Caring for Older Adults

Electronic Records: Rewards and Risks

Practice Opportunities: Independent Medical Exams

Tips for Completing the CMS-1500

Integrated Care Moments

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This “FYI” question-and-answer fact sheet about psychotherapy and depression is the first in a series of public education resources to be included regularly in Good Practice. To make photocopies to distribute to your clients and for use in community outreach activities, remove the fact sheet by tearing carefully along the perforated edge. To download this fact sheet and others for your clients, visit Practice Central at apapracticecentral.org.
Caring and Coping: Working with Older Adults

Three psychologists describe how they have cultivated this focus for their practice.

With the first of the Baby Boomers soon to turn 65, the U.S. population of older adults is expected to more than double from 35 million in 2000 to an estimated 71.5 million in 2030. Many psychologists already are finding rewards in caring for this population.

“Relationship building is absolutely the most critical skill we use with this population...”

In the following vignettes, three psychologists reflect on their work with older adults and help to illustrate this burgeoning area of practice.

Mary Miller Lewis, PhD
Dublin, Ohio

An early career psychologist, Dr. Mary Miller Lewis has worked with older adults for the past six years. But her affinity for this population has roots much earlier in life.

She credits her paternal grandmother as “a wonderful role model of an older adult” who completed her bachelor’s degree when she was 63. “She always impressed upon me the importance of education, no matter someone’s age,” says Dr. Lewis.

A second positive influence stemmed from Lewis’ high
school experience as a dietary aide at a nursing home. She observed that many residents craved emotional interaction. But unfortunately, Lewis says, “Even the most caring staff did not have time to provide that support.”

These days, Lewis provides psychological assessments and individual psychotherapy in long-term care facilities — including nursing homes, skilled rehabilitation centers, assisted living and independent living communities. Her wide-ranging professional activities reflect the multidisciplinary, integrated approach to care in many of these settings.

Dr. Lewis works daily with social workers, physicians, nurses and occupational and physical therapists. Among her responsibilities, she provides in-service training to staff and families. As part of stress management training for caregivers, for example, Lewis leads a group in discussing the mind/body connection and the impact of stress. “Then we do hands-on stress management activities that include relaxation breathing and visualization,” Lewis explains.

She sees herself and other psychologists as well trained and suited to working with older adults. “Relationship building is absolutely the most critical skill we use with this population,” says Lewis, “particularly among the ‘oldest old’ who carry a strong stigma related to mental health problems.” She says another important skill is patience, as older adults may require time to develop rapport and tackle their emotional issues.

Specialized training and knowledge are also vital. “Psychologists need a strong understanding of the emotional, cognitive and physical aspects of aging,” says Lewis. Further, she considers being able to work adeptly with multiple systems — including facilities, families and primary care medical practices — as a critical training issue for psychologists who interact with older adults. Since many health issues and caregivers are often involved in an older person’s care, Lewis considers integrated service delivery essential and believes that psychologists make unique contributions to integrated systems of care. “As a psychologist, you may be the only person who is looking beyond the individual’s physical health to his or her emotional and cognitive well-being,” Lewis says. “And you may be the one person who can assist the older adult, family members and other caregivers with understanding the interactions between the mind and the body.”

Dr. Lewis foresees a bright future for psychologists who are interested in practice opportunities with older adults.

continued on page 4

OLDER AMERICANS AND PROFESSIONAL PSYCHOLOGY BY THE NUMBERS

In 2006, 37 million Americans (12 percent of the U.S. population) were age 65 and older; 5.3 million were 85 and older. Baby Boomers will begin turning 65 in 2011, and the number of older people in the U.S. is expected to be twice as large in 2030 as in 2000.

Source: U.S. Census Bureau

White males age 85 and older have the highest suicide rate in the United States. Depression in older adults “may be overlooked because seniors may show different, less obvious symptoms, and may be less inclined to experience or acknowledge feelings of sadness or grief.”

Source: How Do Older Adults Experience Depression?
National Institute of Mental Health

Among the results of a 2008 email survey by the APA Practice Organization (APAPO) reflecting nearly 3,100 responses from licensed psychologists:

- 13 percent of respondents identified their primary professional identity as geropsychology.
- 56 percent served adults age 65 and older.
- Of the approximately 50 percent of psychologists who derived some practice income from Medicare payments, nearly 40 percent said Medicare represented less than 25 percent of their total practice income.
- In rating the importance of various APAPO advocacy initiatives, 41 percent said that Medicare reimbursement was “extremely important” and another 23 percent rated it as “important.”
With regard to cutting-edge developments, she notes the growing use of technology. “It can be as simple as automated phone calls reminding older clients of appointments or homework assignments,” Lewis observes, “or as sophisticated as computer programs that facilitate cognitive skills training or enable a psychologist to check in face-to-face with a homebound client.”

Working with older adults has its challenges, Lewis acknowledges, beyond the foremost challenge of losing clients to death. “Sometimes progress is slow and halting, and that’s frustrating for me and my clients.”

But Lewis delights in the tangible, positive changes that she and her clients accomplish together. The excitement she experiences as result of this collaboration fuels her longstanding passion for interacting with older adults.

“I am learning from my clients each and every day,” she says, “and I feel I make a difference in their lives.”

Barry J. Jacobs, PsyD
Swarthmore, PA

From his days as staff psychologist at a physical medicine rehab hospital to his current multifaceted professional life, Dr. Barry Jacobs has worked with older adults for nearly 20 years.

He’s director of behavioral sciences for the Crozer-Keystone Family Medicine Residency Program in suburban Philadelphia. In his capacity as a clinician/educator, Jacobs sees clients — with or without his family medicine residents — in the outpatient family medicine center, as well as in the acute care hospital.

