How to Build Your Cultural Competence

Nine Ways to Draw More People to Your Website
PAGE 8

Serving Patients in Poverty
PAGE 22

Cognitive Problems in Patients Living with HIV
PAGE 18
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CONTENTS

NEWS WRAP-UP
2  Reimbursement Changes You Need to Know About Now
3  How Psychologists Are Using Telehealth to Reach New Parents

TECHNOLOGY IN PRACTICE
4  Comparing the Latest Telehealth Solutions
8  Nine Ways to Draw More People to Your Website

ENHANCING YOUR SKILLS
12  How You Can Be More Culturally Competent

ADVANCING PRACTICE
18  On the Lookout for Cognitive Problems in Patients Living with HIV
22  Serving Patients in Poverty

LEGAL AND REGULATORY ISSUES
26  What Private-Pay Practitioners Need to Know About Insurance
Every January, the Centers for Medicare and Medicaid Services (CMS) implement changes to the Physician Fee Schedule—the set of detailed instructions, payment policies, and new or modified Current Procedural Terminology codes (CPT®) and their relative values they use reimburse Medicare providers for the services they provide. These updates often lead other third-party payers to change their coding requirements and payment rates, too. Here are the most notable changes in effect for 2020.

NEW BILLING CODES FOR COGNITIVE FUNCTION SERVICES
Psychologists will now use two time-based codes for performing therapeutic interventions that focus on cognitive function.

97129: Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving; and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
» Work RVU: 0.50

+97130: Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
» Work RVU: 0.48

These codes replace deleted codes 97217 and G0515. Psychologists must now use the stand-alone base code, 97129, to report the first 15 minutes of performing the primary service, and a 15-minute add-on code, 97130, which can be reported in multiple units, to report time beyond the initial 30 minutes that is required to complete the overall service.

HIGHER PAYMENTS FOR HEALTH BEHAVIOR SERVICES
Psychologists who help Medicare patients cope with or manage a physical health condition will see an increase in their payments when billing health behavior assessment and intervention CPT codes. CMS announced the higher work relative value units after receiving feedback from more than 6,000 psychologists on proposed changes to these services.

Learn more about the codes and their new values in the Reimbursement section of APA’s website at apaservices.org/practice/reimbursement/health-codes.

Those who are not exempt, and fail to report to MIPS, will see reimbursement penalties in 2022.

Psychologists are not required to—but may—report measures in the “Promoting Interoperability” category—one of four parts of MIPS. This category in MIPS contains measures for providers who integrate electronic health records into their practice.

Psychologists who participate in MIPS can report measures for other categories through APA’s Mental and Behavioral Health Registry. Visit the registry at MBHRegistry.com.

PSYCHOLOGISTS’ PARTICIPATION IN MIPS

In 2020, psychologists who bill Medicare will be expected to report to the CMS Merit-Based Incentive Payment System (MIPS) unless they fall under the low volume threshold. Psychologists can check their eligibility status on the CMS website: qpp.cms.gov/participation-lookup.

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Clinicians are bringing therapy sessions to new moms via phone or web video conferencing.

Dr. Dharai Meghani, PhD, has spent years working with children, pregnant women, and new mothers, learning about how their backgrounds can affect their development as parents. But after giving birth to her first child, she saw first-hand how new parents’ demanding schedules keep them from getting the mental health support they need. And for some new moms, the need is great for mental health care: About one in nine women experience symptoms of postpartum depression, according to the Centers for Disease Control and Prevention.

In response to that need, in 2016 Meghani joined colleague and fellow new mom Paulina Barahona, MS, to create Parentline San Francisco, a free telebehavioral health service specifically for new parents, based out of the University of San Francisco (USF) clinical psychology program where Meghani is an assistant professor and core faculty member.

“We were wondering how we could provide a service that is accessible to new parents—because it’s so hard to get out the door and have regular therapy appointments—that is also brief and solutions focused,” Meghani says. “Parents have a hard time coming to us, but we could go to them through telemental health services.”

Pediatricians and pediatric nurses direct patients—usually new parents who are worried about their babies’ behaviors or who are experiencing symptoms of depression and anxiety—to call the Parentline voicemail number. Then, within 24 hours, USF psychology doctoral students return the calls and schedule times parents can speak with a clinician, either via phone or Zoom, a web video conferencing platform that is compliant with the Health Insurance Portability and Accountability Act.

Grants from the USF Jesuit foundation, USF Faculty Development Fund and the American Psychological Association have funded the program’s development, promotion, and research efforts.

The USF program caught the attention of Tracy Vozar, PhD, director of Infant and Early Childhood Mental Health Specialty at the University of Denver, so she worked with Meghani to launch Parentline Colorado at the university in December 2019.

“Twenty-two counties in Colorado do not have a licensed psychologist and many prospective clients live in rural or mountainous regions. This is a great opportunity to provide services to folks who maybe thought they wanted to come in for therapy, but for a variety of reasons it’s harder for them to come into the clinic,” says Vozar.

Parentline Colorado is also free for patients, paid for by a grant for the first year. In future years, the program will offer sliding-fee schedules and allow patients to use Medicaid.

And like the patients, the doctoral students and clinicians participating in Parentline enjoy the same flexibility benefits that telehealth services provide.

“Psychologists, we have a tendency to think about our clinical appointments being one time a week, 50 minutes long, but when you’re offering these services on Zoom or over the phone there is an option to really be flexible in a way that’s helpful rather than hindering,” Vozar says. She adds that the doctoral trainees love being able to offer Parentline services from anywhere, as long as they have access to good WiFi and are in a location that guarantees privacy and confidentiality.

Barahona says the next steps for Parentline include sharing some of the data they’ve been collecting on new parent experiences and possibly launching Parentline in more areas.

For more information about Parentline, visit parentlineusf.com.

University of Denver’s CUB Clinic website provides more information about Parentline Colorado: du.edu/gspp/services/cub/index.html
video conferencing technology enables health professionals to provide services regardless of their location—breaking down a significant barrier to care. With third-party payers increasingly reimbursing for telehealth services, it has become a viable option for many psychologists who want to enhance their practices. But how do you find a user-friendly, high-functioning platform that is also compliant with the Health Insurance Portability and Accountability Act (HIPAA) and won’t break your bank?

