CBD in Practice
What Psychologists Need to Know

Practitioners Who Offer More Than Psychotherapy
Page 8

Get More of Your Claims Accepted
Page 12

Treating Chronic Pain
Page 22
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CONTENTS

LEGAL AND REGULATORY ISSUES
2   APA Seeks to Accredit Master’s Programs
26  Thinking of Retirement?

LET’S GET TECHNICAL
4   Practice Management Software

TRENDS AND OPPORTUNITIES
8   Offering More Than Psychotherapy
14  How to Make Your Practice Green
18  CBD in Practice: What Psychologists Need to Know

REIMBURSEMENT
12  Claim Accepted

PRACTITIONER PROFILES
22  Treating Chronic Pain
APA SEeks TO ACCREDIT Psychology Master’s Programs

Increasing demand for psychological services and other factors have led APA to create competencies and offer accreditation to master’s-level psychology programs, just as it does for doctoral-level programs

BY STACEY Larson, JD, PsyD

APA policy states that the doctorate is the minimum level of education required for entry into professional practice as a psychologist. But several factors—including the need to expand access to mental health care, concerns about current standards for accrediting master’s-level psychology programs and the scope of practice for master’s-level practitioners—have prompted APA to re-examine its stance on accrediting master’s programs.

APA is the only psychology program accreditor recognized by the U.S. Department of Education. APA only accredits doctoral psychology programs, internships and postdoctoral programs, although it has developed national standards for high school psychology curricula as well as guidelines for the undergraduate psychology major, core competencies for interprofessional collaborative practice for doctoral-level health service psychology (HSP) and standards for providers of continuing education.

Many master’s programs in psychology are not accredited. The Masters in Psychology and Counseling Accreditation Council (MPCAC)—which is not a federally recognized accreditor—is the only organization that accredits master’s-level clinical and counseling psychology programs. There are more than 30 accredited programs.

Cathi Grus, PhD, APA’s acting chief education officer, says accrediting master’s programs would help APA close a gap in the psychology training spectrum and ensure that students graduating from those programs have the knowledge, skills and attitudes needed for professional practice. “Accreditation provides quality assurance for students and is part of protecting the public by ensuring students are trained in programs that meet standards set by the profession,” Grus says.

To continue promoting quality and excellence in education and training across all levels of education, in 2018 APA’s Council of Representatives approved a motion to pursue the accreditation of HSP master’s-level programs, which include clinical, counseling and school psychology. Competencies for these programs are now being developed.

“Developing competencies for these programs and accrediting them could increase the numbers of clinicians trained in the science of psychology practice at the master’s level and increase access to psychological services for consumers,” says Lynn Bufka, PhD, APA’s senior director for practice research and policy.

A PUSH FOR APA INVOLVEMENT

One issue that’s driving APA to accredit master’s programs is the changes to the standards used by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) to accredit master’s-level counseling programs. In 2013, CACREP began to require counseling program faculty to have doctoral degrees in counselor education, not psychology. As a result, some counseling psychology master’s programs were forced to close, resulting in a smaller pool of future clinicians available to provide services. Other programs ended up replacing most of their psychology faculty members.

“CACREP standards have affected who we can hire,” says Jesse Owen, PhD, a professor in the University of Denver (DU) counseling psychology department. “Our counseling psychology folks have been training master’s-level counselors for decades, so it seems odd to have an accreditation body that excludes an interdisciplinary approach to training.”

These types of changes in accreditation standards affect the makeup of graduate program faculty as well as licensing regulations. State licensing boards rely on outside organizations, such as MPCAC and CACREP, to develop standards for education and training leading to licensure for master’s-level providers of psychological services.

“CACREP now has more accredited programs than APA does,” says Owen, who along with several other psychologists, faculty and staff from DU is a member of the DU Licensure Task Force, chaired by Lynett Henderson Metzger, JD, PsyD, a clinical associate professor and assistant director of DU’s master’s in forensic psychology program.

“Scope of practice is directly tied to
how powerful these accreditation bodies are at the national level and the state level, and they can have a major influence on insurance companies and state licensure boards,” says Owen.

In line with APA’s stance on accreditation of doctoral programs, APA’s Model Act for State Licensure of Psychologists encourages state licensing boards to recognize the doctorate as the minimum educational requirement for providing professional services as a psychologist, but this is not the consensus at the state level. Currently, 34 states require practitioners to have a doctorate, while 17 states allow individuals with master’s degrees to practice independently or with supervision.

Many of these 17 states require graduates to have a master’s degree from a psychology program, or from a related field, to apply for licensure. However, there is no consistency in the scope of practice of master’s-trained providers or in the titles they use for themselves once licensed.

“The lack of defined competencies differentiating doctoral-level psychology programs from master’s-level programs combined with a lack of defined scope of practice and clear title distinction differentiating master’s and doctoral psychology providers have led to increased confusion among consumers,” says Deborah Baker, JD, APA’s director of legal and regulatory policy. For example, in West Virginia, master’s-level providers can refer to themselves as psychologists. In Kansas, independent master’s-level practitioners take the title of licensed clinical psychotherapist.

“Without clear delineations specifying the differences in training, title and scope of practice for a doctoral-level psychologist versus a master’s-level provider, people trying to access psychological services may be easily confused when trying to select the appropriate provider,” Baker adds.

For graduates applying for licensure as a professional counselor (LPC), several states now have policies requiring that they have master’s degrees from CACREP-accredited counseling programs. These statutes disenfranchise thousands of individuals with psychology master’s degrees, or degrees from programs not accredited by CACREP, from becoming licensed providers of mental health services. Data from APA’s Center for Workforce Studies show that 22 percent of people—more than 130,000 individuals—with a master’s degree in psychology worked as counselors in 2017. In addition, 15 percent of those with doctorates in psychology teach at postsecondary programs, including counseling programs.

“Master’s-level practitioners typically work with more underserved clients, often in specialized areas, so they are not necessarily competing head-to-head with psychologists for work,” says Henderson Metzger. “The idea of closing doors to practice seems antithetical to the idea of creating a qualified workforce to meet the unmet mental health needs of many marginalized groups.”

APA’s development of competencies for HSP master’s programs and its work to expand its accreditation standards will not change the state requirements for doctoral licensure, Bufka says, “and it will ensure that APA continues to maintain relevance in the field of psychology.”

Rehabilitation psychologist and APA council member Kim Gorgens, PhD, ABPP, adds that it’s important for APA to have a voice in master’s-level accreditation because this issue has major implications for practicing psychologists. “Psychologists’ job security is in APA having a voice and saying here are the competencies for professional practice at the doctoral level and here are competencies for professional practice at the master’s level,” says Gorgens. “If APA isn’t dictating the competencies required for master’s-level practice, someone else will.”

Others point out that accrediting master’s-level programs could also provide psychologists with a larger pool of candidates to train and mentor, helping psychologists fulfill supervision and consultation competencies. “Accrediting master’s programs allows for psychologists to expand on the competencies we already have to really be able to own them,” says Lavita Nadkarni, PhD, associate dean and director of forensic studies at DU.

