s work also involves assessment, communication and support.

“I work to elicit the veteran’s values—what do they want; what drives them; what should direct their end-of-life care?” she says. That can be a challenging task if the veteran’s cognitive status is compromised by delirium or dementia, but Shead works to assess the veteran’s capacity for decision-making, to understand the veteran’s wishes—often in partnership with their family—and to help convey those wishes to medical staff.

Shead also helps veterans and their families cope with anticipatory and pressing grief.

“Facing illness and death can bring up past losses, and ill veterans are also grieving their own functional losses. Loss of independence and

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“We owe our veterans a dignified, comfortable end-of-life experience consistent with their goals and values”

— Michele Karel, PhD

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**About 600,000 veterans die in the United States each year, amounting to one in four American deaths.**
control can be extremely difficult for them,” Shead says.

Sometimes, these emotions are compounded by anxiety, depression, post-traumatic stress and other serious mental health issues which may or may not be connected to their service.

“Military and related trauma experiences may impact the end-of-life process, which requires special attention,” Shead says.

The VA also acknowledges that many veterans—particularly those who are elderly, disabled or have life-limiting illnesses—prefer to receive care in their homes. That’s where VA Home-Based Primary Care (HBPC), which often has a palliative component, comes in.

Chris Heaney, PsyD, is a staff clinical psychologist at the VA Nebraska-Western Iowa Health Care System in Omaha. He works on an interdisciplinary HBPC team and has an additional role with a palliative care team at the VA facility.

“HBPC is often, in essence, palliative care, which can begin the moment the diagnosis of a debilitating illness is made,” he says. “We try to relieve symptoms, address pain and improve quality of life.”

Like Shead, Heaney performs specialized assessments and psychotherapy when cognitive or mental health issues are apparent. He also performs behavioral interventions, provides caregiver support, and helps terminally ill veterans determine meaningful treatment goals.

“Veterans can teach us so much about post-traumatic growth,” he says. “When given the opportunity to talk about how they got through traumatic experiences—like combat or the loss of a spouse—we can often apply that to what they’re facing now.”

Shreve, Karel, Shead and Heaney all say they find their work to be singularly rewarding.

“Terminally ill veterans have to directly confront the reality of death, which most people avoid thinking about. They remind us that our time is limited,” Heaney says. “And that brings a real urgency and authenticity to the work.”

Shead agrees, saying that for her, there is nothing more powerful than providing peace and comfort to those in grief. However, she finds it disappointing that mental health-integrated hospice and palliative care services aren’t accessible to everyone in the community beyond the VA.

“Many of our loved ones don’t receive the same level of care that veterans do, because comprehensive, interprofessional care that’s inclusive of psychologists just isn’t widely available,” she says.

But Heaney, meanwhile, is optimistic that the VA’s commitment to interdisciplinary care, and its embrace of psychologists, will spread to the private sector.

“The trend will grow,” he says. “The VA demonstrates how beneficial it is, both for the patient and for health systems, when interdisciplinary teams collaborate on holistic, life-affirming treatment.”
Practitioners who have been found in violation of the HIPAA Security Rule after a breach has occurred have sometimes had to pay several thousand dollars in fines and notify several hundred patients.

**Implementation/documentation**

Once you have completed your risk analysis and considered the different options to take to best protect your practice, you must document thoroughly. When drafting your Security Rule compliance plan, you should show:

- the areas of risk you identified;
- the security measures you considered; and
- the final decision you made that will allow you to best protect your practice.

The process of analyzing the risks to your practice will be an ongoing one. The Security Rule does not spell out how often practitioners need to update the security measures, but it does say it should be done “as needed.” The frequency of updating your security rule compliance plan will vary with the size of your practice and your risks. Practices with greater risks and resources may do this annually.

Some events would trigger the update of your risk analysis:

- one or more security breaches;
- adding new or more technology to your practice;
- disposing of any device, technology or a significant volume of files; or
- insufficient security measures.

**What are the risks of non-compliance?**

Not complying with the Security Rule increases the risk of a security breach. Protected health information could be hacked, stolen or lost. We believe that security breaches—which trigger your obligation to notify patients and HHS—are how most practitioners’ HIPAA problems come to light. Breaches often result in HHS conducting a comprehensive review of other aspects of a practice’s HIPAA compliance. Finally, breaches affecting more than 500 patients put the practitioner’s name on HHS’s published list—known as the “Wall of Shame” to members of the health care industry—where HHS lists practitioners who have suffered large security breaches.

In addition to breaches, a psychologist’s lack of Security Rule compliance can be revealed through complaints by patients to HHS and HHS audits.

**Audits.** The HHS Office for Civil Rights began ramping up audits last year and enforcement actions have continued this year. Some of these audits are random—practitioners are “picked out of a hat.” Some of the audits may be more selective, where a practitioner is chosen from a group of practitioners who have reported a past breach.