Our panel of psychologists rate and review three popular telehealth platforms to help you find one that might be the right fit.

A review of Doxy.me, ther a-LINK and Zoom

BY NICOLE OWINGS-FONNER, MA

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

This column 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 (nowings-fonner@apa.org).

LET’S GET TECHNICAL

COMPARING THE LATEST TELEHEALTH SOLUTIONS

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.
Doxy.me casts itself as an easy-to-use, secure telemedicine tool that is available on any device without requiring a download. Its free version is fully functional, HIPAA compliant and includes a Business Associate Agreement (BAA) at no charge, supporting the company’s mission to make telemedicine available to everyone. Doxy.me offers two premium versions which enable customization options and real-time customer support, file transfer, payment processing, and text and email notifications.

**KEY TO PSYCHOLOGIST RATINGS**

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<th>Categories are rated from 1 to 5, with 5 being the most positive score</th>
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<td><strong>Does this software provide good value for the money spent?</strong></td>
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<td><strong>Would you recommend this software to other psychologists?</strong></td>
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**Doxy.me**

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**KRISTI K. PHILLIPS, PsyD**

Doxy.me is easy to use and provides a seamless, HIPAA compliant telehealth experience for both the psychologist and the client. I would recommend the premium version of Doxy.me to psychologists who want an intuitive, high-resolution telehealth platform. I particularly enjoy the customization feature that the premium version provides, because it helps the client feel secure knowing they are in the appropriate waiting room with the practice logos and other identifying information. I rate the free version as a 4 out of 5. The customer service would be more effective if they offered support either by telephone or by chat. I appreciate the peace of mind that comes with knowing that if problems arise, there is immediate support with the premium version, especially given the sensitivity of our work.

**CHARMAIN F. JACKMAN, PhD**

I have been using Doxy.me for the past three years and would definitely recommend it to other practitioners. Doxy is easy to use, especially from the client perspective. Doxy provides the best value for the money as it is free and offers a free BAA. It provides security and data-encryption for all users. I love that Doxy’s mission is to make telehealth available to everyone!
thera-LINK describes itself as a HIPAA secure video platform created by therapists for therapists. In addition to useful features such as payment processing, custom waiting rooms and patient self-scheduling, thera-LINK’s Plus and Ultimate plans offer a public listing for consumers who are looking for a telepsychology provider. After a free trial, thera-LINK offers three tiers of paid services.

Zoom is a video conferencing platform with separate products tailored to different industries. Its telehealth solution is HIPAA compliant and promises to deliver consistently high-quality video, regardless of bandwidth, with software that integrates smoothly into the technology and workflow of health professionals. Also included are video conferencing features for internal communications such as meetings and trainings.

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**JOANNA ROMERO CARTAYA, PhD**

thera-LINK is a tailored telehealth service for mental health providers, especially those who may want to develop a regular telepsychology practice. A better range of service options is available in the plus and ultimate plans for not too much additional cost. thera-LINK has the capability to be used on any device; however, it only works well on WiFi and on well-charged devices or those that have a readily available power source. thera-LINK is fairly easy to customize and personalize. Customer service is highly responsive and easy to access through messaging, even while in a session, to troubleshoot.

**KEVIN D. ARNOLD, PhD, ABPP**

I would not generally recommend this software at this time, at least if the psychologist is on a Mac platform. It did not deliver the actual audio-video functionality that one would expect to be at the core of this program. Also, the app was what many would consider out-of-date; the current version appeared to be at least one year old. In contrast, much of the set-up and processing features (e.g., client set-up and payment processing) seemed very straightforward, and customer service is very quick to respond. If a psychologist is looking for an intuitively easy-to-start-up telepsychology platform, thera-LINK may require an investment of time in educating oneself on the operation of the system and ensuring patients are equipped to utilize its technical features.

**JOANNA ROMERO CARTAYA, PhD**

Zoom Healthcare is versatile, easy to use and highly customizable, providing multiple functions in addition to patient care. The service works on all devices and performs well even under low bandwidth conditions. It is HIPAA compliant, with high security and privacy standards. This is a high-performing telehealth service. However, it is quite expensive for those who may have smaller to midsize practices or clinics. For those who are midsize to large and may use Zoom Healthcare for multiple purposes (i.e., training, recording capability, meetings, consultation, seminars, groups and integration with EHR, etc.) the price point is of high value.

**CHARMAIN F. JACKMAN, PhD**

Zoom offers a high level of security with a pricey BAA. The platform is easy to navigate for both providers and clients, offering some unique features such as audio transcription. For a small practice where telehealth is used primarily for individual, group or family therapy, Zoom would not be the best option from a financial perspective, as there are more reasonably priced plans available elsewhere. However, for large practices with video conferencing needs beyond therapy, Zoom might be just right for you.
APA has redesigned its top app. Monitor+ offers the journalism you expect from the world’s favorite magazine for psychologists, plus breaking psychology news and podcasts.

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NINE WAYS TO DRAW MORE PEOPLE TO YOUR WEBSITE

When Alexis Moreno, PsyD, got her degree and launched a Washington, D.C.-based consulting firm called Wit & Reason in 2017, she knew she needed a good website to set her business apart. Many psychologists’ websites looked exactly the same, she noticed—a light color palette and a photo of a lotus flower or succulent. “That didn’t reflect who I was—my personality,” says Moreno. “I wanted a place that was really welcoming, bright and fun.”

After working with a designer, Moreno launched a site (witandreason.com) that enables visitors to learn about her practice’s mission and services, and also to learn about psychology and mental health through articles, videos and even audio content. “My site is friendly and welcoming, without the stigma associated with mental health and psychotherapy,” she says. “It’s a one-stop shop to learn more about us and our industry.”

