Summer 2013

The Maine Psychologist

MePA's Busiest Legislative Session to Date Ends…

By: Diane Tennies, PhD and Sheila Comerford

The MePA legislative committee worked tirelessly with our lobbyist this session to monitor over 1600 bills that were introduced. The committee met 13 times to understand the implications for psychology of each bill and develop strategies as necessary to address bills that might impact our practices in the state of Maine. We introduced legislation (see LD 1155 below) that protected psychological test data in legal settings and provided testimony for numerous bills to educate legislators on the possible implications and our testimony was grounded in the empirical literature available. Here is a sampling of some of these bills and how MePA responded.

LD 47* An Act to Retain the Position of Parent Coordinator in the Judicial *Branch. This bill would have continue the current law past January 2014 which allows appointment of a Parent Coordinator to oversee and arbitrate disputes that arise for parents in interpreting and implementing the parenting plan contained in the final judgment from the Court. MePA testified in favor of LD 47 however, the bill did not pass.

LD 87 An Act to Improve Community Mental Health
This bill would have required DHHS to develop programs to provide services and housing to persons with chronic mental illness. Bill did not pass.

LD 230 An Act to Establish the Commission on Health Care Cost and Quality
This bill would establish a state committee to monitor accessibility cost and quality of health care in Maine. It also reestablishes the State Health Plan. The bill was carried over to the next legislative session.

LD 237: An Act to Establish Uniform Quorum, Meeting and Chair Requirements for Professional and Occupational Licensing Boards
This bill establishes a uniform quorum requirement for the 31 licensing boards within the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation. The bill also repeals provisions in the individual board laws that require a board to meet at least once a year and that authorize the board chair or a majority of the members to convene a meeting. The authority to elect a chair is moved from the individual board laws to the Maine Revised Statutes, Title 10, Section 8010. MePA testified against the bill saying that dropping the language on minimum requirements for meeting and taking away the power from the Chair to call a meeting when necessary relays a message that fiscal austerity is the driving force behind a Board's schedule, not protecting the public. Bill passed. Public Law 236

LD 338: Resolve, Directing the Department of Health and Human Services to Amend Its Rules Governing the Use of Certain Antipsychotic Drugs by Children Enrolled in MaineCare
This resolve directs the Department of Health and Human Services to amend its rules to require that the prescriber of a drug provide documented justification and

Continued on page 6

INSIDE THIS ISSUE

MePA Newsletter
Summer 2013

The MePA Newsletter is the official newsletter of the Maine Psychological Association and is published four times a year. **Deadlines are 1/15 for Winter, 4/15 for Spring, 7/15 for Summer and 10/15 for Fall editions**. News items, brief manuscripts of general interest to psychologists, notices of future meetings, research, activities of MePA members and other items may be sent to:

MePA
P.O. Box 5435
Augusta ME 04332
621-0732 Fax 622-6228
e-mail: mepaaug@aol.com
WebPages: www.mepa.org

Editor:
Laura Slap-Shelton PsyD
Production Editor:
Sheila Comerford

MePA members receive subscriptions free of charge; non-members' subscriptions are $25. Camera-ready ads are $250 for a full page, $135 for a half page, $75 for a quarter page, and $50 for a business card. There is a $15 dollar charge for non-camera ready ads. Classified ads are $5 per line with a $15 minimum.

The Editor reserves the right to reject articles which are not consistent with the goals of the Association. The Editor may also reject abridge or modify any advertising or other material as appropriate. Publication of advertisements does not imply MePA endorsement. Opinions expressed in the MePA Newsletter should not be considered as being endorsed by MePA. Ψ

From the President's Desk

By: Jeff Matranga, PhD ABPP

Staying Fresh, Balanced, and Seeing the Chickens

First, I want to thank all of you for the work you do contributing to the well-being of the people of Maine. May this find you well, hopefully still enjoying the sensual summer in Maine. To paraphrase Joni Mitchell, the seasons go round and round. Change is a constant. Summer will flow into the next season, and the next. In health care, more change is coming; it always has been and always will be. We can brace against it or deny its existence. Or, we can accept the reality and continue to step forward to work with it *and help shape it*.