**Fines.** The *minimum* HIPAA fine increases depending on whether the practitioner knew they were out of compliance and whether he/she promptly took steps to fix it.

Practitioners who make no attempt to comply with the Security Rule open themselves up for the highest penalties: a minimum penalty of $50,000 per violation.

HHS has levied large multi-million-dollar HIPAA fines under presidential administrations that are viewed as pro-consumer, and administrations that are viewed as pro-business and anti-regulation. HHS has also levied fines against both large and small practices. Fortunately, HHS also has discretion to waive the HIPAA fine, and instead educate the practitioner who violated the law on proper Security Rule compliance.

**Still not sure if your practice is Security Rule compliant?**

The Office of the National Coordinator for Health Information Technology offers a free risk assessment tool at healthit.gov/providers-professionals/security-risk-assessment-tool for healthcare providers who want to assess their federal compliance.

Sherry Delaney contributed to this article.
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A Psychologist’s Role in Providing Letters for Emotional Support Animals  continued from page 9

always realize that a diagnosis will be part of their health record that may have to be disclosed in certain instances (for example, if applying for a life insurance policy or certain jobs). The person will have to sign an appropriate informed consent form, and understand that if he or she shares the letter with an airline or landlord, they are revealing health information.

If the person’s sole reason for a visit to your office is to secure a letter for an ESA, and not to obtain treatment, you will want to take steps to manage the person’s expectations. You may want to prepare the person that the results of an evaluation may not render a diagnosis to support their petition for an ESA, which means you will not be able to provide the letter. If the person wishes to proceed, you can conduct the appropriate testing or evaluation to make the diagnosis, if one can be made. If a diagnosis is rendered that you believe requires follow up, you may then want to refer the person to another provider for treatment.

Risk management considerations

If you are thinking of writing a letter for a patient, you should take steps to mitigate potential risk. Some of these steps include:

1. Limit the letter to fit the exact need. If the patient wants to fly with his dog, for example, state that the purpose of the letter is to allow the patient to fly with the dog for a specified trip.
2. Base the letter on your diagnosis, clinical impressions, the patient’s self-report and research to support the efficacy of animal companionship.
3. You may want to indicate any limitations to the evaluation (for example, any test you did not do).
4. Be prepared to defend this position if the patient ends up suing the landlord or airline for not accepting the letter.

If you decide you don’t want to offer your patients the service of writing letters like this, you should update your policy and intake forms to reflect this position.

ESAs serve an important role for people who need comfort and companionship. If you have questions or concerns about whether to provide a letter of support, contact Legal and Regulatory Affairs at praclegal@apa.org.

Legal issues are complex and highly fact-specific and state-specific. They require legal expertise that cannot be provided in this article. Moreover, APA/PO attorneys do not, and cannot, provide legal advice to our membership or state associations. The information in this article does not constitute and should not be relied upon as legal advice, and should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions.

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provide that data after ASPPB launches it in January 2020.

“The EPPP Part Two may give us a more objective way to measure whether graduates have the requisite skills for entry into practice,” he says. “But until we have that data, ASPPB’s position is that the postdoc requirement is in place for the protection of the public.”

Mardi F. Allen, PhD, former ASPPB president and current consultant to the Mississippi Board of Psychology, shares Siegel’s view. “The comparative study of candidate scores on the EPPP Part Two will provide statistical data for making a more informed decision,” she says.

Another major concern with changing the requirements, as noted in Lutz’s 2014 article, is mobility. Psychologists who haven’t completed a postdoc will face challenges getting licensed in states that require it, said Siegel.

He advises graduates with the option of forgoing a postdoc to weigh immediate flexibility versus future mobility. “If there is even a one percent chance you might one day move to a state that requires it, it’s in your best interests to complete postdoc before licensure, if you can,” he says.

Siegel and Allen’s views reflect the generally more cautious approach taken by state licensure boards compared to that of state associations.

“Board members understand the outside pressures on the profession and daunting encroachments by other providers as they compete in the marketplace,” Allen says. “However, upon appointment, they must distance themselves from a professional enhancement agenda and focus explicitly on the sole priority of the protection of the public being served.”

While applicants weigh whether postdoctoral hours will be important to their current and future practices, many states have a choice to make, too, relative to licensure laws. APA’s Office on Early Career Psychologists is supporting changemakers with a toolkit and a grant for state psychological associations willing to work on this issue.

Says Eddy Ameen, PhD, director of that office: “We believe the postdoc is important for specialization, but not entry to independent practice. There’s no logical reason why specialty trainees cannot be licensed.”
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CAPP members are elected by members of the APA Practice Organization to serve a three-year term. Committee members are licensed psychologists who belong to the APA Practice Organization and a state, provincial or territorial psychological association or an APA division. CAPP also includes a graduate student and up to four appointed members.

Nominations to CAPP for 2019 are being accepted through March 2018. To learn how to submit a nomination, visit apapracticecentral.org. Elections will be held between September 1 and September 30, 2018, and new members will be announced in the fall.

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