To make sure your website achieves your goals and best represents you:

1. Consider hiring a website pro. At first, Marc Martinez, PhD, went the do-it-yourself website route, but as his Penfield, New York, practice, grew, he turned to a local web designer to create a new site. “Because of my lack of technological sophistication, the first website just didn’t look very professional,” he says. Although Martinez already has a steady stream of referrals, the website helps him put his “best professional foot forward” as he seeks to expand his practice throughout New York. While Martinez heard of colleagues spending between $5,000 and $10,000 on their websites, he paid around $2,000 to $3,000, an investment in his marketing efforts he feels was well worth it. Although you can build your own site for free at sites like wix.com or squarespace.com, the average price

Essential steps for creating an internet home for your practice that draws people in and encourages them stay

BY REBECCA A. CLAY
for having a professional designer build a small business website is $3,000 to $6,000, according to website designer Mark Brinker, author of *The Modern Website Makeover*. Costs can be as high as $20,000, he says, if your site has lots of pages and needs lots of customization.

2. Take into account your brand, your personality and the patients you want to serve. Whether you’re going to design your site yourself or work with a designer, think about your brand and what makes your practice different. While the services your practice offers may be similar to those of your peers, says Moreno, “we each have our own unique style, orientation, personality and values that we bring into how we do our work.” Your website should reflect that, she says, adding that she showed her designer artwork she liked to help inspire her website design.

3. Make sure your website reflects your practice. Many of the patients Lisa Caren Litt, PhD, sees at her New York City private practice are women, many of whom have survived sexual assault and other trauma and who are addressing substance use concerns. To appeal to that clientele and reflect her own personal aesthetic, Litt created a website design (drlisalitt.com) featuring colors and images—such as photographs of orchids and other vibrant flowers—that project a soothing, feminine feeling. On Martinez’s site, images of legal tomes, scales and brain scans underscore his specialization in forensic psychology services.

4. Keep your site uncluttered. Make sure users don’t have to dig for the information they need, says Martinez. “I wanted my site to be simple, not flashy,” he says. “I wanted it to be easy to navigate so people wouldn’t be overwhelmed with information but could learn about me and my practice.” To do that, be sure to focus on the main reasons someone would be coming to your site, says Jaswant Pujari, co-founder and chief executive officer of Therasoft, which offers website design and support, practice-management software and other tools to mental health professionals. Engage potential clients with a message about how you can help them, then offer information about you, your services, your rates and what insurance you accept. Make your website functional, too, says Pujari. Visitors should be able to book appointments and make payments, for example. And make it easy to contact you. On Moreno’s site, for instance, there’s information about how to contact the practice and book a session on every page. “We don’t want visitors to struggle at all,” she says, adding that the site gives users the option to call, email or use an online form.

5. Ensure your website is accessible to all users. In October 2019, the Supreme Court decided not to hear a case about website accessibility and let stand a Ninth Circuit decision saying that websites must be accessible to the visually impaired under the Americans With Disabilities Act. While there are still no nationwide accessibility standards for websites, you and your website designer can work your way through the items in the Web Content Accessibility Guidelines (w3.org/WAI).
standards-guidelines/wcag) developed by the World Wide Web Consortium’s Web Accessibility Initiative. According to Samantha Benn, a team leader at TherapySites, good places to start include using high-contrast color schemes, adding transcripts to video and audio components and using “alt text” for all images, which offers a written description so that individuals who use text readers can “see” what the pictures depict. You can also add an “accessibility view” button to your site that strips the site “down to the bare bones” to make it easier for users to find key content, she adds.

6. Make sure people can find your website when they search for mental health services. Use keywords on your site to enhance results via search engine optimization (SEO), or strategies that boost your website’s chances of coming up in Google and other search engine results. Think about what words or phrases the people who need your services might use to find you, suggests Entrepreneur magazine, then use a tool like Keyword Explorer (moz.com/explorer) to see how often people search for those terms and how much competition you’ll have if you use them. “Throughout my website, I included terms that I thought people would search for,” says Litt, citing as examples “trauma,” “PTSD,” “cognitive-behavioral therapy” and “substance use.” “I sprinkled those words around.” Be sure to use the words and phrases would-be patients or clients actually use, adds Moreno. “‘Mental health,’ ‘wellness, ‘self-care’—those are big ones that the average person is looking for,” she says. “It’s not necessarily going to be psychology language.” Even photos and videos have tags that boost the site during searches, she adds.

7. Consider Google ads. Google ads pop up on search result pages along with what Google calls “organic results,” the usual results where your website itself might show up. “Running some Google ads primes the pump and helps your website become visible more quickly,” says Pujari. “A lot of people say, ‘I’m not going to spend $500 in Google ads; I’m just going to create a nice website,’” he says. “But as soon as you spend that $500, Google pulls your website out and puts it right up front in search results.”

8. Be consistent across platforms. Whether it’s her website, her business card or other marketing materials, Moreno reinforces her brand by using the same font, color scheme and other design elements. Every page on the Wit & Reason site also has links to the company’s Facebook, Instagram, Twitter, LinkedIn, YouTube and other accounts. Also add your website address to your email signature line.

9. Update your site regularly. When Moreno first launched her website, she tried blogging as a way to boost SEO, but she quickly found it too time-consuming. Now, she and her colleagues link to TED Talks, news articles, their own radio shows—anything they think clients might find useful. Even small changes can help entice visitors to return to your site and boost your results on search engines. “If you have a static website that never changes, Google doesn’t come back to you,” says Pujari, explaining that Google and other search engines scour the internet to build a huge index of website content. If you haven’t used keywords and other strategies for making your site “crawler friendly,” warns Pujari, the crawlers will skip your site. Similarly, if your site never changes, the crawlers won’t come back. “If you have a blog on the site, if you’re adding articles and constantly changing things, Google keeps coming back there,” he says. Maintaining the site properly means you’ll have to call on your designer periodically or learn how to do updates yourself. “We definitely didn’t want a site designer who was going to launch something we couldn’t maintain,” says Moreno, who asked her designer to teach her to update the site.