Along those lines, with all the changes in psychology and health care, how does one stay fresh and vibrant? It seems to be a matter of attitude and approach. New learning is stimulating and it can be fun. Practicing flexibility has a number of benefits. We all know that new learning is good for our brain health and for our mood.

That brings me to a real life example of one psychologist and close friend, **Tom Aikins, Ph.D.** Tom is in his mid-60s. Tom is well-regarded. Last fall, he received an award for 40 years of service to our veterans at the Salt Lake City VA. In addition to being a very experienced psychologist and therapist, he has supervised and trained scores of psychologists over the decades. **He loves his work**. Outside of work, Tom is an avid cyclist; he has ridden the RAGBRI (ride across Iowa) many

times and has put in thousands of miles around the state of Utah. Tom is also an oil painter. He has gradually cultivated his painting abilities over the years. He has painted in France, in Italy, and has travelled to Maine twice now to engage with his senses and the landscape to paint on the coast. He has shown his work in Manhattan several times now.

Tom was my primary supervisor during my year of internship at the Salt Lake City VA. When I started my internship in 1986, I was (and still am) enthusiastic about health psychology, CBT, and the power of Psychology contributes to health care. In addition to being a great psychologist mentor, Tom taught me some other things, like how to enjoy riding a bicycle at a slow to moderate pace for hours on back roads in the Utah desert.

Tom stays fresh in his work because he enjoys it; or, maybe he enjoys it because he stays fresh – open to

learning. Tom has happily embraced and integrated newer learning and approaches. Over the last few years, Tom has enthusiastically completed extensive training and supervision in the following: ACT for Depression, Cognitive-Behavioral Couples Therapy,

Interpersonal Psychotherapy for Depression, Cognitive-Behavioral Conjoint Therapy for PTSD, and less formally Prolonged Exposure for PTSD.

Why do this? Tom is financially secure and could retire any time. He could just sort of hide in his office to some extent so why bother?

Tom replies that he sees the following benefits: "It keeps me up to date. The structure of initial sessions enhances my effectiveness as a psychotherapist. The audiotaping and critique/feedback required for certification has been invaluable. I hadn't had my work really reviewed since graduate school. I found out I'm not half bad! It has been good modeling for the Psychology Interns I supervise."

And at the same time: "I've been told I've never internalized being a Psychologist. It wasn't said in a critical way. I've always thought, since that comment, that maybe not having internalized this has made me a better therapist and supervisor. Last evening I hosted all the Psychology staff for a sort of party at my house - to say goodbye to the outgoing Psychology Interns [including one from Maine]. People wanted their kids to see the chickens. That's part of trying to keep the life in balance."

Speaking of learning, thank you to **John O'Brien** and others who have put together two conferences for the fall:

Friday, September 6:
"Boundaries and Therapist Use of Self-Disclosure: Ethical and Clinical Considerations"
Speaker: Christopher Muncie, PsyD
9:00am-noon
University of Maine at Augusta

Friday, October 25:
David Barlow, Ph.D., ABPP.
Dr. Barlow is an internationally recognized psychologist. In 2000, he was recognized by the APA with the **award** for **Distinguished Scientific Applications of Psychology.**

For more on Dr. Barlow**:**
http://www.bu.edu/card/about-us/dhb-biography/

Thanks again for all that you do.

Jeff Matranga
jeff@hpmaine.com

David Mills Appointed APA Council Rep

President Jeff Matranga has appointed David Mills, PhD of Little Deer Isle to fill out the remaining one year term of Diana Prescott, PhD as APA Representative.

Dr. Mills worked at APA as the Ethics Officer for a number of years before "retiring" to Deer Isle.

"I have been to at least twenty APA Council meetings as an APA staff member, so it will be good to be on the other side of the fence helping make policy. " said Dr. Mills after being notified of his appointment. " I am looking forward to it, though Diana is certainly an impossible act to follow!"

Dr. Mills term will be calendar year 2014.

Boundaries and Therapist Use of Self-Disclosure: Ethical and Clinical Considerations

Presenter: Christopher Muncie, Psy.D.