The residency has a home medical program that involves caring for frail, bedbound elderly. Jacobs confers with the residents involved with this program and sometimes meets with family members and patients in their homes.

Adding to his busy schedule, Jacobs is part of a large family medicine practice where he does an average of 20 to 25 hours of psychotherapy per week. He also sees clients and does consultations with staff around behavioral and family issues at a nearby life care community for older adults. Participants in the family education program run by Jacobs raise critical matters related to conflict resolution, medical decision making and end-of-life issues.

Though Jacobs wears many professional hats, his clinical and educational specialty is working with family caregivers. “I help family members better cope with caring for aging parents, disabled spouses and chronically ill children,” says Jacobs. He’s a member of Dr. Carol Goodheart’s APA Presidential Task Force on Caregivers.

Jacobs notes research suggesting high rates of depression and anxiety in those who serve as caregivers, especially over a period of several years. “Providing daily care takes a toll,” he says, “yet many caregivers are reluctant to reach out for help. I look for ways to engage them and help them manage this difficult process.”

Demographic trends are fueling marketplace opportunities for psychologists, observes Jacobs, particularly with regard
to Baby Boomers. Beyond those who may need psychological services, others may be looking for guidance — for example, in implementing a caregiving plan for their parents. Additional opportunities involve program development and implementation. Several local agencies have hired Jacobs to do stress management training for their staff who work with older adults.

Marketplace opportunities abound in community education. Jacobs gives lots of presentations about psychological issues, in part resulting from his involvement with community groups — for example, serving on the board of his local senior citizens association. These educational activities get his name out in the community, which in turn generates referrals to his private practice.

Yet Jacobs is concerned that, from his perspective, a lot of health and mental health professionals don’t want to provide services to older people. “They miss out on the richness of interacting with individuals who have lived a lifetime.” Jacobs added that some may have negative but inaccurate stereotypes about older adults, for example, that they are unable and unwilling to change.

As a child, Jacobs delighted in listening to both sets of grandparents tell stories and recount their varied experiences. As a psychologist, he says that reflecting on life with older adults is one of the most rewarding aspects of his professional work.

Jacobs did family therapy for a year and a half with a woman in her 90s and her daughter, who had a strained relationship. After her mother died recently, the daughter reached out to Jacobs. Thanking him for the gift of therapy, she said it enabled her to set aside issues that had inhibited her appreciation of her mother, and it vastly improved their relationship.

The call reminded Jacobs why he loves his work.

Merla Arnold, PhD, RN
Long Island, New York

After working as a registered nurse for 10 years, Merla Arnold completed a counseling psychology program. During her training, she decided that working with older adults would be a specialty area for her practice. “Everything I did from then on had a focus on older adults,” says Arnold.

That focus was reflected from her earliest days of building a practice. She reached out to assisted living facilities and nursing homes, along with cancer care specialists, physical therapists and others in the community who worked with older adults. Arnold says the enthusiastic response fueled her interest in developing a specialized practice.

Eight years after graduating from her doctoral program, Arnold’s private independent practice is thriving. Among

HELPFUL RESOURCES

The American Psychological Association (APA) Guidelines for Psychological Practice with Older Adults document is available online in the CE and Professional Development section of Practice Central at apapracticecentral.org, the APA Practice Organization Web site that launches in December 2009.

Further, the Office of Aging section of the APA Web site is an excellent source of material for practicing psychologists on working with older adults. Visit apa.org/pi/aging to access these resources.

A small sampling includes:
- What Practitioners Should Know About Working with Older Adults
- Multicultural Competency in Geropsychology
- Resource Guide on Depression and Suicide in Older Adults
Rewards and Risks of Electronic Health Record Keeping

A neuropsychologist reflects on one model involving assessment data.

As the U.S. government seeks to implement a nationwide, interoperable system of electronic health records (EHR) by 2014, psychologists are gaining first-hand experience with the trend toward EHR. Tyler Story, PhD, a neuropsychologist affiliated with the Duke University Medical Center, shared his experience and perspective in question-and-answer format with Good Practice.

Q. What was involved in creating the medical center record system?

A. The Duke University Medical Center model for electronic health records (EHR) involves a software system designed to integrate a variety of specialties. Many departments were already using EHR, and it proved challenging to integrate pre-existing software unique to the practices of each specialty. The EHR system at Duke is now considered the official medical record for patients.

While neuropsychology records are included in the general medical record, they involve a tiered-access system.

Mental health records are separate from the general medical record in two ways. Psychotherapy progress notes are kept in a separate EHR that is independently maintained by mental health specialties, which include psychologists and psychiatrists. While neuropsychology records are included in the general medical record, they involve a tiered-access system (described in more detail below).

Q. What content is included in the neuropsychology record?

A. The neuropsychological record for the EHR system includes a simple summary statement documenting that a neuropsychological assessment was conducted, with contact information for our service. The full report is available as a “sensitive record” for providers who have additional security privileges.

The sensitive record includes the complete neuropsychological report, providing the patient’s presenting complaints, medical history, relevant psychiatric history, descriptive test results, and summary and interpretations.

Q. What issues and risks are unique to psychological assessment records in EHR systems such as the one at Duke?

A. One of the primary risks is the potential diffusion of responsibility for maintaining confidentiality. As a neuropsychologist, I do not manage the credentialing process for accessing sensitive records. The records
department at Duke handles credentialing. While the hospital has HIPAA compliance officers and legal representation to ensure confidentiality, these individuals may not fully understand the unique nature of psychological data. For this reason, raw testing data and summary data are not kept in the EHR.