“Your website is like a business card and brochure you don’t have to hand people; they’re coming and getting it on their own,” says Pujari. “If it grabs their attention and is relevant to what they’re looking for, they’ll stay.”

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WHAT, WHEN, AND HOW MUCH TO POST
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Brand Identity
HOW TO BUILD A BRAND THAT REPRESENTS YOUR UNIQUE VALUES AND SPEAKS TO YOUR IDEAL CLIENT
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HOW YOU CAN BE MORE CULTURALLY COMPETENT

Building a multicultural, inclusive practice isn’t as difficult as many psychologists may think

BY HANNAH CALKINS
In today’s increasingly diverse world, cultural competence is a critical skill for psychologists, yet it may not have been well integrated into their training, if it was covered at all. Cultural competence is defined as an individual’s demonstrated ability to interact and communicate effectively, respectfully and empathetically with people whose cultural identities and backgrounds may differ from their own. Without it, clinicians risk alienating or even harming their patients.

“I can’t tell you how many people have come to our practice after not feeling heard by therapists who they didn’t believe understood them, their background or their values,” says Amanda Rios, PsyD, who co-owns a multicultural, inclusive practice in the Chicago area.

Cultural competence is also important from an industry standpoint. The U.S. Census Bureau estimates that nonwhite racial and ethnic groups will represent more than 56% of the population by 2050, and yet, APA’s Center for Workforce Studies recently reported that most psychologists infrequently provide services to nonwhite clients. Meanwhile, multiple reports have shown that inequality in health care, including mental health care, is a pervasive problem with dire consequences.

Whether you have a solo practice or work in an organization, psychology practice that is diverse, multicultural and inclusive of people of all backgrounds and identities is both ethical and sustainable. However, you may feel overwhelmed or uncertain about what it takes to become culturally competent.

So, how do you get there? Here is what you need to know—and do—to put cultural competence into practice.

UNDERSTAND WHAT “CULTURAL COMPETENCE” MEANS—AND WHAT IT DOESN’T

Becoming culturally competent involves learning about other cultures, but it also means understanding your own cultural context, says Rios.

“Knowledge and skills certainly matter, but it’s more than that. Cultural competence is about understanding yourself as a cultural being, and the impact that you have on other cultural beings in a variety of spaces and contexts,” she says.
Psychologists should be especially mindful that people whose identities don’t align with the prevailing culture in the United States—which tends to be white, male-dominated, Christian, able-bodied and hetero- and cisgender-normative—face distinct challenges, says Rahul Sharma, PsyD, a licensed clinical psychologist and consultant in Chicago. “If we don’t have the acuity to incorporate other lived experiences into our understanding, we’re missing the boat when it comes to truly getting somebody,” he says.

Ammara Khalid, PsyD, who co-owns the practice with Rios, emphasizes that true cultural competence is an aspirational goal. “This isn’t something we can master or complete, because we’re always learning, and cultures are always evolving,” she says. “I like to think of it in terms of proficiency versus fluency, as with languages,” says Sharma. “Proficiency is the floor and fluency—or competence—is the goal.”

CONDUCT A CULTURAL SELF-ASSESSMENT
The first step toward becoming culturally competent is acknowledging that you have a cultural lens, says Sharma. “Who we are as people is our biggest tool for growth and healing with our clients,” Rios says. “Ask yourself: What are your values? What are you bringing into the room with clients?”

Khalid agrees. “The important questions to ask yourself are: What are my identifiers? What are my clients’ identifiers? Where do we match, and where are we different? What do I still need to learn, and what stereotypes, prejudices or biases may be influencing me?” At the same time, she says, be mindful of overidentifying with your patients. “I’m South Asian, and so are many of my clients,” says Khalid. “I always have to ask myself: Am I making assumptions about our shared experience? Or am I keeping their experience separate from mine?”

The next step in conducting a cultural self-assessment is taking an honest look at your social and professional circle and understanding how it might reflect your biases, says Sharma. “What are the demographics of your clients and your co-workers?” he says. “Ask yourself that without a sense of shame or rationalizing. And then ask: What can I do to make sure the

“If we don’t have the acuity to incorporate other lived experiences into our understanding, we’re missing the boat when it comes to truly getting somebody.”

RAHUL SHARMA, PsyD
“The important questions to ask yourself are: What are my identifiers? What are my clients’ identifiers?... What do I still need to learn, and what stereotypes, prejudices or biases may be influencing me?”

AMMARA KHALID, PsyD

GET COMFORTABLE WITH DISCOMFORT
Practitioners must take initiative to seek out new experiences, learn and—crucially—make mistakes. Fortunately, there are many ways to educate yourself, Sharma says.

“Form a multicultural consulting group, or join a book club focused on multiculturalism. Attend diversity summits and conferences. Check in with APA’s Div. 45 (Society for the Psychological Study of Culture, Ethnicity and Race),” he suggests. “You will be a better clinician for doing it.”

The main objective is to avoid burdening your clients with the task of educating you.

“It’s unfair to use them to teach you about [their] culture. That’s not to say you can’t learn from them, but that’s not their role,” Rios says.

Even with the best of intentions, you will make mistakes, but that’s part of the learning process, Khalid says.

“It will happen, so how you respond is key in developing the therapeutic relationship,” she says. “Can you apologize, accept responsibility and give yourself permission to make mistakes?”

Rios agrees, adding that it’s “important to make room for error and repair with clients.”

RETHINK YOUR PROFESSIONAL PRESENTATION
“Look at your website and marketing materials,” suggests Khalid. “Do you have a mission statement that broadcasts inclusivity? Do you mention it in your practice description?”

In their practice, Rios and Khalid list the gender pronouns on their providers’ profiles, and their intake forms use gender-neutral language. They also ask their clients to self-identify on intake forms using fill-in-the-blanks, not check boxes.

During therapy sessions, Rios, Khalid and Sharma encourage practitioners to approach
ENHANCING YOUR SKILLS

clients with curiosity, humility and respect.
“Cultural competence is synonymous with listening,” says Khalid. “Your clients need to be heard, and to really hear them, you can’t separate them from their cultural context.”