Friday, September 6, 2013
9:00AM-12:00PM

University of Maine at Augusta, Augusta, Maine

Register at mepa.org or
Call MePA for more information:
1/800-287-5065

Don't Forge

Interview with Dr. Ben Miller

By Jeff Matranga, Ph.D. ABPP

Dr. Ben Miller, psychologist, is a national leader working to bring together systems which have historically been separate. Dr. Miller specializes in collaborative care, health care policy, health behavior change interventions, and collaborative care models. Housed in a department which sees no delineation between the mind and the body, Dr. Miller is able to work on community programs and health policy which address health comprehensively.

Dr. Miller received his doctorate degree in clinical psychology from Spalding University in Louisville, Kentucky. He completed his predoctoral internship at the University of Colorado Health Sciences Center, where he trained in primary care psychology. In addition, Miller worked as a postdoctoral fellow in primary care psychology at the University of Massachusetts Medical School in the Department of Family Medicine and Community Health. Currently, Miller is an Assistant Professor in the Department of Family Medicine at the University of Colorado Denver School of Medicine where he directs the Office of Integrated Healthcare Research and Policy.

Dr. Matranga: *What would you advise early, mid, and late-career psychologists to do to help thrive in health care reform?*

Dr. Miller: In order to best thrive in healthcare reform, psychologists must know and recognize that health policy is their responsibility. No longer are we in a field that can passively sit by and watch health care change around us knowing that our place at the table is safe. Now, we are in a time where it truly is critical that our voice be heard. To thrive in healthcare, psychologists need to recognize the problem they can help solve. The problem that everyone is facing is that of **fragmentation**. Fragmentation continues to perpetuate the false notion that we should be treating mental health separately from physical health. We have a fragmented delivery system that has led our patients, our communities, to expect fragmented care. What we need -- and we do need all psychologists to understand this -- is that integrated care is the only way to fundamentally achieve the **Triple Aim of decreasing costs, improving outcomes, and enhancing the patient experience**. To this end, psychologists must become more outspoken on how their services can impact both mental and physical health outcomes.

Fragmentation continues to perpetuate the false notion that we should be treating mental health separately from physical health."

Dr. Matranga: Psychologists have a demonstrated track record of being useful for patients who have both a medical condition and either anxiety or depression or other mental health needs. How might a psychologist present such collaboration to area clinics and hospitals?

Dr. Miller: While this is indeed true, most commonly, primary care reports not having access to specialty behavioral health. Take for example a study that was in Health Affairs in 2009. Peter Cunningham surveyed 6600 primary care physicians and found that 2/3 could not gain access to specialty mental health; in fact, he found that it was the most difficult medical specialty to gain access to. Primary care, and other medical providers, need (and want) specialty mental health services for their patients. Part of the reason we advocate so adamantly about integration and "co-locating" care is that it removes one of the barriers for patients in accessing mental health services. Said differently, the healthcare system and its often over complex and fragmented structure does not allow patients and providers "ease" at accessing mental health. So, having a psychologist become more connected to local primary care practices and the like is one way to bridge this divide.

However, psychologists need to know which providers in their community are more open to collaboration than others. Like any good researcher, there is a need to do a preliminary assessment of what is actually happening on the ground. Do psychologists know the primary care providers that are in close

proximity to them? Have psychologists taken the steps to introduce themselves and their services to these providers? Is there a way to foster better collaboration through these relationships? All of these

questions must be considered in order for psychology to get in front of the providers that often need them the most and for the patients who might most benefit from them.

Dr. Matranga: To what extent is being empirically-based important in this era?

Dr. Miller: Being evidence-based is always an important factor to consider for any healthcare professional; we want to do what works. Further, we want to be able to evaluate how effective we are at doing what we do. Psychologists know a thing or two about both of these areas. It is important that as we blaze new trails in a field that is relatively young, we do so balancing our rigor with our need to be patient-centered. It is inevitable that healthcare will begin to focus in more on how well we help patients achieve out comes over simple process metrics around access; it is inevitable that payments will start being aligned with how well people do in their treatment; it is inevitable that antiquated payment methodologies like fee for service go away; and, it is inevitable that the system will want continued proof that all of our services help work towards achieving the "Triple Aim" (improving outcomes, decreasing cost, and enhancing the patient experience). So, is being evidence based important – yes, but it must always be tempered with other contextual factors in healthcare.

Dr. Matranga: In a rural state, if a psychologist and collaborating physician are sure to communicate well, e.g., fax each contact note promptly, talk on the phone as necessary, to what extent does this accomplish good collaboration?