In addition, APA accreditation would provide a path to accreditation for master’s-level psychology programs that cannot, or do not want to, pursue CACREP accreditation in counseling.

**APA ACTION**

In February 2019, an APA Board of Educational Affairs task force developed a blueprint for APA to follow in pursing accreditation of master’s programs in health service psychology.

Based on that blueprint, APA has formed a new task force to develop competencies for students in master’s-level health service psychology programs. The group plans to present their competencies to APA’s council in 2020. Bufka says that group will aim to differentiate the expected competencies of graduates with a master’s degree in health service psychology from those with a doctoral degree.

“APA will continue to monitor developments,” Grus says, “but members and students should also be on the alert for any potential changes introduced at the state level regarding licensure eligibility.”

Jewel Edwards-Ashman contributed to this report.

**Resources**

- Report of the BEA Task Force to Develop a Blueprint for APA Accreditation of Master’s Programs in Health Service Psychology. (2019).
The right practice management software can help a psychologist be more organized, efficient and even more appealing to clients. Software packages designed for mental and behavioral health offer resources for paperless practice, streamlined billing and invoicing, and secure and effective client communication. “Superior packages make it easy for practice owners to track key metrics and generate financial reports such as cash flow, productivity, outstanding payments, insurance aging and accounts receivable ... all essential to the financial health and growth of any practice,” notes Charmain Jackman, PhD.

Our panel of psychologists share their ratings and reviews of three practice management software packages that practitioners may wish to consider for streamlining their practice administration.

Software was reviewed in June 2019. This article has been edited for length. Visit APAServices.org for more information on the privacy and security risks, evidence base, cost, business models and user feedback associated with each app.

Let’s Get Technical is a column that discusses various software and applications available to psychologists for their professional use. The views expressed in this column are the views of the authors and do not reflect the views of the American Psychological Association or any of its divisions or subunits. All authors have no financial interests in the apps or software discussed. APA does not recommend or endorse any practitioners, products, procedures, opinions or other information that may be mentioned in this column; those who use these applications or products do so at their own risk. Please direct updates and feedback about apps to Communications Office Staff (ncomings-fonner@apa.org).

PSYCHOLOGIST REVIEW PANEL

Kristi K. Phillips, PsyD, is a licensed psychologist and health service provider in Minnesota. She also serves on APA’s Committee on Rural Health. Phillips is dedicated to the removal of barriers to comprehensive health care within rural and remote areas, and she has found that utilizing smartphone-based mental health apps within her practice along with other tools can be helpful for her patients to self-manage mental health symptoms between sessions.

JoAnna Romero Cartaya, PhD, is a licensed psychologist and health service provider in Iowa and is the owner of the Cartaya Clinic in Humanistic and Behavioral Psychology PLLC, housed at Virtue Medicine, P.C. Cartaya is also an adjunct associate professor at the University of Iowa Hospitals and Clinics in the department of psychiatry. Cartaya is an active member of the Iowa Psychological Association (IPA) and has a specific interest in the integration of technology in clinical practice and ethical considerations.

Charmain F. Jackman, PhD, is a licensed psychologist with a doctoral degree in counseling psychology from the University of Southern Mississippi. Jackman is the founder and CEO of Innovative Psychological Services (InnoPsych), a thriving solo practice in the Boston metro area. She also offers business development coaching and marketing support to clinicians who are poised to launch or grow their private practices.

Kevin D. Arnold, PhD, ABPP, is a psychologist who is board certified in behavioral and cognitive psychology. He serves on the boards of several organizations and is an APA fellow. He is the founder and president/CEO of the Center for Cognitive and Behavioral Therapy in Columbus, Ohio, a large group practice that specializes in cognitive-behavioral therapy and co-locating in primary-care offices. Arnold has served as the president of the Ohio Psychological Association and the Ohio Board of Psychology, as well as in other national organizations.
SimplePractice is a cloud-based practice management software designed for health and wellness professionals. The software offers a client portal for appointment booking, secure messaging, custom paperless intake forms and progress notes, electronic claim filing, a template library, free appointment reminders (SMS text, voicemail or email), billing and invoicing, and integrated telehealth capabilities.

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**Kристи K. Phillips, PsyD**
I would recommend the SimplePractice platform to other psychologists. I was very impressed with the privacy and security, extensive features, ease of use and the functionality that makes the software ideal for providing a psychologist in private practice most everything they might need to run the business side of their practice. I think that SimplePractice could be even more effective if they hired trained customer service staff to answer questions regarding the use of the software.

**Kevin D. Arnold, PhD, ABPP**
SimplePractice offers an online subscription-based office management, electronic health record and billing/payment software that provides more than required precautions to protect the privacy of the data. The platform has all the features a practice would normally need. For the cost, this software is more than adequately functional for groups or individual offices unless integrated into primary care, where interoperability is usually necessary. There were some confusing aspects to the features when corresponding with the customer service office compared to the company’s website. Overall, though, the software seems well suited to psychologists; however, when migrating data, one would be well-served to be certain of what data will transfer and any costs associated with cleaning the data set once migrated.
TherapyNotes is a cloud-based electronic health record (EHR), practice management and billing software designed for mental health professionals. The software can be used for appointment scheduling (by office staff or through a patient portal), to document session notes, and to update client records, and to create and submit insurance claims.

JOANNA ROMERO CARTAYA, PhD
TherapyNotes is a visually pleasant software with good security measures. It provides multiple integrated functions and ways to customize its use based on roles or practice features; however, it does not include all services that a psychologist may provide. As TherapyNotes is web-based, if there is an issue with their servers or the user’s internet, the software cannot be used. TherapyNotes provides good unlimited phone support as well as online resources. Larger practices or clinicians who want a one-stop shop for all their practice needs may find the cost reasonable and the software easier to use as current third-party companies are integrated within the software rather than contracting with multiple companies.

CHARMAIN F. JACKMAN, PhD
TherapyNotes provides a simple, straightforward platform for clinicians and group practice. The software is web-based and requires an internet connection. The software is HIPAA compliant and includes a BAA for providers. It has all the needed components for clinical documentation, billing, appointment management and some basic revenue and financial reports. You have a free 30-day trial and you can start using the platform immediately. Customer support is available in English and Spanish. TherapyNotes provides a great value and offers reduced fee structures for nonprofits and educational/training settings. I have been using TherapyNotes for two years and have been satisfied with it.

Valant offers a fully integrated suite of behavioral health management tools for providers including certified EHR with secure patient portal, streamlined intake forms, robust reporting for productivity and revenue cycle, and a library of automatically scored outcome measures.

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CHARMAIN F. JACKMAN, PhD *
Valant goes above and beyond with the features it offers. The financial and productivity reports are excellent and allow practitioners to understand how the business is doing from a financial perspective. The screening tools cut down on wait time in the office as patients can complete forms at home. The ability to track patient outcomes gives providers data they can use to negotiate better reimbursement rates. One drawback of the Valant platform is the outdated user interface. However, Valant is scheduled to have an update within the next six months. Valant is ideally suited for group practices and large enterprises. Solo practitioners, especially those interested in understanding their productivity and other financial metrics should weigh the benefits versus costs for their practice of this pricier platform.