This is true for every client, she says, even those who don’t belong to underrepresented or marginalized groups. These contextual factors must be acknowledged in every case note or report, she says.

Who you work with matters, too. “If you own a practice, ask yourself what you’re doing to be more inclusive in your hiring,” says Rios. “And if you aren’t in a position of hiring power, ask questions in your job interviews that are about cultural competence and representation.”

It’s also important to be mindful that therapy can be prohibitively expensive for many people, especially those who belong to marginalized groups. Rios suggests coming up with creative ways to make therapy more affordable, such as by offering a sliding scale or employing therapists-in-training.

CHALLENGE STRUCTURAL PROBLEMS
Psychologists must work together to break down the barriers that preclude many people from accessing care and prevent the profession from being as diverse and inclusive as it could be.

On a societal level, Sharma suggests getting involved in political advocacy, or speaking to the news media about improving access to mental health care. He also suggests partnering with community leaders to do mental health outreach in underrepresented communities.

Within the profession, psychologists can address systemic problems by acknowledging the inherent biases in the research, literature and tools they rely on, which are still defined by a white, heteronormative, cisgender perspective, says Khalid.

Many psychologists are already working toward this and other significant reforms. For example, in August 2019, the APA Council of Representatives adopted the APA Guidelines on Race and Ethnicity in Psychology: Promoting Responsiveness and Equity, which aim to update and augment an earlier set of guidelines on multicultural practice. The guidelines call for psychologists to create a “supportive, inclusive environment for racially and ethnically diverse students and professional psychologists,” which could include strategic mentorship and leadership development for psychologists from underrepresented groups.

But this kind of recruitment could start long before graduate school, says Rios. “I think we need an intervention even before the undergraduate level. We need outreach to juniors and seniors in high school,” she says.

These goals are ambitious, but they are in reach—and their realization will benefit you and your clients. As Khalid, Rios and Sharma demonstrate, aspiring toward cultural competence is an opportunity to be a more empathetic, effective and successful practitioner. ●

The APA Guidelines on Race and Ethnicity in Psychology are available online at apa.org/about/policy/guidelines-race-ethnicity.pdf
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ON THE LOOKOUT FOR COGNITIVE PROBLEMS IN PATIENTS LIVING WITH HIV

A new APA resolution recommends ways to provide neuropsychological assessments for patients with cognitive disorders related to their HIV status

BY HANNAH CALKINS
In the mid-1990s, combined antiretroviral therapy (cART) revolutionized the treatment of HIV, enabling people with the virus who receive treatment to live nearly as long as people without it. However, people living with HIV are still at risk for HIV-associated neurocognitive disorders, or HAND, says David J. Moore, PhD, a professor of psychiatry at the University of California San Diego and an investigator at the university’s HIV Neurobehavioral Research Center.

“Impairments caused by HAND are often mild, but they still may impact people’s lives, and so we need to be able to detect them,” says Moore, who is also a member of APA’s Committee on Psychology and AIDS (COPA).

Research suggests that HAND is likely caused by pathogens crossing the blood-brain barrier and setting off a neuroinflammatory response in the brain that may never recede, even if the person is being successfully treated with cART. The resulting chronic low-grade inflammation can cause neurocognitive impairments, says April Thames, PhD, an associate professor of psychology at the University of Southern California and practicing neuropsychologist. According to some reports, about 52% of people living with HIV have some form of HAND. Those over age 50 may be at increased risk for developing these disorders. Additional risk factors for HAND include poor disease control, co-occurring health conditions, and affective symptoms, such as depression and apathy.

In August 2019, the APA Council of Representatives adopted a resolution that seeks to increase awareness of HAND among psychologists and encourages a sensitive and nuanced approach to the neuropsychological assessment of people living with HIV.

“The resolution is intended to increase awareness that HAND can exist, and try and decrease the stigma associated with it,” said Moore. “Now that people with HIV are getting older, how can we make sure that they’re getting the highest quality of life they can in their older years?”

A SUBTLE CONDITION

People with HAND may have trouble performing complex daily tasks, such as driving a car or managing finances, as well as difficulties with multitasking, says Pariya Fazeli Wheeler, PhD, a developmental psychologist and assistant professor in the School of Nursing at the University of Alabama at Birmingham.

However, these impairments generally do not get progressively worse.

“The most common trajectory with HAND is a stable-mild impairment, in contrast to other neurodegenerative conditions, such as Alzheimer’s,” Moore says. In fact, some people with HAND improve over time.

Still, even subtle impairments can have negative effects on an individual’s livelihood, health and relationships. People at risk for HAND should be appropriately and routinely assessed, and those assessments should inform their treatment, says Moore.

According to APA’s resolution, brief screening measures of cognitive status aren’t sensitive enough to detect milder forms of HAND.

Also, neuropsychologists who are used to identifying very clear etiologies—such as...
with traumatic brain injuries or non-HIV-associated dementias—may need to readjust their approach to fully appreciate the complexity of how HIV affects the brain, says Thames.

To address this complexity, the resolution calls for “reliable, valid and culturally and linguistically appropriate assessments” to evaluate and diagnose HAND.

That means tests for HAND need to pick up on what may be the “patchy” or fluctuating nature of the impairment, says Maria Marquine, PhD, also at the University of California San Diego and, along with Moore, a researcher in the HIV Neurobehavioral Research Center.

The “culturally and linguistically appropriate” piece of the resolution requires particular attention, she says. HIV disproportionately affects people who are racial and ethnic minorities, and those populations are also at increased risk for HAND. However, they are not well represented in the data many assessment tools rely on, says Marquine.

“We don’t have very good normative adjustments for many cultural groups, but we’re working on developing them,” she says. That’s why practitioners should be culturally competent when “seeing and evaluating persons of diverse racial or ethnic origin, especially when from a different linguistic background than them,” says Marquine.

If a psychologist does not feel that he or she has the cultural competency to work with certain patients, it may be best to make a referral to another practitioner, she says.