Dr. Miller: Rurality definitely plays a role in our ability to collaborate. It has been well known for some time that proximity is one of the greatest enablers of collaboration; however, what happens when within our communities we simply have no ability to be next to each other? Rural communities have often solved this problem in creative ways (e.g. telemedicine, weekly visits to practices)). As it relates to communication using timely faxes and phone calls, psychologists would do well to consider that historically, we do not have a strong track record showing how communication is a two way street. For example, in a recent study colleagues and I did surveying NCQA Patient-Centered Medical Homes (PCMH), we found that there was relatively little communication both coming in and going out about behavioral health (see here for more: http://link.springer.com/article/10.1007%2Fs13142-012-0153-4). Aside from some of the other findings (primary care has very little infrastructure to assist in scheduling patients with outpatient behavioral health), this study found that we could do a great deal more to enhance our ability to communicate and collaborate even in the most urban of settings. If psychologists have not established a relationship with the primary care providers in their community (e.g. coming to the office, shaking hands, talking about services), this may be a tremendous first step in enhancing collaboration and communication even if proximity is a limiting factor.

Dr. Matranga: What types of outcomes measures might a general psychologist or a group practice use to help demonstrate their effectiveness?

This data set has traditional mental health measures (e.g. depression – PHQ-9, generalized anxiety – GAD-7), but also includes measures for conditions we would expect to see psychology impact in as well (e.g. hypertension, diabetes with HbA1c)."

Dr. Miller: While collecting any outcomes is likely a great idea for the field, we know that psychologists do so much more than just mental health. To this end, psychologists who are practicing in integrated and/or collaborative settings may find that using measures that also address other health conditions often classified as physical health conditions demonstrates the "whole person" value add for a psychologist. In Colorado, we have adopted a minimal data set for many of our primary care practices who have integrated a mental health provider. This data set has traditional mental health measures (e.g. depression – PHQ-9, generalized anxiety – GAD-7), but also

Continued on page 8

Legislative Update

Continued from page 1

perform a timely assessments and ongoing monitoring of the patients' metabolic and neurologic variables. MePA supported and provided testimony. The resolve passed.

LD 528: An Act to Require Parental Consent for a School to Conduct Mental Health or Behavioral Screening on a Student

This bill would have required a school administrative unit to obtain written consent from a student's parent or guardian before conducting any mental health or behavioral screening or testing of the student. It would also require test forms to be available to parents. MePA testified against. The bill did not pass.

LD 534: An Act to Improve Care Coordination for Persons with Mental Illness

This bill provides an exception to the health care information confidentiality laws that protect mental health information for the purposes of care management and coordination of care. MePA raised questions about the need for the bill at the hearing. MePA monitored this bill. The bill passed. Public Law 236

LD 609 An Act to Increase Suicide Awareness and Prevention in Maine Public Schools

This bill requires the Department of Education to adopt rules on standards for schools and school administrative units for suicide prevention education and training. The training and education will include suicide prevention awareness education for all personnel and more advanced suicide prevention and intervention training for at least 2 persons per school district. Passed. Public Law 53.

LD 716: Resolve, to Review and Make Recommendations on Appropriate Prescribing of Certain Medications for Children with Attention Deficit Hyperactivity Disorder That Are Reimbursed under the MaineCare Program

This bill directs the Department of Health and Human Services to adopt a program regarding prescription medications for children that consists of a prescription medication protocol, monitoring and prior authorization for reimbursement under the MaineCare program. The program must ensure that children have access to medically needed prescription medications in compliance with the requirements of this bill and the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Passed. Public Law 68.

LD 727: An Act Establishing Health Care Practitioner Transparency Requirements

This bill requires that health care practitioners, including psychologists, wear name tags designating their name and licensed profession. MePA testified neither for nor against requesting the bill be amended to carve out psychologists in private practice who do not work in health care facilities. The bill passed, however the part of the amendment excluding psychologists from wearing name tags did not pass while the part which allowed the posted license to be the same size as the state issued license did pass. Public Law 285.

LD 755: An Act to Require Estimates of Patient Costs Prior to Treatment

This bill would have required a provider to give a patient cost estimate of nonemergency procedures or course of treatment, other options and their costs, and the amount that would be paid by the insurer. MePA monitored the bill and spoke with the bill's sponsor to express concerns. The bill did not pass.