“As we rely more and more on technology in providing services, we will also have to rely on guidance from information technology professionals who lack expertise in health or mental health services delivery.”

This scenario raises an interesting issue for psychologists. As we rely more and more on technology in providing services, we will also have to rely on guidance from information technology (IT) professionals who lack expertise in health or mental health services delivery.

Q. How has the Duke model addressed privacy and security concerns that apply to mental health records?

A. The Duke model for neuropsychological reports involves a tiered privileges system. The general record includes a basic summary statement accessible to staff with clinical privileges for viewing EHR. The next security level involves access to the sensitive record containing the full neuropsychological report. Clinicians specifically apply for access to this sensitive record, which is typically granted to licensed psychologists who specialize in assessment.

The final level of access includes summary scores and copies of raw data that are directly provided by our neuropsychology service after proper release forms have been provided. Consistent with position papers and the APA’s Ethical Principles of Psychologists and Code of Conduct, we only release data to licensed psychologists.

Q. What are the principal benefits of this system for psychologists and patients?

A. In my experience, our neuropsychology service has benefited from the Duke EHR system by the increased access that it provides to our service and to results of individual assessments.

For example, including neuropsychological reports in the Duke EHR system has increased the number of pre-surgical evaluations for organ transplant patients. We now receive regular referrals from organ transplant teams because our evaluations provide important information regarding the patient’s cognitive capacity to consent to the procedure and participate in recommended programs for rehabilitation. In addition, we help identify patients who are at increased risk for post-operative cognitive decline based on early signs of dementia and other risk factors.

Participating in an EHR system also benefits patient care. As with many large medical centers, Duke promotes a multidisciplinary team approach to treating patients. By including our neuropsychological reports in the EHR system, clinicians access patient reports while viewing other records, often from secure computer stations while working in clinic. In my experience, this real-time access to neuropsychological results improves communication and continuity of care.

The U.S. Department of Health and Human Services (HHS) has issued regulations governing whether and how psychologists and other entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must give notice to patients and HHS if they discover that protected health information has been “breached” — for example, stolen or improperly accessed in a way that poses a significant risk of patient harm. The HHS rule applies to any breaches discovered on or after September 23, 2009.

The September 2009 issue of the PracticeUpdate e-newsletter from the APA Practice Organization (APAPO) offers guidance for psychologists about the HIPAA breach notification rule. Members can find back issues of the e-newsletter online at Practice Central, the new APAPO Web site, by visiting apapracticecentral.org.
Independent Medical Examinations Offer Practice Opportunities

Psychologists find a variety of options.

A factory worker becomes depressed after losing three fingers in an accident at work. An apartment-dweller develops post-traumatic stress disorder after being assaulted and robbed in a complex with inadequate security. An office worker makes comments his co-workers find alarming. All of these situations could lead to an independent medical examination (IME) — an assessment performed by a health-care professional uninvolved in the person’s care and designed to provide objective information for use by a third party. That third party might be an employer, law firm, insurance company or government agency, and what’s at stake for the affected individual involved might be workers’ compensation, disability benefits, a successful personal injury lawsuit or an OK to return to work.

Psychologists are well-positioned to provide this service when there are psychological aspects to the evaluation, says psychologist Lisa Drago Piechowski, PhD, a private practitioner in Glastonbury, Conn. In fact, practitioners’ expertise in psychological assessment and their ability to understand and analyze data give them a unique advantage. And IMEs are a growth area, Piechowski says, adding that many psychologists are seeking out this kind of work because it’s not based on health insurance. Tough economic times are increasing stress in the workplace, she points out. The population is aging and becoming more vulnerable to a variety of health issues. And the Department of Veterans Affairs is already struggling to handle evaluations of veterans returning from Iraq and Afghanistan.

A different skill set

Of course, says Piechowski, you can’t just jump into doing IMEs without preparation. “Just being a good clinical psychologist isn’t sufficient to do this kind of evaluation,” she says.

That’s because an IME isn’t the same as a standard psychological evaluation, explains psychologist Angela J. Koestler, PhD, a practitioner in Jackson, Miss.

“Just being a good clinical psychologist isn’t sufficient to do this kind of evaluation.”

Instead of performing a traditional psychological evaluation, she says, “There are specific referral questions you have to address.” For example, those questions may include whether the individual is experiencing psychological symptoms, if those symptoms are related to a work-related or personal injury, whether the psychological symptoms are pre-existing and if mental health intervention is needed.

“When there’s such a lot at stake, there’s an unconscious and conscious motivation to present oneself in a way that would lead to obtaining rather than being denied the benefit,” says Piechowski. “You cannot rely completely on what the individual is saying about what their
capacity is.” Instead, the examiner must supplement the individual’s report with information from written records, psychological testing and interviews with treatment providers, employers, family members or others.

The final report focuses exclusively on answering the referral questions and excludes irrelevant findings you’ve uncovered, no matter how interesting. Suppositions are another no-no, says Koestler, emphasizing that the report must be objective and based on the evidence you’ve found — from the clinical interview, structured mental status examination, review of medical and other records, or psychological testing, for example.

The report also has to avoid jargon and be more succinct than what psychologists might normally produce, adds Piechowski. “Most of the people who receive these reports are insurance company personnel, lawyers and the like,” she says. “Typically they flip to the half-page summary you’ve written. They don’t read 40-page reports.”

Another core difference between IMEs and traditional psychological practice is the nature of the relationship between the psychologist and examinee. “Your role is to maintain objectivity with no conflicting interests,” Koestler emphasizes. In the informed consent process, the examiner should clearly explain the purpose of the evaluation and how the information will be shared.