*Jackman was only able to access and navigate the Valant platform with the support of a team member.

KEVIN D. ARNOLD, PhD, ABPP
I strongly recommend Valant practice management software. The developers have created an online subscription-based office management, electronic health record and billing/payment software that takes excellent precautions to protect the privacy of the data. Valant is easily navigated in the desktop mode with intuitive sidebar menus and an option to enter the user-friendly mobile notes version. Overall, Valant performs well most of the time; however, there are periods when it is not available for access as it is web-based. For the cost, this software is highly functional for groups or individual offices. The company states it is close to releasing an updated software. Early reports from a pilot site are that it operates even better than the current version.
APA is currently seeking proposals for CE workshops and APA 2020 sessions. Are you a practitioner and subject matter expert with ideas or applications to share, and a speaker who can connect with an audience? Then we want to hear from you!

ALL SUBMISSIONS MUST BE COMPLETED ONLINE.
Visit convention.apa.org/proposals to get started.
An increasing number of practitioners are incorporating yoga, meditation or other mind-body therapies into their practices. Here’s how you can, too.

BY TORI DEANGELIS

In 2008, Mitchell Greene, PhD, took a risk that paid off: launching a sport psychology practice in Haverford, Pennsylvania, to fuel a longtime passion for sports. Today, about 80% of his clientele at Greenepsych are either athletes, coaches or both. His work includes speaking engagements and consulting gigs, and his income is about 15% higher than it was when he practiced traditional clinical psychology.

Last year, Greene took another leap: adding holistic services, such as yoga and mindfulness, to his practice.

“The word ‘wellness’ kept floating through my mind, and I thought, ‘Why not have someone in my practice who could integrate holistic services into what I’m already doing?’” he says. While the thought was inconceivable to him five years ago, “now these modalities seem to fit under my umbrella,” he says. His practice now includes a yoga instructor and mindfulness coach, as well as a psychology doctoral student with a master’s degree in kinesiology and training in mindfulness techniques.
Greene is among a growing number of psychologists who are beginning to incorporate such services into their practices. Conceptually, the move makes sense—after all, integrating mind and body is a key tenet of psychological health. But you need adequate planning; a good understanding of the legal, ethical and regulatory issues involved; the right people and sufficient capital to achieve success.

As a veteran consultant to psychologists interested in launching a niche practice, Jeff Zimmerman, PhD, ABPP, has seen his share of new-business successes and snafus, especially when they involve an idealistic concept like a wellness practice. “What tends to happen is that [interested providers] get to know each other and say, ‘Wow, this is a great idea. Let’s do it,’” he says. “However, they don’t really think through the possible ways it could go wrong.”

To avoid potential pitfalls and to reap the benefits of running your own wellness practice, consider these tips from practice consultants and seasoned practice owners.

Consult with the right experts. First, meet with an attorney who is versed in your state’s corporate statutes and mental health laws. An attorney can help determine whether your state allows you to pursue the kind of practice you have in mind, says Connie Galietti, JD, APA’s director of legal and professional affairs. Several states, for example, only allow psychologists to co-own a practice or incorporate with other mental health professionals. In Alabama, for instance, professional corporations can be organized “only for the purpose of rendering professional services ... within a single profession.” Other states are more lenient but have varying stipulations, she says.

Even if your state allows you to include other practitioners as part of your business, “consider starting with a less formal collaboration,” Galietti adds. This will help to ensure that all parties are comfortable with your practice and partnership plans before you formalize a business relationship.

Once you are clear what’s allowed in your state, consider meeting with an experienced practice consultant who understands the mental health field and the nature of your potential business, Zimmerman notes. A consultant can help you develop your practice vision and strategy, he says, including your business model, record-keeping and management, billing, ideal partners, structure for decision-making and governance, and how you will fund your enterprise.

“You need to work with someone who can help you do the planning on the front end—who can help you figure out the basis of your relationship as potential business partners and the principles and practices you’ll follow,” he says.

Over time, these professionals can help you grow and refine the concept of your organization clinically, administratively and financially, Zimmerman adds. Consultants can help you consider future contingencies—for example, determining staff benefits, or how to handle payment if one partner makes considerably more or less than others—and be on call if problems or questions emerge. For further help in some of these areas, visit Apaservices.org, which includes information on alternative practice models, practice management, marketing, financial management and more.

Choose a role and a structure that you (and others) are comfortable with. Do you want to be the leader of your practice or a co-owner? Have a full-time staff, hire independent contractors or both? Be a sole proprietor, a general partner, a corporation, an independent practice organization or something else? Address all of these questions in the beginning, advisers say. (See the APA article, “Choosing the Best Legal Structure for Your Practice,” at on.apa.org/practice-legal-structure for more on this topic.)

Greene has developed a system that works well for him. He is full owner of Greenepsych, employing independent contractors who receive a percentage of what they bring in without paying rent. He also meets monthly with a billing manager who keeps track of client payments and follows up as necessary.

Andrew Tatarsky, PhD, founder and owner of the Center for Optimal Living, an addiction treatment center and professional corporation in New York, employs a mix of salaried providers and independent contractors, including 11 psychotherapists, a Chinese medicine practitioner and practitioners versed in yoga and meditation.

**Holistic Specialties**

*These are some holistic services you may want to consider when building a wellness practice.*

- **Meditation**
- **Massage**
- **Mindfulness**
- **Kinesiology**
- **Acupuncture/Acupressure**
He became sole owner of his business after an unsuccessful attempt to work with partners. “I’ve come to learn that I operate best when I’m the leader, but I bring in a whole team of people who can actively collaborate in developing ideas, materials and programs,” he says.

Choose your colleagues carefully. While credentialing is standardized for psychology, that is not the case for complementary and alternative practitioners: Some are licensed, some are certified and some are neither. As a result, choose providers in these domains carefully, advises Pauline Wallin, PhD, a clinical psychologist in Camp Hill, Pennsylvania, and co-founder with Zimmerman of The Practice Institute, a behavioral health consulting firm. Your practice may be liable for the actions of others and your reputation may suffer as a result.

“If you have a practitioner who’s doing some really fringy stuff—that is not well supported by evidence but is being popularized by some celebrity—things can go bad really quickly,” she says. An extreme example is a 10-year-old girl who died in 2000 after being smothered during a “rebirthing,” a dubious treatment for attachment disorder.

“You want to make sure that the people you’re working with are well respected by their peers,” she says, “because they’ll be part of the face that your practice presents.”

Also important? Getting your attorney’s input on issues related to informed consent and privacy, Wallin says. For example, ask holistic practitioners to create and use their own informed consent forms that do not implicate you in the effects of their treatments. In addition, make sure that the other practitioners will not create issues or liability for you under the Health Insurance Portability and Accountability Act (HIPAA) privacy or security rules—something your attorney can help to address. Another good move is consulting with your malpractice insurance provider to make sure your policy applies to services beyond psychology, as well as to contractors or employees who may not be licensed, Galietti advises.

More generally, choose your staff with the health of the whole organization in mind, Tatarsky says.