LD 872: An Act to Improve the Quality of Guardian ad Litem Services for the Children and Families of Maine

MePA testified in favor. Ultimately, the bill was reworked in committee and passed resulting in minor changes primarily around how complaints are handled.

LD 968: An Act to Provide Needed Psychiatric Hospitalization for Persons with Mental Illness

This bill will require the state to fund additional hospital beds for individuals in mental health crisis. MePA testified in support. The bill was carried over to the next legislative session.

LD 990: An Act to Require Public Disclosure of Health Care Prices

This bill requires health care providers to maintain and make available to clients a price list of their most frequently provided services, charged when the patient does not have insurance or when insurance coverage is denied. MePA monitored and expressed concern to the bill's

sponsor. The bill passed. Public Law 332.

LD 1024: An Act to Enhance Enforcement of the Mandatory Reporting of Abuse and Neglect
This bill requires DHHS to make a report to the licensing board of a professional who appears to have violated the mandatory reporting law. The bill passed. Public Law 293.

LD 1066: An Act to Increase Access to Health Coverage and Qualify Maine for Federal Funding This bill would have expanded MaineCare coverage to adults up to 133% of poverty. The bill did not pass.

LD 1155: An Act to Ensure the Integrity of Neuropsychological and Psychological Testing Materials
This bill, which was initiated by MePA in response to lawyers' requests for all client data, will limit who a psychologist must share raw testing data with. The bill passed. Public Law 353

LD 1166: An Act Regarding Record Retention by Mental Health Practitioners
This bill would have required state rules which far exceed current laws for Maine psychologists including mandatory patient notification in newspapers, and stipulation of record destruction companies. MePA testified against and explained psychologists already have requirements in place. The bill did not pass.

LD 1200: An Act to Impose a Duty to Warn and Protect Mental Health Professionals
This bill imposes on physicians, psychologists, social workers, counseling professionals and alcohol and drug counselors a duty to warn and protect if a patient or client is likely to engage in physical violence that poses a serious risk of harm to self and others or that constitutes a serious threat of substantial damage to real property. MePA testified that psychologists currently have a duty to warn for persons and do not believe it is appropriate for threat of harm to property. The bill did not pass.

LD 1238: An Act to Improve Professional Training for Licensed Mental Health Clinicians
This bill makes changes to the laws governing the licensure requirements for psychologists, LCPCs and clinical social workers. MePA worked with the sponsors of the bill and a compromise occurred allowing psychologists to have less CEU requirements than other mental health professionals. Beginning in 2020, psychologists will be required to obtain 3 hours of continuing education in domestic violence topics upon licensure or first renewal of their license. LCSWs and LCPCs will be required to obtain 12 hours. The bill passed.

LD 1429: An Act to Allow School Administrative Units to Establish Rules, Procedures and Guidelines for Properly Trained Staff to Carry a Concealed Handgun on School Property with Acting in their Official Capacities
This bill would allow school administrative units to develop rules and guidelines to allow employees to carry a handgun on school property. The bill would require a psychological evaluation to be conducted on employees applying to carry a handgun. MePA testified against the bill. The bill did not pass.

LD 1466: An Act to Amend the Law Governing Provider Contracts with Insurance Companies
This bill imposes requirements and restrictions on PPO contracts, including: 1. Requiring a carrier who offers the contract to a health care provider to include in the contract a fee schedule and to provide any policies or procedures referred to in the contract to the provider, upon request by the provider; 2. Requiring the approval of a provider, in writing, of an amendment to the contract that materially and adversely affects provider reimbursement, including, but not limited to, increased documentation, preauthorization or utilization review requirements; 3. Prohibiting a carrier from subjecting enrollees under health plans included in the contract to preauthorization requirements if the enrollee's health plan does not require prior authorization as a condition of coverage for the applicable service; and 4. Requiring the provisions of law regarding these contracts to be included in each contract. The bill passed. Public Law 399

LD 1491: An Act to Strengthen the Laws Regarding Certain Crimes Committed by a Person in a Position of Authority
This bill requires that a civil action based on a sexual act that is committed by an actor with authority may be commenced at any time, that the statute of limitations on prosecutions for such crimes be extended to 10 years. The bill passed. Public Law 392. Ψ

Miller Interview

Continued from page 5

includes measures for conditions we would expect to see psychology impact in as well (e.g. hypertension, diabetes with HbA1c). The goal of using these measures together in concert is to better show the impact of the psychologist on all aspects of the person health.