And if the person needs psychological treatment, says Koestler, the examiner shouldn’t be the one to provide it. “You don’t have a [therapeutic] relationship with the individual. Your role is that of independent evaluator,” she says. “It’s important not to muddy the waters.”

Special challenges

Doing IMEs poses special challenges.

Managing time is one, says Piechowski. A single evaluation can involve review of a six-inch stack of records, a seven-hour session of testing and evaluation and a thorough report — all within two or three weeks.

Maintaining objectivity can be another challenge. “When the person you’re evaluating tells you how desperate they are to receive benefits because they’ll lose their house if they don’t, you have to remember you’re an evaluator, not a therapist,” says Piechowski.

Knowing when to refer is another issue, adds Koestler. Since conducting neuropsychological testing is outside her area of expertise, for example, she refers such cases to psychologists who are proficient in this area. Koestler also considers it important for psychologists who are thinking of performing IMEs to have training and experience in relevant specific areas — such as work injury, pain and traumatic brain injury — that are required to address referral questions.

Special training, such as working with a mentor, is key to preparing for this work. Specialized continuing education opportunities provided by such organizations as the American Academy of Forensic Psychology and PsyBar, LLC, are also helpful.

“If you’re a mid-career psychologist, obviously you’re not going to go back to school to do a postdoc,” says Piechowski, though a forensic postdoc offers yet another opportunity for specialized training. Whatever forms of training a practitioner pursues, Piechowski emphasizes, “You have to take on [the responsibility] to educate yourself.”

A RANGE OF OPTIONS

Independent medical examinations can take place in a variety of contexts, including the following:

- Workers’ compensation.
- Personal injury.
- Disability insurance.
- Veterans Affairs.
- Fitness for duty.

For additional information, see “Should You Consider Doing Independent Medical Examinations for Workers’ Comp?” This article appeared in the September 30, 2009 issue of the PracticeUpdate e-newsletter from the APA Practice Organization (APAPO). Back issues are available online at the APAPO’s new Web site, Practice Central, at apapracticecentral.org.
Completing the CMS-1500 Claim Form

A basic guide for psychologists

![Image of CMS-1500 Claim Form]

1. Indicate the type of insurance coverage on the claim form.
2. Fill in the patient's name and address.
3. Indicate the patient's date of birth.
4. Indicate the patient's sex.
5. Indicate the date of service.
6. Indicate the amount billed and the amount paid.
7. Indicate the provider's name and address.
8. Sign and date the claim form.

---

**Example Data**

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Amount Billed</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/12/09</td>
<td>170.00</td>
<td>140.00</td>
</tr>
<tr>
<td>08/19/09</td>
<td>110.00</td>
<td>110.00</td>
</tr>
</tbody>
</table>

Note: The table above is a sample and should be filled in with actual data.
**Especially for Early Career Psychologists**

The CMS-1500 insurance claim is used by Medicare for reimbursement and is accepted throughout the U.S. by most private insurance companies. The copy below relates to the graphic at left and is intended as general guidance for completing the form.

All Medicare Administrative Contractors (MAC) have extensive instructions on their Web sites on how to complete forms. Please use the following information simply as a basic guide and refer to your MAC Web site for further instructions.

- **SECTION 1** of the form identifies who is receiving the care. You input patient information in this section.

- **SECTION 2** identifies the policy holder whose insurance is paying for the care that you provided. If the patient’s insurance company is the one being billed, input the information requested, even if some of it has already been noted in Section 1.

- **SECTION 3** addresses the diagnosis for which you are treating the patient. ICD-9-CM codes are now required for billing. Insurance companies typically will not accept a DSM-4 code, so be sure to use the proper ICD-9-CM code. The ICD-9-CM book includes specific information regarding when to code a service to the fourth or fifth digit. The ICD book is also very helpful when you are billing for services under the health and behavior codes since the book includes all of the medical diagnoses.

- **SECTION 4** identifies what services were provided to the patient. This section includes:
  - **Date of service.** Up to six dates can be listed.
  - **Place of service.** This can be the office, hospital or other facility.
  - **CPT.** The Current Procedural Terminology, or CPT, code identifies what service was provided. As an example, 90806 would indicate 45 to 50 minutes of psychotherapy provided in an office.
  - **Units.** Some services require billing in units. For example, when a health and behavior service is rendered, it is billed in 15-minute increments. If a patient is seen for 30 minutes, the number of units will equal two.
  - **Modifiers.** Psychologists typically do not use modifiers, which indicate special circumstances related to billing. However, they sometimes are required for testing services. Modifiers are found in the CPT book.
  - **NPI.** Your National Provider Identifier, or NPI, identifies you as the person who provided the service.
  - **Fee.** Regardless of what the insurance company may pay or Medicare may reimburse, be sure to indicate your actual typical fee. It does not matter what the patient pays.

- **SECTION 5** is the finance section. It indicates who provided the service and where the check should be sent. The signature of the person who provided the service is required here, as is the provider’s NPI.
By the time psychologist Parinda Khatri, PhD, met with her, the teenager had made half a dozen trips to the emergency room complaining of chest pains. After a series of expensive medical work-ups revealed no problems, the girl came to see a pediatrician at Cherokee Health Systems in Knoxville, Tenn., who sent her for a quick consultation with Khatri.

“It was unlikely that a 16-year-old girl was having a heart attack,” says Khatri, director of integrated care at Cherokee. A 15-minute assessment revealed the real problem: panic attacks that began after a date rape.

“We have epiphanies like that every day,” says Khatri. “We call them ‘integrated care moments’ — moments when we realize that we’re really able to make a difference in a person’s life because we’re bringing in medical, behavioral and other areas of expertise and working together as a team.”