“If the team isn’t really working together—if the chemistry isn’t right, the communication isn’t right, the culture isn’t one that everybody feels a part of—that becomes a real problem,” he says. “So, it’s important to be really clear about your vision and the people that you invite to be part of it.” In fact, colleague dynamics are another reason to consider practicing together informally for a while before creating a combined legal entity, Galietti notes.

Target your marketing. Gear your marketing efforts toward potential clients who are already inclined toward integrative approaches, Wallin suggests.

“Rather than trying to convince the general population that these services are good for them,” she says, “target your promotion, marketing and messaging to people who are already invested in wellness.” For example, tap owners of health food stores, members of gyms and physicians who see patients who might be interested in these services. “Such people already appreciate the value of wellness, and are more likely to pay for professional wellness services,” she says.

College students are a big part of Tatarsky’s practice because there’s an abundance of colleges and universities in New York, and students tend to be interested in integrative approaches and many have insurance that pays for addiction-related services. As a result, he has developed a referral network with New York University, The New School and other area institutions, which also serve as training pipelines for his center, he says.

Meanwhile, Greene chose the greater Philadelphia area because of its access to college-prep schools. “There are a lot of high schools in the area and a lot of competitive parents with competitive kids who are aiming for college scholarships,” he says. “It’s a prime location to do the kind of work that I do.” As he launches the wellness aspects of his practice, he’s finding that athletes enjoy adding them to their therapy and coaching work, thanks to their physical nature.

Manage your time wisely. Before offering these different services, decide how you will keep and share records, deal with net losses or gains, compensate staff and contractors and address other practical aspects of business management. Wallin is a big fan of hiring others who can do certain aspects of the job better and less expensively than you.

“Outsource noncontroversial roles like bookkeeping and reception so that you’re using your professional time to organize, reach out, promote your practice—the big-picture stuff,” she says.

As Tatarsky’s business has grown, techniques like these have made a huge difference in his ability to manage his workload, he says.

“I’ve put a lot of attention into goal-setting, limit-setting, self-care, being able to say no, being able to delegate—to really manage myself in the midst of growing interest and success and growth,” he says. He also meets regularly with leaders of similar businesses in order to tap their expertise and experience.

With advance planning, a strong vision and input from others, a wellness-oriented practice can be a meaningful new direction for some psychologists.

“It’s a leap of faith,” he says, “but if you really believe in it—if you really think the community needs it—I think it’s a leap worth taking.”
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Advice for smoother billing and fewer rejected claims

Getting reimbursed for services can be a complex task. Not only do practicing psychologists have to wade through the varying third-party payer plans that cover their patients, they also must determine which health-care service and diagnosis codes they should bill under. As a result, practitioners are bound to make a few mistakes when submitting claims for reimbursement. The chart below lists some of the most common mistakes psychologists make and how to prevent them.

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<td>Putting the wrong provider, patient or third-party payer information on your claim form</td>
<td>Mistakes happen, and so do typos, misspelled names and incorrect addresses. Sometimes the wrong information can end up on a claim form because it is written or typed in wrong from the start and then scanned onto the claim form from your computer.</td>
<td>Double check and reread everything before you submit a claim. Pay close attention to birthdays, addresses and names. Keep in mind that submitting the wrong patient name on a claim form may trigger your reporting obligations under the Health Insurance Portability and Accountability Act (HIPAA) breach notification rule.</td>
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<td>Applying the wrong CPT® code to a service</td>
<td>Using the wrong CPT® code is usually the result of writing the wrong code number or wrong combination of numbers. CPT® codes can also change, and new codes can be created for services. If you aren’t aware of those changes, you could mistakenly use old or incorrect codes.</td>
<td>Watch for any changes or updates to CPT® codes relevant to psychologists. You can read APA’s bimonthly PracticeUpdate newsletter for the information on changes to billing codes. Each January, the Centers for Medicare and Medicaid Services publishes billing codes and values for health-care services in the Physician Fee Schedule, available at CMS.gov. Every fall, the American Medical Association publishes new and updated codes in the CPT® Professional Edition coding manual.</td>
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<td>Using the wrong combination of CPT® codes and International Classification of Diseases (ICD) diagnosis codes for a service you provide.</td>
<td>H&amp;B codes are a specific set of CPT® codes that apply to psychological services that address behavioral, social and psychophysiological conditions in the treatment or management of patients diagnosed with physical health problems. When you bill for H&amp;B codes, you are also required to use an ICD code that corresponds to a physical health diagnosis. A mental health condition cannot be the primary diagnosis for providing an H&amp;B service.</td>
<td>To use H&amp;B codes, you need to find out which physical health diagnosis the patient was given from the physician. Ask for a copy of the patient’s diagnosis from the physician who provided the physical health diagnosis. Use the diagnosis code that they provide as the reason for performing an H&amp;B service: You are helping the patient deal with a physical health diagnosis they received from the physician. Your services may include evaluation of the patient’s responses to disease, illness or injury; patient adherence to medical treatment; coping strategies; removal of psychological barriers to recovery; and promotion of functional improvement.</td>
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<tr>
<td>Using an incorrect ICD diagnosis code on the claim form</td>
<td>ICD diagnosis codes are usually longer than CPT® codes, so errors may be the result of missing or incorrect numbers. Practitioners should also be mindful that third-party payers, including Medicare, may not accept all ICD codes. For example, dementia has several ICD codes that correspond to that diagnosis, and not all insurance companies accept every code.</td>
<td>Contact the payer or visit their website and obtain a copy of their coverage policy to find out which ICD codes they will reimburse.</td>
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<tr>
<td>Using a code with a description that does not match the service you provided. For example, incorrectly billing the 30-minute CPT® code for a 39-minute session with a patient, instead of using the 45-minute code.</td>
<td>This is a common error with time-based services, or services that have a specific time stated in the code descriptor. Often, the mistake is due to confusion over the “CPT® time rule.” The rule states that “a unit of time is attained when the midpoint is passed.” For example, an hour of service time is attained when 31 minutes have elapsed.</td>
<td>Choose the CPT® code closest to the actual time of the service you provide. For example, under the CPT® time rule, if you provide 16 to 37 minutes of psychotherapy, bill 90832 (the 30-minute code). If you provide 38 to 52 minutes of psychotherapy, bill 90834 (the 45-minute code). Keep in mind that some companies have policies that restrict or discourage the use of the 60-minute code.</td>
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<tr>
<td>Submitting a claim late</td>
<td>Late claims submissions can be the result of simply being unaware of a payer’s deadlines and time limits on claims.</td>
<td>Contact the third-party payer to find out the deadlines and time limits for submitting patient claims. With Medicare, for example, you have one year from the date of service to submit the claim.</td>
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<td>Improperly calculating the number of units billed</td>
<td>This type of mistake usually happens when there are changes to codes and the way they are used, such as the changes to neuropsychological and psychological testing codes that took effect in 2019. Miscalculations also happen when billing multiple units of the same service. Some practitioners incorrectly round the amount of time up or down for each individual unit.</td>
<td>Review the CPT® code descriptor for the service you want to bill. For time-based services, the CPT® time rule (discussed above) will apply. When billing multiple units of the same service, combine all units of time per service before rounding up or down. For example, if you are billing several hours of test administration under 96136/37, combine all of the time under 96137 before rounding the number of units up or down. Calculating the proper number of units to be billed requires you to carefully document the time you spent performing each service and converting that time to the proper number of units billed on your claim form.</td>
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<tr>
<td>Incorrectly using base and add-on code pairs</td>
<td>You can report most procedures using a single code that describes the total service performed. However, in certain cases, you may have to report two or more codes to completely describe the service. For example, 96130 is a base code that is reported for the first hour of psychological testing evaluation services; but if you are performing evaluation services that go beyond 91 minutes, a second hour may be reported using the add-on code 96131.</td>
<td>Add-on codes can be billed only if the primary service, or base code, is also on the claim form. Add-on codes submitted without a base code will be denied. In addition, add-on codes will be denied if the corresponding base code is denied.</td>
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Visit the Practice section of APAServices.org for more information on getting reimbursed.
More than half (56%) of Americans say that legislators should prioritize protecting the environment and addressing climate change, according to data from the Pew Research Center. That’s an increase from a decade ago, when only 41% of Americans viewed climate change as a top issue. With a growing number of Americans worried about the effects of climate change, some psychologists are doing more than helping their patients cope with the anticipated changes: They are creating eco-friendly, or “green,” practices.