Psychologists should also be aware of the high correlation between education level and performance on cognitive tests, say Marquine and Thames. Additionally, Fazeli notes that quality of education can also affect test results, which may be an issue when testing individuals from disadvantaged groups.

Similarly, socioeconomic status plays a role both in the trajectory of HAND and on individual performance on cognitive tests, says Thames. People living with HIV who have little or no access to health care are more susceptible to HAND, but at the same time, typical measures of daily functioning may not apply to them, and therefore may not be good indicators of impairment.

“Whether someone is still managing their finances well, or regularly doing their grocery shopping and cooking, is only a good barometer for functional impairment if they were already doing those things,” she says.

**CO-OCCURRING CONDITIONS**

Co-occurring conditions play a significant role in the development and trajectory of HAND, even though researchers have not yet determined precisely why or how.

According to Moore, metabolic syndrome factors—such as obesity, hypertension and diabetes—seem to put people at greater risk for HAND. People living with HIV are also more likely to have these conditions, along with histories of trauma, anxiety and depression.

In particular, psychologists should be aware that depression and HAND share some symptoms, such as lack of concentration, sleeping difficulties, apathy and psychomotor issues, says Thames.

Furthermore, “depression or apathy may impact reporting or perception of daily functioning difficulties,” says Fazeli.

Treating psychologists who notice these issues “may need to refer the patient for neuropsychological assessment to disentangle what is mood and what is HAND,” Thames says.

At the same time, Moore says that treating suspected depression can have a clarifying effect. “If you treat the depression and have some resolution, then maybe you have a clearer picture of how the cognitive problems related to mood,” he says.

Still, Moore emphasizes that not all patients will have co-occurring conditions. Psychologists should be careful not to overpathologize people living with HIV, he says.

**KEY TAKEAWAYS**

Marquine says psychologists should be aware that a patient’s overall health isn’t necessarily a good indication of whether they have HAND. “Their HIV may be well controlled, but that doesn’t necessarily mean that their cognitive function is intact,” she says.

Also notable, says Fazeli, is the fact that many older adults living with HIV do not have any neurocognitive impairments.
So, says Moore, the best rule of thumb when working with patients living with HIV is to ask them whether they are having any problems with cognition. If so, they should be referred for assessment, he says. If HAND is diagnosed, that diagnosis can begin to inform treatment.

“We don’t have great interventions, but there is some evidence that increased physical activity can have a positive effect on HAND,” says Moore.

Fazeli agrees, adding that some interventions focused on compensation methods—such as making lists and using medication reminders—can counteract some memory deficits.

“Bolstering health literacy in this population may also be able to buffer some of the effects of cognitive impairment, particularly with respect to treatment management abilities,” she says.

A major takeaway from the resolution, says Moore, is that there is a significant role for psychologists to play in identifying and treating HAND, as well as in improving quality of life for people who have it.

“Make sure your patients know that a diagnosis of HAND doesn’t mean they will get dementia. It can be stabilized or even largely resolved,” Moore says. “Ultimately, the message of the resolution is one of hope and possibilities.”

To read the APA Resolution on Neuropsychological Assessment of Persons Living With HIV Infection, go to apa.org/about/policy/resolution-neuropsychological-assessment-hiv.pdf.

RESOURCES

Serving Patients in Poverty

Homelessness, joblessness and immigration concerns are just a few of the issues that lead economically marginalized people to mental health services. Here’s how to build a successful practice that serves people in poverty.

BY REBECCA A. CLAY
If you’re in private practice, chances are most of your patients are not homeless, unemployed or considered members of the “working poor.” These are patients with great behavioral health needs that psychologists are uniquely suited to meet, says APA Past-President Rosie Phillips Davis, PhD, who made combating poverty her main presidential initiative. “But unless you’re working for an agency, a hospital or a clinic, you probably don’t see poor people in practice,” says Davis.

According to a report from APA’s Center for Workforce Studies, almost two-thirds of psychologists responding to APA’s 2015 Survey of Psychology Health Service Providers never, rarely or only occasionally worked with the working poor. For homeless people, the figure was 91%.

That shortage of practitioners is why Arlene Noriega, PhD, decided to target economically marginalized Latinx immigrants when she opened her Atlanta-area psychotherapy practice in 2000. “I’ve dedicated my professional career to the working poor,” says Noriega, whose two-person practice provides bilingual services primarily to children on Medicaid.

Shilpa Trivedi, PsyD, of Trivedi Psychological Services in Houston, is another psychologist whose patients are economically marginalized, some of them homeless or living in single-room-occupancy housing. Trivedi’s practice focuses on psychological testing, parent evaluations for child protective services and other forensic assessments.

“There aren’t enough psychologists who want to work with this population—not necessarily because of the population but because of payment issues,” Most of her patients have publicly funded health insurance, which has a reputation of low reimbursement rates for psychological services.

Want to join Noriega and Trivedi in filling the gap in services for economically marginalized individuals? To do so, they say, you may need to heighten your awareness about certain things:

» Be ready for the kind of complex needs and serious problems your training prepared you for.

“Every other patient has a trauma history, which is sometimes hard to hear constantly,” says Trivedi. “They’re not getting their basic needs met.” Noriega’s patients include many children who are American citizens but have undocumented parents. “I see a lot of children who will say to me, ‘Please, doctor, can you talk to ICE [Immigration and Customs Enforcement] and tell them not to take my mommy away?’” she says. “The children I see have a great deal of anxiety and fear of the police.” In some cases, parents have returned to their countries of origin, leaving their children behind to finish their educations or look after younger siblings—scenarios that can add huge stress to young lives.

» Focus on strengths, not deficits.

“[Economically marginalized patients] may not have physical assets like bank accounts, but they have friends, someone to stay with, someone who cares about them,” says Trivedi. Noriega also focuses on assessing internal and external strengths. These include a patient’s level of resilience and their history of having weathered challenges in the past, as well as more tangible assets like having two parents at home or having a car and a valid driver’s license. It’s important to communicate that strengths-based approach to clients, says Trivedi, noting that could mean using the word “survivor” rather than the word “victim.”