Making a difference

When Khatri arrived at Cherokee as a part-timer in 2001, the organization was already well on its way toward the complete integration of psychological and physical health services. That shift began in the early 1980s when Cherokee — which started as a community mental health center — opened its first primary care clinic. Once Khatri was ready to come on board full-time a year later, Cherokee created the position of director of integrated care for her.

Today Khatri supervises psychologists and other “embedded behaviorists” in 15 primary care clinics across 11 counties. During a typical day, she handles a variety of professional activities that include providing clinical supervision, developing new clinical practices or programs, working on quality improvement initiatives and, of course, caring for patients.

Working as part of a team within the primary care area, Khatri and her fellow behaviorists tackle problems like depression and anxiety. They also help people stop smoking, manage their weight and make other lifestyle changes to improve their health. And they enable people to manage their illnesses, whether that means helping patients with diabetes stick with their treatment regimens or teaching those with asthma how to avoid situations that trigger attacks.

“We all have something unique to add when it comes to improving the health and psychological wellness of our patients.”

As team members, says Khatri, psychologists contribute their clinical experience, knowledge of evidence-based interventions and critical thinking skills. But while psychologists bring much to the table, so do other healthcare providers. “We all have something unique to add when it comes to improving the health and psychological wellness of our patients,” she says.

Plus, the team members are constantly helping each other. “The physicians, nurses and nurse practitioners are also behavioral health ‘extenders’ who help address behavioral health issues, just like we’re helping address physical health issues,” she says.

That high level of interdisciplinary collaboration isn’t the only way this work differs from traditional psychotherapy. The environment is fast-paced, and interventions are brief and focused. “Patients access us as they need to, just like they would a primary care provider,” she explains. “You don’t see your primary care provider every two weeks for 45 minutes.”

Integration allows behaviorists to identify problems and intervene even if patients have just come in for a flu shot or blood pressure check, says Khatri. By reducing the stigma associated with mental health care, she adds, that approach
helps to ensure that people get the treatment they need.

The care patients receive is also more convenient. Instead of waiting a few weeks to see a psychologist and having to go someplace else, for example, they have immediate access to a psychologist at Cherokee.

But convenience is only the beginning, emphasizes Khatri. “The care is better when all the different providers are talking with one another and collaborating,” she says. “We’re all supporting each other to improve the patient’s overall health status.”

The Cherokee approach also saves money. “What we find is that when a patient sees a behavioral health consultant, it actually reduces medical utilization,” says Khatri, who explains that psychosocial distress accounts for a huge proportion of medical visits.

When Cherokee compared medical utilization in the two years after a visit with a behavioral health consultant to utilization in the two years before, the health system found that seeing the consultant decreased medical utilization 37 percent for pediatric Medicaid patients, 27 percent for adult Medicaid patients and 20 percent for commercially insured patients. According to insurance claims data, the approach has also reduced emergency room use.

Those data are especially important given Cherokee’s role as a hybrid community mental health center/federally qualified health center that serves patients regardless of their ability to pay, says Khatri.

A growth opportunity

Data like Cherokee’s have helped convince an ever-growing number of primary care practices that they need a psychologist. “There’s a tremendous need,” says Khatri.

But not every psychologist can jump right into an integrated setting, she warns. Because decisions must be made very quickly, psychologists need significant clinical experience and knowledge of evidence-based practice. Psychologists in these settings should also have some familiarity with primary care medicine, such as what lab results may suggest or when a patient’s medication regimen may need to be altered.

Those are things any psychologist can learn, says Khatri. What’s even more important are the right personality and aptitude. Those who thrive in an integrated care setting are good communicators who are flexible, able to think on their feet and attracted to variety and high-energy environments.

Khatri’s own training — she received a clinical psychology doctorate from the University of North Carolina in 1996 — didn’t completely prepare her for this work. “I got really good training in traditional clinical psychology, but I had very limited contact with primary care or other health-care providers,” she says.

What was more helpful was a behavioral medicine postdoc at Duke University Medical Center. Working in a cardiac rehab program, Khatri learned a new way to work with patients. “I'd be walking with people on the track or [talking with them] while they were on the exercise bike,” she explains. “It wasn’t the traditional, private 45-minute psychotherapy session.” Khatri also had earlier stints as a consulting psychologist for an obstetrics/gynecology practice and a cardiology practice and as a clinical psychologist working as part of a pediatric cardiac and lung transplant team.

“‘There’s so much cross-fertilization of knowledge ... That’s really exciting as a health-care professional — to teach something and learn something every day.’

Khatri now finds herself re-orienting students in the psychology internship program she directs at Cherokee. Often when people are more traditionally trained, they come to primary care and think they can use traditional mental health assessment and treatment strategies, says Khatri. Not so. For example, she notes, interns in primary care can’t take several sessions to establish a diagnosis.

“Our primary care providers are not going to wait,” she says. “They’re asking us, ‘Why is this patient not taking his blood pressure medication? Why are her sugar levels out of control? What’s going on with this patient?’”

The director of primary care also meets with trainees to provide an overview of primary care medicine, language and protocols.

“There’s so much cross-fertilization of knowledge,” says Khatri. “The primary care providers will learn things like behavioral intervention and deep breathing exercises from us, and we’ll learn about Coumadin management and TSH levels from them,” she says. “That’s really exciting as a health-care professional — to teach something and learn something every day.”
EBPP Checklist for Psychologists

Do you follow these effective practices?

Evidence-based practice in psychology (EBPP) is the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences.

The checklist below is part of the online continuing education (CE) course from the APA Practice Organization (APAPO) entitled, “Evidence-Based Practice in Psychology,” available at Practice Central. Visit apapracticecentral.org to access this and other CE courses from APAPO.