“For a practice to be green, it’s not about deprivation. It’s about living well as a positive contributor to the systems on which all life depends,” says conservation psychologist John Fraser, PhD, president and chief executive officer of Knology, a nonprofit transdisciplinary social science think tank. Fraser is also the past president of APA Div. 34 (Society for Environmental, Population and Conservation Psychology). “As psychologists, we are the best-equipped people to be self-aware. We can understand how and why we do something and how our actions influence others.”

Want to build your own cleaner and greener practice? Follow these six tips:

1. **DETERMINE WHY YOU WANT A GREEN PRACTICE**

   Before changing out all the light bulbs in your office to their energy-efficient counterparts, Thomas Doherty, PsyD, recommends identifying your environmental values and why it’s important to run a green practice. “People tend to rush to actions, but
TRENDS AND OPPORTUNITIES

SMALL CHANGES, BIG IMPACT

There are many ways to affect positive environmental change, and there are mental benefits that go with them.

Green spaces reduce stress levels and promote positive social interactions.

Physical commuting can reduce stress and other mental illnesses, as well as improve cognitive function and academic performance.

Public transportation invigorates community mental health by creating opportunities and networks to increase community cohesion.

Buildings that are certified green must take many factors into account, including water use, waste recycling, appliance energy consumption and even the type of paint used.

Some modes of transportation, while fuel efficient, have large carbon footprints, like air travel.

For an in-depth report on mental health and climate change, visit on.apa.org/practice-climate-change.

there’s a preconversation to have,“ says Doherty, a licensed psychologist who runs Sustainable Self, a practice in Portland, Oregon. “Your actions will change as you get more experience, and as technology changes and as the needs of the environment change. But your values will remain fairly stable through your life. Celebrate these and let them be your guide.”

Doherty says these three sets of values tend to influence people’s approach to protecting the environment:

» **Egocentric**: actions that benefit the individual, their family or inner circle;

» **Altruistic**: actions that benefit the health and well-being of people in the community;

» **Biocentric**: actions that improve nature and the global landscape.

2. **CONDUCT A “GREEN AUDIT”**

To help decide what you can change, Nancy Piotrowski, PhD, a San Francisco–based clinical and consultant psychologist, urges practitioners to consider the impact their practices have on the planet. What is your carbon footprint—the amount of carbon dioxide each person produces resulting from fossil fuel use in their daily life?

How do you get to work? Is your practice paperless? Are you recycling and can you do more? Is your office located in a building that uses green technologies and energies? Are you using energy efficient lighting?

3. **USE ELECTRONIC HEALTH RECORDS**

Electronic health records (EHRs) can dramatically reduce a practice’s paper trail—and some clients prefer it, Piotrowski says. With EHRs, you can keep all your patients’ clinical details in one place, track outcomes and share information with other providers. Many EHRs also help with practice management tasks, like billing and scheduling, without the added paperwork.

4. **MOVE YOUR OFFICE TO A GREEN BUILDING**

Use your rent and utilities payments to support green building programs. Leadership in Energy and Environmental Design (LEED), for example, is one of a number of internationally recognized rating systems that examine the green components of buildings. LEED buildings are rated for their performance in conserving...
resources and using energy efficiently. APA’s headquarters in Washington, D.C., received LEED certification in 2013.


Fraser says you can also select wind or solar suppliers for your energy utility.

5. LESSEN YOUR CARBON FOOTPRINT
Due to the nature of their work, most practicing psychologists probably have a low carbon footprint. Still, Doherty says, psychologists can be mindful of their travel. Doherty lives close to his office and limits his plane travel, for example.

Piotrowski encourages teleconferencing with colleagues instead of physical meetings.

“I know a lot of us are hooked on physical meetings. That has value, but I find that we spend a lot of money traveling, and there’s a higher carbon footprint with air travel. So, if I can do something with webinars and conference calls and electronic communications, I try to do that.”

She also provides psychological services via telephone or videoconferencing. “That’s another green savings because I’m not commuting, and I have a lot more control over my environment.”

6. SHOW AFFECTED COMMUNITIES HOW YOU CAN HELP
Psychology practitioners can also become more green by increasing their outreach to communities that may need help managing the trauma and anxiety related to environmental change, says Piotrowski, who lives near Napa Valley, where wildfires raged for weeks in 2017 and destroyed nearly 9,000 buildings.

“Psychologists don’t have to become an expert on every natural catastrophe, but you can learn about the potential impact on your clients,” says Piotrowski, who talks with people in her community about air quality monitoring, making good health decisions and managing anxiety when the air-quality is poor.

“People don’t know that they can talk to a psychologist about these issues,” she adds. “Psychologists can be green just by putting themselves in the right place and working with their community.”
Annabidiol, a chemical compound found in the cannabis plant, is springing up nationwide in the form of oils, salves, teas, edible concoctions and more. Popularly known as CBD, the substance is being touted as a cure for sleep disorders, anxiety, pain, epilepsy and even cancer.

CBD became more widely available in 2018, when Congress legalized the growing of hemp, the plant from which CBD is derived. As a result, more patients are asking their psychologists and other health-care providers about CBD, wondering whether they should try it to manage their sleep, anxiety, pain or other conditions. CBD products can easily be purchased online, in medical marijuana dispensaries and in specialty retail stores, including health food outlets and smoke shops, for example.

But the legal and regulatory status of CBD remains unclear. And research on the substance is limited and inconclusive, though larger randomized controlled trials are underway.

Given CBD’s status as a relatively unvetted substance, how should a psychologist proceed if a patient asks about its use? What’s in the patient’s best interests and within the scope of practice? Here’s some background and advice from the experts.