» Be thoughtful about what you recommend.

Make sure your treatments and recommendations work for your patients, not someone else’s. “What sounds very typical, innocent, middle class may be outside the scope of reality for some individuals,” says Noriega. She recalls blithely suggesting that a young patient join a scout troop, for example. Unfortunately, Noriega remembers, that suggestion turned out to be impossible because the scout troop met in an area that was just too dangerous for him to go to. Similarly, a casual suggestion that a child join a soccer team may not be feasible when the uniform alone costs $60. To avoid such blunders, get “intel” about the local community by asking school social workers, community leaders and the patients.

Get Involved

Specific accommodations can make your services more easily available to people living in poverty.

EXTENDED HOURS
Staying open before and after business hours can be essential for patients whose jobs have limited schedule flexibility.

COMMUNICATION OPTIONS
Accessing the internet or making a phone call may not be easy. Offer different ways to communicate so patients can choose what works for them.

LOCAL NETWORK
Market your services to community doctors, lawyers and social workers to build a referral and word of mouth network.

ACCEPT MEDICAID
Payment challenges are a huge barrier for many patients. Consider how you can serve Medicaid patients and expand access to care.
Advancing Practice

Advancing Practice

themselves to help you understand the neighborhood, suggests Noriega. Gathering information can uncover alternative, more appropriate resources, such as a church in Noriega’s neighborhood that provides free classes to kids on Saturday afternoons.

» Think about your patients’ potential needs. Staying open before and after regular business hours can help accommodate individuals whose jobs offer little flexibility in their schedules. Noriega’s practice, for instance, is open from 7:30 in the morning to 7:30 in the evening, with a colleague taking the early shift and Noriega taking the later one. A location near bus or subway lines is also key for people who rely on public transportation. And it’s important to provide snacks, since patients and their family members may be hungry. Trivedi’s practice offers bottled water, cheese and crackers, and other snacks in the waiting room, and she plans to add hot snacks soon. “Someone may not have eaten that day or made time to take care of themselves,” says Trivedi, adding that some may be trying to save money by skipping meals. “I want to make sure food is not an issue for them.”

» Communicate in new ways. Patients living in poverty may not have easy access to communications technology. “Some of my patients have cellphones but maybe don’t have minutes [for calls], so texting [about upcoming appointments] is the only way they can communicate for free,” says Trivedi. For others, email appointment reminders work best. Trivedi makes appointment reminder calls herself as a way of increasing the likelihood that clients will show up. “When you talk to the person you’re going to see, it means more than having a receptionist call,” she says, adding that she asks clients to give her 24 hours’ notice if they can’t make an appointment and then gives them two strikes before referring them back to their case workers.

Noriega has decreased her no-show rate significantly by implementing repeated appointment reminders. At their first appointment, patients receive a paper handout of appointment times and sign up for the practice’s patient portal, which emails a reminder the night before an appointment. Patients also get a call the day before.

» Find creative ways to market your practice. “I spend zero dollars on marketing,” says Noriega. Instead, she reached out early in her practice to local pediatricians, immigration

91% of psychologists never, rarely or only occasionally work with homeless people

APA’s 2015 Survey of Psychology Health Service Providers
How to Get Paid

One barrier to working with patients in poverty can be reimbursement. Here are factors to consider.

Becoming a Medicaid provider is one option. While it’s true that Medicaid and other public programs typically pay less than private insurers and self-pay clients, serving Medicaid patients expands access to care.

“Medicaid is an important part of building a practice that serves clients from all walks of life,” says Caroline Bergner, JD, legal and policy affairs officer for APA. Accepting Medicaid can be especially helpful for early career practitioners who want to build their practices, Bergner adds. Even if serving patients in poverty is not your focus, she suggests, “consider incorporating a small number of these patients into your practice as part of public service.”

Because there are still a handful of states that prohibit private practitioners from participating independently or outside a facility, check with your state Medicaid office to see if this is a possibility, adds Bergner.

Not all patients in deep poverty are covered by Medicaid. Offering a sliding scale or providing services pro bono are other options for those outside the program, says Connie Galietti, JD, director of legal and professional affairs at APA. Before you start offering these options to any patient, however, you should check with your state Medicaid office.

Whether patients are on Medicaid or not, it’s important to have a policy in place that lays out criteria for financial hardship for all patients, says Galietti. “You don’t want to be accused of being discriminatory because you offered pro bono services or a sliding fee scale to one person and not to someone else,” she says.

It’s also important to spell out financial arrangements in patients’ charts, says Galietti, explaining that the informed consent paperwork patients sign should include how much they’re paying per session, when payment is due and what steps you will take if patients fall behind in payment. And don’t let a balance build up, Galietti adds. If it becomes clear a patient can’t afford services even with a reduced fee, she says, you need to decide whether to offer pro bono services or refer the patient to someone else.

RESOURCES

APA Guidelines for Psychological Practice for People With Low-Incomes or Economic Marginalization
apa.org/about/policy/guidelines-low-income.pdf

Deep Poverty Initiative Toolkit
apa.org/about/governance/president/deep-poverty-psychology

Deep Poverty Initiative Practitioners Action Guide
apa.org/about/governance/president/practitioners-guide.pdf

Some psychologists are choosing not to participate on insurance panels (also called networks). While the insurance referral source is constant and the income stream can be more predictable, some psychologists decide to forgo serving on panels due to stagnant reimbursement rates, frustrations with billing and appeals, and perceived patient privacy concerns. Others find that some panels are “closed” and not accepting additional providers, so they are not able to participate.

But even psychologists who accept only private-pay clients¹ have to interact with insurance companies from time to time, such as when a patient submits a bill to their insurer. What information do private-pay practitioners still need to provide to insurers? What happens if a patient commits insurance fraud?

This article provides answers to those questions and additional examples of how insurance might still affect a private-pay practice.