EBPP Effective Practices Checklist

▶ BEST RESEARCH EVIDENCE
Is it based on ...
• Systematic reviews?
• Reasonable effect sizes?
• Statistical and clinical significance?
• A body of supporting evidence?

▶ PATIENT CHARACTERISTICS
Are you responsive to your patients’ ...
• Functional status?
• Readiness to change?
• Level of social support?
• Variations in presenting problems or disorders, etiology, concurrent symptoms or syndromes and behavior?
• Chronological age, developmental status, developmental history and life stage?
• Sociocultural and familial factors?
• Environmental context and stressors?
• Personal preferences, values and preferences related to treatment?

▶ CLINICAL EXPERTISE
Do you ...
• Conduct assessments to assign diagnoses and develop systematic case formulations and treatment plans?
• Have a rationale for clinical decisions?
• Systematically implement treatment strategies?
• Monitor patient progress?
• Possess and use interpersonal expertise, including the formation of therapeutic alliances?
• Continue to self-reflect and acquire professional skills?
• Evaluate and use research evidence from both basic and applied psychological science?
• Understand the influence of individual, cultural and contextual differences on treatment?
• Seek available resources?

▶ PSYCHOLOGIST’S ACTIONS
Do you ...
• Ask about current and past functioning, risk and safety, presenting concerns, patients’ life context?
• Acquire patient information and relevant clinical and research evidence regarding presenting concerns, relevant treatment options and other psychological contributors?
• Appraise your current knowledge and need for new knowledge?
• Apply proposed intervention strategies coordinated with other providers, if appropriate?
• Analyze individual progress and the effectiveness of your services?
• Adjust your approach based on your analysis?

Overarching question: Do you collect outcomes data to determine if you provide high quality care?
her professional activities, she works in long-term care settings where she conducts assessments of facility-based residents resulting from referrals by social workers and nursing staff.

With some additional education and training beyond that of a generalist, she sees psychologists as well suited to working with older adults. “We do quality, in-depth assessments of cognition, functional capacity, personality assessment and other areas,” says Arnold. “And we know how to address anxiety disorders, psychotic episodes and suicidal ideation.”

In addition to assessment and psychotherapy, Arnold provides counseling services focused on behavioral health issues — for example, exploring behaviors that contribute to an older person’s chronic pain or unhealthy weight.

She notes that psychologists are skilled at providing training and consultation to family members and groups that work with older adults, and she finds ample opportunity to put her own consultation skills to work.

Arnold consults with physicians about systems of care and how a patient’s status may relate to a medical issue or medications prescribed. “Physicians have changed their medication regimens and patient symptoms have improved based on these consultations,” Arnold observes. As the American Psychological Association’s representative to the AQA (formerly the Ambulatory Care Quality Alliance), Arnold has further opportunities to “help physicians understand that health care is a team sport and psychology is a key contributor.”

Her consultation services also involve working with facility-based nursing staff, along with aides and other support staff. Arnold works in a middle- to upper-middle-class area that is predominately Caucasian. A large majority of local nursing home aides are persons of color. “Particularly among those [facility residents] who have issues with impulse control, some individuals have no qualms about expressing bigoted opinions to staff caregivers,” says Arnold. She consults with the caregivers about these experiences as well as additional issues, including their ongoing experiences of loss and the power hierarchy they confront in the facility.

Arnold sees other fundamental issues of diversity. “Ageism is a problem related to working with older adults,” she says. Arnold encourages her colleagues to identify their assumptions and biases about aging and issues of loss, and to evaluate how these factors may affect their interactions with older clients. “Treatment failures may be related to biases getting in the way [of successful outcomes],” she says.

Arnold says practice opportunities abound for psychologists in working with older adults. According to Arnold, the health and behavior codes have broadened her delivery of health psychology services. Further, she finds that, in her geographic area, Medicare remains a payor that offers reasonable reimbursement without the same bureaucratic complications of an HMO.”

Adaptability and creativity, Arnold says, are key ingredients in cultivating an older clientele. “Clients don’t come to me. I need to go where older adults are — their homes, senior centers and long-term care settings,” she says.

In short, she says, psychologists working with older adults need to leave their offices. “We need to develop practices without walls.”
Bringing Comprehensive Change to Kentucky’s Correctional System

Practitioner profile: Elizabeth W. McKune, EdD

Psychologist Elizabeth W. McKune, EdD, never imagined she would end up “behind the fence.”

“If you had told me in graduate school I would end up working in a prison, I would have said, ‘Are you crazy?’” says McKune.

It was a chance comment from a student she was supervising at a chronic pain clinic that led McKune to the Kentucky State Reformatory. He mentioned that the prison system was opening a new medical unit and might need a psychologist. They did, and McKune entered the world of corrections in 1999.

Today she is assistant director for psychological services for the Kentucky Department of Corrections. Unlike many psychologists within the correctional system who address individual inmates’ psychological issues, McKune is working to help the system as a whole function better.

Growing influence

McKune’s role has evolved over her years with the Department of Corrections, with the target audience of her interventions growing bigger with each move up.

In her first job in the system, for example, McKune provided health psychology services to inmates in the reformatory’s medical unit and nursing home. She also led support groups designed to help offenders cope with conditions like hepatitis C and chronic pain.

When she launched the chronic pain group, McKune discovered that the materials were inadequate. “The traditional workbooks used examples like being stuck in traffic that just weren’t appropriate for this setting,” she says. She wrote her own workbook and facilitator’s guide, collected data and discovered that the group effectively reduced inmates’ depression, anxiety and somatization. “It’s important to consider the whole person when dealing with medical issues,” she says.

In her next position, McKune developed and coordinated psychological services for adult correctional institutions statewide. She also supervised psychologists in facilities across the state.