**WHAT DO WE KNOW ABOUT CBD?**

CBD is one of at least 113 chemical compounds, or cannabinoids, found in cannabis, a genus of flowering plants in the Cannabaceae family, which includes hemp and marijuana. There’s a fuzzy distinction...
between hemp and marijuana, since both are derived from the same plant species, but according to federal law:

» Legal CBD-containing products come from hemp, which federal law defines as any plant in the cannabis family containing less than 0.3% THC—tetrahydrocannabinol, the principal psychoactive component of cannabis.

» Marijuana is any cannabis plant containing more than 0.3% THC.

CBD doesn't have the same psychoactive properties as marijuana: Users don’t feel “stoned” when they use it. Instead, research suggests, CBD has mild calming effects. Emerging evidence finds that CBD may help with some health conditions, including chronic pain, inflammation, anxiety, multiple sclerosis and opioid cravings. Research also finds that CBD may interact with other medications, such as the blood thinner Coumadin, for example, and that it has potential side effects such as nausea, fatigue and irritability.

The effects of CBD vary according to dose and the mode of administration, so it is unclear which types and amounts of CBD work, how and for whom, says psychologist Ryan Vandrey, PhD, an associate professor of psychiatry and behavioral sciences at Johns Hopkins School of Medicine who studies the effects of cannabis.

“You have to treat CBD as a novel therapeutic and weigh the potential risks and benefits for each individual patient,” he says, “but at the same time recognize that there is growing evidence that it might be helpful for people with certain health conditions.”

To add to the uncertainty, the Food and Drug Administration (FDA) has not yet regulated CBD. At this point, topical products including oils and lotions are legally permissible. Foods and beverages containing CBD are still considered illegal, although manufacturers aren’t necessarily taking heed.

And while growing hemp is legal, states still have the power to determine whether to license local businesses to cultivate hemp or cannabis, though manufacturers in nonlicensing states are selling their products nationally anyway.

“When you have an industry without standards and with relatively poor regulatory oversight, you have problems,” Vandrey notes, among them mislabeling, false advertising and contamination.

HOW SHOULD PSYCHOLOGISTS PROCEED?
Ethical experts and experienced clinicians provide the following recommendations:

Use your professional and scientific judgment. A good rule of thumb is APA Ethical Standard 2.04—using your best professional and scientific judgment, says Lindsay Childress-Beatty, JD, PhD, acting director of APA’s Ethics Office. Psychologists should understand state and federal regulations related to CBD, examine the latest literature on the safety and efficacy of different types of CBD products and the conditions they may treat, and tie that literature to their individual patients. In general, recommending CBD (for example, a specific product and dose) is ill-advised, given that the only FDA-approved version is for epilepsy.

“Because CBD is a chemical substance that can interact with other medications,
it’s not advisable to recommend that a patient take CBD without suggesting further exploration with their medical provider,” Childress-Beatty says.

Sarah Burgamy, PsyD, past-president of the Colorado Psychological Association, takes that tack with her patients—educating them on the latest research on CBD, but not recommending it.

“As a professional, I consider it my duty to tell clients that there is a paucity of research around this chemical,” Burgamy says. “As a behavioral scientist, I feel my job is to ‘prescribe’ exercise or sleep hygiene—to talk to people about ways they can behaviorally amend what they’re doing in their day-to-day lives to improve their wellness,” she says. “But for me, it’s touchy territory to say to a client, ‘Why don’t you try this?’ because I’m a professional telling them that. I’m not their neighbor saying, ‘Hey, I’ve heard great things about CBD oil! Why don’t you go check it out?’”

If a patient asks about CBD—or any other psychiatric medication or quasi-medication—Burgamy advises them to check with their primary-care physician or to consider a psychiatric consultation. Medical professionals are better equipped to gauge the advisability of trying a CBD product for a health condition than nonprescribing psychologists, she says. Psychologists can also contact their state licensing board about how the state regulates psychologists’ recommendations of CBD, Childress-Beatty adds.

**Consider scope of practice.** Burgamy also considers scope-of-practice issues. In the case of CBD products and others in a similar arena—Saint-John’s-wort for depression or melatonin for sleep problems—her stance is to stay within her realm of expertise.

“As a behavioral scientist, I feel my job is to ‘prescribe’ exercise or sleep hygiene—to talk to people about ways they can behaviorally amend what they’re doing in their day-to-day lives to improve their wellness,” she says. “But for me, it’s touchy territory to say to a client, ‘Why don’t you try this?’ because I’m a professional telling them that. I’m not their neighbor saying, ‘Hey, I’ve heard great things about CBD oil! Why don’t you go check it out?’”

Keep up with new developments. The research on CBD is changing rapidly, so experts advise staying abreast of the literature, such as medical and other peer-reviewed journals. Meanwhile, to educate its members, the Colorado Psychological Association in 2016 launched an annual “Green Symposium,” a half-day workshop where experts talk about the latest developments in cannabis.

Encourage independent thinking. Daniel Rockers, PhD, president of the California Psychological Association and a private practitioner in Sacramento, says he has seen numerous patients who use or have considered using medical marijuana or CBD after finding little relief from conventional treatments. When working with such clients, he asks questions to help them clarify how they think CBD could help them in terms of better functioning. He encourages them to research the products and return to discuss their findings.

“Because self-efficacy can be a significant predictor of success in behavior change,” he says, “I want to help clients increase their agency and ability to make independent decisions.”

**Encourage investigation, but make sure to refer.** Diane Cohen, PhD, a practitioner in Oakland, California, had firsthand experience with CBD after injuring her neck in a car accident. While visiting Washington state following the incident, she went to a cannabis dispensary, where she purchased a topical form of CBD. Cohen says she experienced pain relief and was grateful that she didn’t have to rely on nonsteroidal anti-inflammatories, to which she’s allergic, or on stronger pain medications.

That experience has led her to encourage patients who are interested in trying CBD to discuss it with their primary-care physicians or psychiatrists, as well as with a dispensary’s “budtender” or on-site physician.

Although Johns Hopkins researcher Vandrey errs on the side of caution, he believes providers should at least be open to having these conversations with their patients.

“You need to be open and honest and evaluate the risks and benefits for that particular individual,” he says, “the same as you would for any other treatment or therapy.”

**Resources**

Food and Drug Administration
For consumer updates on products containing cannabis or cannabis-derived compounds, including CBD, visit fda.gov/consumers.

TREATING CHRONIC PAIN

How three practitioners are working to help patients and providers better understand and treat chronic pain

BY AMY NOVOTNEY
About 20% of U.S. adults have chronic pain, according to the Centers for Disease Control and Prevention. As experts in helping patients better understand and manage their thoughts, emotions and behaviors, pain psychologists are an important piece of an interdisciplinary puzzle when it comes to helping patients cope with pain and reduce its intensity. Brent Van Dorsten, PhD, for example, helps patients who have experienced multiple injuries and amputations manage their pain through cognitive behavioral therapy (CBT) and other behavioral techniques. Jennifer Naylor, PhD, approaches pain management from a research and clinical perspective, devoting her career to helping veterans combat chronic pain. And on a systemic level, Jennifer L. Murphy, PhD, educates and trains providers on taking a biopsychosocial approach to chronic pain management.