**WHEN PATIENTS GO OUT OF NETWORK**
A patient may choose a psychologist who is not in their insurance network and utilize their out-of-network (OON) benefits by submitting the bill for direct

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1 Some psychologists prefer to use the word “client.” For purposes of the article, we use the word “patient.”
Even though a nonparticipating provider has no contractual relationship with and no direct obligation to the insurer, the patient does.

reimbursement. In these cases, the patient may be obligated to provide certain information to the insurance company, including copies of treatment records. So, even though you, as a nonparticipating provider, have no contractual relationship with and no direct obligation to the insurer, the patient does. As a result, you may be required to respond to requests for records so that the patient can be reimbursed.

You should be sure your patients understand that if they decide to use their OON benefits, you may need to respond to requests from their insurer. So, be sure to include language in your informed consent forms allowing you to disclose protected health information (PHI) in response to reasonable requests from insurance companies, even though you don’t accept insurance. Patients should understand the consequences of you or them failing to comply with those requests and give you clear direction on how to respond should you be asked to provide records.

If the patient does not want you to provide treatment records or information to the insurer, honor their wishes. Just be sure they understand that they may not get reimbursed—and that they are still responsible for paying you.

To help your patients get reimbursed for your services, familiarize yourself with the record-keeping requirements of different payers. Many insurers require certain details in the patient’s record, which can usually be found on the provider section of the website. Some examples of required documentation in the clinical record might include:

» Member name or identification number on each page
» Presenting problems
» History and dates of service
» Start and stop times for therapy
» Treatment plans
» Progress notes
» Your signature

It is also advisable to keep records that document why this treatment was medically necessary. For example, any insurer review will go better if your records reflect, at least in basic terms, how your treatment is addressing your patient’s mental illness and/or its symptoms, as well as your patient’s progress toward objective treatment goals.

Remember that if you keep psychotherapy notes (as defined by the Health Insurance Portability and Accountability Act [HIPAA]), payers are generally not allowed to access them.²

FRAUD ALLEGATIONS
A few psychologists have reported receiving calls from insurers alerting them to suspicious OON claims by patients. In these instances, patients allegedly used old bills to create and submit claims for services they did not receive. One patient allegedly received close to $100,000 in reimbursement checks for services never provided. A key issue is whether you are permitted to confirm to insurers that services were provided on certain dates.

In most states, the combination of HIPAA and state law allows you to release PHI to insurers asking about dates of service if your patient

² For additional tips on record-keeping to comply with HIPAA, see the Winter 2007 issue of Good Practice article “Practitioners: Take Note” available at apaservices.org/practice/good-practice/Winter07-Note.pdf.
has signed a consent form (typically at the start of treatment) covering releases to insurers or releases to insurers for payment issues. If you are unsure about your state law or the applicability of your consent form language to this scenario, or how to address potential fraud by a patient, contact your professional liability carrier or APA’s Legal and Regulatory Affairs Office, at spracticelegalandregulatory@apa.org.

GROUP PRACTICE IMPLICATIONS
What happens when a provider works for a group or facility that does accept insurance? If their employer accepts Cigna, for example, does a psychologist have to accept a Cigna patient in his/her outside private practice? It depends.

Typically, a group practice or facility will empanel employees with insurers under the group’s National Provider Identifier (NPI) number and location address (all of the providers in the practice, or facility, join the insurance panel). This allows the business to bill the insurer for the psychologist’s work with them; however, the “in-network” status does not automatically follow him/her to outside private practice. Psychologists with side private-pay practices (who are not themselves individually on the insurance panel) should check with the group or facility’s billing person to clarify whether the in-network status and contract applies only to work done for the group/facility.

TRANSITIONING TO PRIVATE PAY
Psychologists who want to discontinue accepting insurance and move to a private-pay business model need to be mindful of a few details when making the transition. They include:

» **HIPAA.** If the psychologist triggered HIPAA (for example, through electronic transmissions of patient information in connection with insurance claims), they need to continue to comply with HIPAA in their private-pay practice. At this time, there is no federal guidance that would allow a psychologist to escape continued HIPAA obligations. APA will continue to explore psychologists’ ability to step back from HIPAA compliance as they phase into retirement.

» **Contract terms.** During the transition, psychologists may be hesitant to quit panels because they want to finish treating existing patients, or just in case a former patient needs to be seen again. This becomes problematic if a patient with that insurance comes to the psychologist for treatment: The insurer may prohibit the psychologist from requiring the patient to pay out of pocket. Even if the patient agrees to pay that way, the psychologist may still be prohibited from charging more than the in-network rate. Review your contracts carefully regarding these issues, and for the necessary notice period and other procedures for you to terminate your contracts. Some psychologists also report problems with insurers claiming not to receive the psychologist’s notice that they are no longer part of the provider network. To avoid any problems, submit your termination notice according to the insurer’s requirements and also provide it in writing, such as by certified mail or email, so that you have proof. You should also check the insurance company’s website after termination to make sure that your name has been removed from their list of in-network providers.

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.

Practitioners’ informed consent forms should include language allowing them to disclose patients’ protected health information to insurers.
The American Psychological Foundation Congratulates the Winners of the 2019 Visionary Grants

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Dr. Luz Garcini
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Susan Murray and Naoise Mac Giollabhui
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Mental Health Service Preferences Among Latinx Caregivers: A Step Towards Culturally Congruent Intervention Formats for Children and Adolescents

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An Examination of Multi-level Factors Influencing Vietnamese-American Parents’ HPV Vaccine Uptake for Their Adolescent Children

Dr. Jonathan Stange
University of Illinois at Chicago
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Indiana University
Centering Those at The Margins: Understanding Counterspaces as an Avenue to Advance STEM Persistence Among Women of Color

Melek Yildiz Spinel
Graduate Student, University of South Carolina
Gender Role Discrepancy, Relationship Satisfaction, and Intimate Partner Violence Risk for Latina Women

The Visionary Grants are APF’s flagship program, providing funding to psychology graduate students and early career psychologists to seed innovation through supporting research, education, and intervention projects and programs that use psychology to solve social problems.

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If you have additional questions, contact APF’s Interim COO, Miriam Isserow at misserow@apa.org or 202-336-5622.
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