Afterward, McKune led the Division of Mental Health and Substance Abuse Organizational Developmental Services. There her focus was strategic planning and goal-setting.

With the state’s budget becoming ever more strained, she welcomed the opportunity to review the division’s programs and employee retention efforts. “The literature shows that employees who feel they’ve made a difference tend to stay where they are,” she says. To help achieve that goal, she guided each unit through the process of developing a vision and a plan for making it a reality.

“Just five percent of the offenders who receive the program’s intensive case management end up back behind bars within two years...”

Then the department created McKune’s current position. Her primary focus is to make sure what the division is doing really works. “Dollars are becoming tighter and tighter,” she says. “Legislators want to know that the dollars they spend are being used effectively.” McKune has led the charge when it comes to determining whether the division’s programs reduce symptoms and recidivism.

So far, she says, the evidence is very promising. Take the division’s re-integration program for severely mentally ill offenders returning to the community. Thanks to the program, the recidivism rate for these offenders has plummeted. Just five percent of the offenders who receive the program’s intensive case management end up back behind bars within two years, compared to the state’s
overall recidivism rate of 35 percent. “And these are offenders who would probably be more vulnerable, because they have more risk factors,” says McKune. The program won a 2009 Lilly Reintegration Award from Eli Lilly and Company.

**Opportunities for psychologists**

Working in a prison isn’t scary, McKune insists. “I get asked that all the time,” she says. “I have a lot of faith in the staff who work here.” Of course, you do have to pay attention to where you are, watch out for manipulation and avoid revealing personal information, she says, noting that some offenders are predators. “Offenders are like wallpaper,” she says. “They’re always there, listening and looking for opportunities.”

What McKune loves about her job isn’t just the chance to have a big impact but the variety it offers. A recent week included a trip to Frankfort, Kentucky, for system-wide meetings about re-entry, a day with the partners who help ease offenders’ transition back into the community and a visit with staff at a facility where inmates had burned down buildings during a riot.

> “Kentucky is incarcerating people at a faster rate than any other state. We have to help these people change their lives to create safer communities for all of us.”

For psychologists doing more traditional work in prisons, there are other benefits. For one thing, many psychologists working in corrections can provide services to anyone who needs them and don’t have the hassle of dealing with third-party payers denying services. Inmates come to sessions because they have to, she explains. “You have a captive audience.”

Psychologists interested in corrections “should be good generalists first,” says McKune, recommending that they then seek more specialized training in health or forensic psychology. McKune herself earned a doctorate of education in counseling and personnel services from the University of Louisville in 1999. Her undergraduate degree was educational and counseling psychology, with an emphasis on business and industrial psychology.

She gained experience in health psychology through stints at pain centers and a gynecological practice and as director of the psychology, neuropsychology and brain injury program at a rehab center. There she supervised interdisciplinary teams of speech, occupational, recreational and physical therapists providing inpatient and outpatient services for brain injury patients.

> “Integrated care is my passion,” says McKune, who will serve in 2010 as president-elect of the Brain Injury Alliance of Kentucky. In 2007, she helped the Kentucky Psychological Association develop an integrated care model to help combat the silo model that still dominates the state.

McKune is also helping to prepare the next generation of psychologists as a part-time faculty member at Spalding University’s Professional School of Psychology. She encourages her students to consider corrections. McKune has developed a practicum rotation in the reformatory’s medical unit. She’s also developing an internship program. Noting that it was a student who got her into corrections in the first place, she now returns the favor: “I have brought a lot of them here,” she says. McKune welcomes the help. “Kentucky is incarcerating people at a faster rate than any other state,” she says. “We have to help these people change their lives to create safer communities for all of us.”
Q. Generally speaking, how do large medical center models for EHR compare to private practice models?

A. I see several primary differences. First, large medical centers have the technical and financial means to develop EHR systems that fit the particular practices of the hospital. In contrast, private practitioners typically purchase software developed by a third-party, or hire an IT specialist to design a small system. Second, medical center EHR systems are more likely to be maintained, updated and protected by an IT team, while private practitioners generally are responsible for maintaining their own systems. Finally, private practice models may focus on electronic storage, organization and protection of records, but not on integrating into a general record with other specialties.

Q. What do you see as challenges to implementing EHR nationwide in institutions as well as private practices?

A. For institutions, I see the biggest challenges coming from working with existing systems. While Duke has one model that works well for our hospital, other major medical centers have unique EHR systems. How well these systems can communicate with one another, or with a national system, remains to be seen. In my experience, these systems do not have a direct way of linking, and moving in this direction will involve considerable costs and staff training.

Our profession faces several challenges as the U.S. moves toward implementing a nationwide EHR system. One challenge involves finding the financial and technical means to establish useful and secure systems for individual practices. The reluctance of some psychologists to fully integrate into a nationwide system poses another hurdle.

This process may pose a perceived or actual threat to the independence of private practice. While there may be advantages for the profession, such as greater visibility for psychology, some practitioners weigh such potential benefits against concerns that include records security and confidentiality.

Dr. Story is a member of the Board of Professional Affairs’ Health Information Technology Working Group. This content reflects his presentation during a 2009 APA Convention presentation, “Assessment Data in a National Electronic Health Records System.”
How Psychotherapy Helps People Recover From Depression

According to the National Institute of Mental Health, more than 18 million adult Americans suffer from depression during any one-year period. The Substance Abuse and Mental Health Services Administration has reported that more than two million adolescents in the U.S. experience at least one major depressive episode every year. Many people with depression do not recognize that they have a condition that can be treated effectively. This question-and-answer fact sheet discusses depression with a focus on how psychotherapy can help a person suffering from depression to recover.