“I think one of the most beautiful things about psychologists being involved in this work is our ability to make an enormous difference in a patient’s quality of life,” Murphy says.

Helping patients gain control

**BRENT VAN DORSTEN, PhD**

After graduating from West Virginia University with a PhD in clinical psychology with a health psychology emphasis, Van Dorsten knew that no matter where his career ended up, understanding pain assessment and treatment would be a much-needed skill.

“Pain is a highly disabling and costly phenomenon, so it remains close to the pulse of the American health-care system,” says Van Dorsten, who is now president of the Colorado Center for Behavioral Medicine (CCBM) in Denver.

Van Dorsten has worked as a pain psychologist for more than 30 years, first at the University of Colorado School of Medicine, and since 2012 as the director and sole practitioner at CCBM, a community-based behavioral health psychology center.

He provides cognitive-behavioral assessments and treatments for patients with a variety of chronic pain conditions, though primarily spine pain conditions. He also educates his patients about their chronic pain and assesses factors that may undermine their recovery.

“After doing this for what feels like a lifetime, I truly believe that the provision of accurate information and education about one’s injury, treatments and potential prognosis, and focusing on things the patients themselves can do and have control over to help improve their long-term outcomes, is the most important step in all that we do,” he says. “It’s also a step that is far too often cut short or addressed in a cursory way in most medical settings.”

He also provides mood assessment and mood management for patients, in addition to treatment adherence interventions, relaxation training and sleep hygiene strategies.

“When a patient has pain over a long period of time, it is easy to establish poor sleep habits, just as it is to establish poor dietary and poor exercise habits,” he says. “Simply helping patients change the way they prepare for sleep and their sleep habits can have very positive outcomes for their quality of life.”

In a health-care system where physicians and facilities increasingly set goals to write fewer opioid prescriptions, Van Dorsten also works closely with patients who have been on opioid medications for long term. The inevitable question that follows a decision to taper these meds is “What are we going to do for these patients instead?” he says. CBT for chronic pain and other nonpharmacological interventions are increasingly becoming more respected and sought after by physicians and patients.

Van Dorsten urges psychology graduate students and early career psychologists to get
training in pain psychology to help ensure patients are getting more evidence-based behavioral treatments. "There is a dearth of practitioners nationwide who are well trained in pain management, and the magnitude of the problem is only going to continue to grow," he says.

As a result, Van Dorsten and Jennifer L. Murphy, PhD (also profiled here), are working with Stanford University pain psychologist Beth Darnall, PhD, to boost awareness of the breadth and depth of behavioral interventions for pain. The Effective Management of Pain and Opioid-Free Ways to Enhance Relief (EMPOWER) study is designed to compare the effectiveness of two evidence-based behavioral pain treatments (cognitive-behavioral treatment for pain, designed by Murphy, and chronic pain self-management) in reducing pain and the use of opioids among patients with chronic pain.

The study, which runs through 2023, is active in 10 primary-care and pain clinics in Colorado, Arizona, Utah and California and will include findings from a 1,365 patients tapering off opioids long term, Van Dorsten says.

Embracing a biopsychosocial approach

JENNIFER NAYLOR, PhD

As a health psychologist, Naylor is fascinated by the mix of biology, psychology and social issues behind chronic pain—and the many different ways health-care providers can treat it.

“Chronic pain is not just a physical phenomenon, but a complex interaction of biology, psychology and social support, and it impacts so many different areas of people’s lives,” says Naylor, who provides services at the Interdisciplinary Pain Clinic, Durham VA Health Care System in Durham, North Carolina.

Trained as both an experimental and clinical psychologist, Naylor continues to maintain an active research career examining how neurosteroids—steroid hormones found naturally in the body—may play a role in reducing chronic pain intensity. In a double blind, randomized controlled trial of almost 100 Iraq/Afghanistan-era veterans, Naylor found that participants treated with a pharmaceutical-grade tablet formulation of the neurosteroid pregnenolone showed “significant and meaningful reductions” in low back pain intensity ratings at six weeks compared with their peers who received a matching placebo. The findings were presented at the American Pain Society Scientific Meeting in April.

Naylor is also part of an interdisciplinary team of pain specialists made up of anesthesiologists, psychologists, psychiatrists, primary-care physicians, pharmacists, physiatrists and nurses. Much of her work includes advising the providers on non-opioid and behaviorally based pain management treatment plans for veteran patients, who often experience mental health disorders such as post-traumatic stress disorder, depression and anxiety as well as chronic physical diseases, all of which are contributing to and impacted by chronic pain. The team works together with primary-care physicians to develop tailored recommendations, which may include additional physical measures, such as physical or occupational therapies, and psychological measures, including referrals to mental health, pain school classes offered by the Department of Veterans Affairs (VA; see more below). The team may also suggest engagement strategies for providers to use with their patients, such as motivational interviewing or cognitive-behavioral techniques, and when indicated, they will provide recommendations for a variety of medical interventions such as surgery or injections, as well as medication management for both pain and mental health symptoms or conditions.

“Primary-care providers are not getting a lot of pain care training, so transitioning from a biomedical to a biopsychosocial approach is new for many of them,” she says.

To help address this knowledge gap, about a year ago Naylor helped to develop...
and implement a series of pain courses for patients and providers at the Durham VA Health Care System, thanks to funding from the Mid-Atlantic Mental Illness, Research, Education and Clinical Center. The patient courses, provided on-site and through telehealth, run for three weeks every month. They not only educate patients about managing chronic pain but also promote patients’ active engagement in self-care, Naylor says.

“The more empowered individuals are in their ability to improve their own function, the less dependent they are on more passive modalities such as medication,” she says.

Educating clinicians about pain care

JENNIFER L. MURPHY, PhD

Murphy has seen firsthand how psychologists’ biopsychosocial approach to pain helps patients. As the pain psychology program manager at the James A. Haley Veterans’ Hospital in Tampa, Florida, a tertiary pain center, she supervises a number of services there, including the inpatient Chronic Pain Rehabilitation Program. Patients often present after being in pain for 15 or more years. They may be physically dependent on opioids but not particularly benefiting from them functionally anymore and feel isolated. “Within a matter of a few weeks in the program, being cared for by a nurturing team and receiving education about how to approach pain differently, you really see dramatic changes in affect and physical movement as well as a restoration of hope that is often lost in this population,” she says.

Murphy no longer sees many patients herself as she is focused on system-level initiatives to increase nonpharmacological options for pain management. She has led VA efforts to increase the availability of interdisciplinary pain rehabilitation programs such as the ones in Tampa so that those with complex chronic pain can receive the comprehensive care they need. In addition, Murphy is the VA’s master trainer for cognitive-behavioral therapy for chronic pain (CBT-CP) and the lead author of the VA’s CBT-CP manual. She trains health-care professionals in the public and private sectors on the behavioral management of pain, emphasizing that treatment should focus on increasing individuals’ self-efficacy around chronic pain by better understanding its complex nature and the many active strategies that can reduce its negative impacts.

Murphy encourages any early career psychologist with an interest in this area to gain training experience with the veteran population to see if they might be a good fit. She notes that those with chronic pain are desperately in need of providers who are validating and collaborative.