How does depression differ from occasional sadness?

While everyone occasionally feels sad or “blue,” these feelings tend to pass rather quickly.

By contrast, someone with depression experiences extreme sadness or despair that lasts for at least two weeks or longer. Depressed individuals tend to feel helpless and hopeless and to blame themselves for having these feelings. Depression interferes with activities of daily living—such as working or concentrating on tasks, or even eating and sleeping.

Other possible symptoms of depression include chronic pain, headaches or stomach aches. Some people may feel angry or restless for long periods.

People who are depressed may become overwhelmed and exhausted and stop participating in certain everyday activities altogether. They may withdraw from family and friends. Some depressed individuals may have thoughts of death or suicide.

What causes depression?

A combination of genetic, chemical, biological, psychological, social and environmental factors likely contributes to the disorder. Depression is often a signal that certain mental, emotional and physical aspects of a person’s life are out of balance. Chronic and serious illness such as heart disease or cancer may be accompanied by depression.

Significant transitions and major life stressors such as the death of a loved one or the loss of a job can help bring about depression. Other more subtle factors that lead to a loss of self-identity or self-esteem may also contribute. The causes of depression are not always immediately apparent, so the disorder requires careful evaluation and diagnosis by a trained mental health care professional.

Sometimes the circumstances involved in depression are ones over which an individual has little or no control. At other times, however, depression occurs when people are unable to see that they actually have choices and can bring about change in their lives.

Can depression be treated successfully?

Absolutely. Depression is highly treatable when an individual receives competent care. Licensed psychologists are highly trained mental health professionals with years of experience studying depression and helping patients recover from it.

There is still some stigma or reluctance associated with seeking help for emotional and mental health problems, including depression. Unfortunately, feelings of depression often are viewed as a sign of weakness rather than as a signal that something is out of balance. The fact is that people with depression can not simply “snap out of it” and feel better spontaneously.

Persons with depression who do not seek help suffer needlessly. Unexpressed feelings and concerns accompanied by a sense of isolation can worsen a depression.

Getting quality treatment is crucial. If depression goes untreated, it can last for long time and worsen other illnesses. Even people with severe depression benefit from treatment.

What evidence supports the use of psychotherapy for treatment?

Many research studies have demonstrated that psychotherapy, or talk therapy, is effective for treating depression and relieving symptoms experienced by individuals who suffer from depression. Psychological treatments may prevent a person with milder depression from becoming more severely depressed.
And although a past history of depression increases the risk of future episodes, there is evidence that ongoing psychotherapy may lessen the chance of recurrence.

**How does psychotherapy help people recover?**

There are several approaches to psychotherapy — including cognitive-behavioral, interpersonal and other kinds of talk therapy — that help individuals recover from depression. Psychotherapy helps people identify the factors that contribute to their depression and deal effectively with the psychological, behavioral, interpersonal and situational contributors.

Skilled health and mental health professionals such as licensed psychologists can work with individuals who are depressed to:

- Pinpoint the life problems that contribute to their depression, and help them understand which aspects of those problems they may be able to solve or improve. A licensed psychologist can help depressed patients identify options for the future and set realistic goals that enable them to enhance their mental and emotional well-being. Psychotherapy also can assist individuals who have been depressed in the past with identifying how they have successfully dealt with similar feelings.

- Identify negative or distorted thought patterns that contribute to feelings of hopelessness and helplessness that accompany depression.

- Develop skills to relieve suffering and prevent later bouts of depression. Skills may include developing or strengthening social networks, creating new ways to cope with challenges and crafting a personal self-care plan that includes positive lifestyle changes.

**In what other ways do psychologists help individuals suffering from depression and their loved ones?**

Living with a depressed person can be very difficult and stressful on family members and friends. The pain of watching a loved one suffer from depression can bring about feelings of helplessness and loss.

Family or couples therapy may be beneficial in bringing together all the individuals affected by depression and helping them learn effective ways to cope together. This type of psychotherapy can also provide a good opportunity for individuals who have never experienced depression themselves to learn more about it and identify constructive ways to support a loved one who is suffering from depression.

The support and involvement of family and friends can play a crucial role in aiding someone who is depressed. Individuals in the “support system” can encourage a depressed loved one to stick with treatment and practice the coping techniques and problem-solving skills he or she is learning through psychotherapy.

**Are medications useful for treating depression?**

Medications are helpful for reducing symptoms of depression in some people, particularly when their depression is severe. Some health care professionals treating depression may favor using a combination of psychotherapy and medications. Given the side effects, any use of medication requires close monitoring.

Psychotherapy is often recommended as a first line of treatment for children and adolescents, especially those with mild to moderate depression. Further, some adults with depression may prefer psychotherapy to the use of medications if their depression is not severe.

By conducting a thorough assessment, a licensed and trained mental health professional can help make recommendations about an effective course of treatment for an individual’s depression.

*Depression can seriously impair a person’s ability to function in everyday situations. But the prospects for recovery are good for individuals with depression who receive appropriate professional care.*

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New Resources for Practitioners

Introducing PRACTICE CENTRAL

The APA Practice Organization is pleased to announce the December 2009 launch of a new online home for members: Practice Central. Our Web site at apapрактиcecentral.org offers one-stop access to a wide variety of resources and products tailored to practicing psychologists, including:

- New Continuing Education (CE) courses and other professional development resources
- Guidance and updates on legislative and legal issues for practitioners
- How to use billing codes and other practical pointers on reimbursement
- Information to help build, manage, market and diversify your psychology practice
- Client and public education resources
- ...and much more!

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• Checklist for Evidence-Based Practice
• New Feature: Removable Public Education Resource
  ... and more