“Individuals with chronic pain—particularly those who may have opioid-related issues—often have a reputation in the health-care system as being challenging to work with, which is unfair. Most of them just want their suffering to lessen and don’t know how to make that happen, which is a frustrating experience,” she says. “They are so appreciative of clinicians who listen, believe them and then take the time to build rapport—after that they can begin learning tools to take back control of their pain and their lives.”

Best practices for treatment of pain

In May, the federal Pain Management Best Practices Inter-Agency Task Force released its report on acute and chronic pain management best practices, which calls for a balanced, individualized, patient-centered approach.

Launched in 2017, the task force was convened by the Department of Health and Human Services (HHS) in conjunction with the Department of Defense and the Department of Veterans Affairs with the Office of National Drug Control Policy to ensure best practices in the treatment of pain. The report underscores the need to address stigma and ensure patients receive access to care and education. It also highlights five broad categories for pain treatment: medications, interventional procedures, restorative therapies, behavioral health and complementary and integrative health approaches.

“There is no one-size-fits-all approach when treating and managing patients with painful conditions,” says Vanila M. Singh, MD, task force chair and chief medical officer of the HHS Office of the Assistant Secretary for Health. “Individuals who live with pain are suffering and need compassionate, individualized and effective approaches to improving pain and clinical outcomes.”

The authors emphasize safe opioid stewardship by recommending more time for history-taking, screening tools, lab tests and clinician time with patients to establish a therapeutic alliance and to set clear goals for improved functionality, quality of life and daily activities. The report also highlights the disparities and challenges faced by special populations, including veterans, active military, women, youth, older adults, American Indians and Alaska Natives, and cancer patients and those in palliative care.

“This report is a road map that is desperately needed to treat our nation’s pain crisis,” Singh says.

Read the full report at www.hhs.gov/ash/advisory-committees/pain/reports/index.html.
Transitioning from practice into retirement or other pursuits is often an exciting endeavor for psychologists. But without the right planning and preparation, it can also be daunting. To help guide psychologists who are considering retirement or a career change, here are answers to some of the most common questions APA’s Office of Legal and Regulatory Affairs receives on how to step away from psychology practice.

I’ve set a retirement date. When should I start notifying my existing patients?
The time frame depends on where and for whom you work. To best answer that question:
» Review your contracts or employee handbook. If you’re employed by or contracted with a facility or health-care practice, check to see if your workplace policy documents or your employment contract spell out notice requirements. Then work with the company to ensure a smooth transition.
» Use your clinical judgment. If you are self-employed, or your workplace documents offer no guidance, how...
LEGAL AND REGULATORY ISSUES

You will need to securely store any retained records and be prepared to respond to requests for access, which may be difficult if you have a lot of paper records.

much notice you give may depend on several factors: each patient’s diagnosis, length of the therapeutic relationship and continuing treatment needs. For example, you may want to tell patients with severe conditions who need continued therapy as soon as possible to help them transition to a new psychologist.

Review APA Ethics Code, particularly standards 10.09 and 10.10, offers guidance on how to protect your patients when terminating therapy.

Before making referrals, you should obtain a written authorization from patients that will allow you to provide copies of their records to their new therapists.

Do I have to notify former patients? How do I do that?

Some states require you to give notice in a prescribed manner, while others don’t, so contact your state psychological association or licensing board to find out.

But either way, patients have the right to access the protected health information in their health records for a period of time, so it’s important to tell them how to get that information.

If your state has no requirements about how to notify former patients, you can use one or more of the following ways to publicize your retirement:

» Publish an ad in the local paper.
» Send a letter to all former patients within the retention window.
» Keep your website active with instructions for requesting records.
» Update your voicemail message to include instructions.

You might consider announcing the closure of your practice four to six weeks in advance to give you time to respond to records requests.

How long should patient records be kept? How do I store them?

State and federal regulations dictate how long you must keep patient records. The Centers for Medicare and Medicaid Services, for example, may require you to retain Medicare patient files for 10 years after last date of service. For psychologists not bound by Medicare or state law requirements, or contractual obligations, the APA Record Keeping Guidelines (on.apa.org/practice-guidelines-record-keeping) recommend that

You will need to securely store any retained records and be prepared to respond to requests for access, which may be difficult if you have a lot of paper records.
LEGAL AND REGULATORY ISSUES

you retain adult records for seven years and juvenile records for three years after a patient reaches the age of 18. Be sure to follow your statutory and contractual obligations around record-keeping.

If you are leaving a facility or group practice, contractual arrangements or employer policies may determine whether you or the facility/practice will retain control over your patients’ records for the duration of the required period. If you will be retaining the records after retirement, you will need to store them securely and be prepared to respond to requests for access, which may be difficult if you have a large caseload and a lot of paper records.

If you are unable, or unwilling, to store the records at home or respond in a timely manner to requests for access, make arrangements with a colleague or a Health Insurance Portability and Accountability Act (HIPAA)-compliant storage company to manage this task for you. You will need a HIPAA business associate agreement (BAA) to do this, and there will likely be costs associated with these options. To make document storage more cost effective and efficient, consider using a standard document destruction protocol while you’re still practicing, which will save you from having to sort through everything right before you retire.

If you decide to store records in your home, you could make them more secure by:

» placing them in fire-resistant file cabinets;
» transferring paper records to electronic files for easier storage;
» encrypting your electronic records and using password protection to make sure they are not easily accessed by others.

Under HIPAA, if you store files electronically, you must perform a risk analysis to determine and document any threats and vulnerabilities to the files and document the security measures you’re using to address those risks. Also, under both HIPAA and state laws, you are subject to breach notification requirements if someone were to gain unauthorized access to the files (paper or electronic). Take great care to keep them secure if you store records in your home.

I’ve become close to some of my patients over the years. Is it OK to meet for coffee or pursue friendships after I retire?

The relationship between a psychologist and a patient is not built on equal footing, and the confidential and sensitive nature of your discussions in a professional setting does not equal friendship. You risk harming a former patient by developing a new relationship that can easily slip back into a therapeutic one. Consider why you want to form a friendship and how this would benefit you and the patient. Review APA Ethics Code Section 3 for guidance.

What should I do about my license?

Keep your license active if you think you'll want to see patients again or do volunteer work. If you don't foresee practicing in any capacity, you can switch to inactive or, if your state offers it, retired status. Contact your state’s regulatory board to research the options, requirements and costs.

I’m starting to have second thoughts about retiring. What if I’m not sure?

Retirement is your decision. It’s also not permanent, so you can change your mind. If you aren’t sure, consider a trial run by keeping your license active for another year (or two) and reassessing. You will have to meet your state’s CE requirements and pay the fees, but this will give you the time to decide if retirement is right for you.

The words “patient” and “client” are often used interchangeably. This article uses “patient.”

A checklist of tasks for closing your practice can be downloaded atapaservices.org/practice/business/management/tips/closing.pdf.

Disclaimer: Legal issues are complex and highly fact-specific and state-specific. They require legal expertise that cannot be provided in this article. Moreover, APA and APA Services, Inc. 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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