Dr. Matranga: For the psychologist who is interested in expanding their background in health psychology or integrated care, how might he/she proceed?

To help combat fragmentation and better integrate mental health, behavioral health, and substance abuse into larger healthcare efforts, psychology must become more connected in primary care and healthcare redesign (e.g. systematically tackling issues related to training and education, research and evaluation, healthcare delivery). While there are many ways to better the field for inclusion, the following are three simple ways psychology can position itself to inform health care policy and integration.

Psychology should be constantly aware and involved in healthcare policy issues in order to respond in a timely manner.

Policy is often thought of as someone else's responsibility, and this sentiment is often true within psychology circles. However, it is critical for psychology to see policy as everyone's responsibility, affecting the entire profession. Because change in healthcare is a moving target of decoding, deciphering and prioritizing what is needed to adequately address public health needs , psychologists can apply their understanding of complexity and systems to make policy recommendations. For psychologists, policy is frequently about being reactive rather than proactive. We are often advocating for restoring something lost rather than planning ahead for ways the profession can be more involved in healthcare. In order to change the dominant paradigm, psychologists must be aware of opportunities to structure where the discipline needs to go.. Ho accomplish this, psychology must have a strategic plan for the profession, and be aware of the policies that need to be promoted to get there.

Psychologists working in their respective communities can keep abreast of healthcare policy issues by establishing connections with those outside the traditional mental health circles. For example, a psychologist may find that attending meetings on primary care (state primary care associations) will shed new light on larger healthcare issues and opportunities within their state. Additionally, a psychologist joining their state psychological association and participating on the legislative/policy committee may help in connection to healthcare policy specific activities happening in the state.

We must begin to prepare professional psychologists for their role in policy through specialized training and education programs. Current training efforts include those like the post graduate certificate program out of the University of Massachusetts. In general, most traditional psychology graduate programs do not prepare professionals to work in the context of primary care (Blount & Miller, 2009). Likewise, psychologists will need training on how to affect healthcare policy. One of the best ways to receive training in the area of healthcare policy is through practical experience.

Psychology should participate in research to inform national healthcare policy in support of integration.

Research aimed at influencing healthcare policy at the legislative level is more important than ever, and psychologists are well positioned to do this policy-relevant research because of the solid research training they receive (B. F. Miller, 2010). It is important to note that the type of research needed to inform policy around integration will not be completed or collected in traditional ways. That is, the location of the integrated primary care site will

become the subject of the study, as opposed to the intervention and the select population receiving the intervention. Integrating psychology into primary care changes the entire fabric of the practice, regardless of the model promulgated, and allows for the field to apply their research training to think through new methods of how to study this newly integrated practice.

The healthcare policy paradigm stresses the importance of the "triple aim" (better care for individuals, better health for the population and decrease in healthcare costs); likewise, psychology's research in primary care should include how the profession addresses each aim (Berwick, Nolan, & Whittington, 2008). This is consistent with Peek's (2008) framework for healthcare change, which requires healthcare systems to address the clinical, operational and financial worlds simultaneously to change healthcare (B.F. Miller, Mendenhall, & Malik, 2009). Psychologists must conduct new research to demonstrate how integrating psychological services in PCMH settings offsets healthcare costs (Chiles, Lambert, & Hatch, 1999; Levant, House, May, & Smith, 2006). Research should also target how psychology reduces costs such as freeing up primary care providers to see more patients (Phillps, Miller, Petterson, & Teevan, 2011). To do anything less will cement professional psychology's reputation as a "Johnny-come-lately" with regard to policy formation and will substantially impede the profession's growth and sustainability in integrated primary care. The field must be aware of what current healthcare policy discussions are being had locally, at the state level and nationally and what economic arguments are/are not being made for psychology.

Psychology should collect data to inform the business of integrated healthcare practice

One of the biggest challenges to implementing the PCMH and integrating primary care psychologists into the medical home is the current financial structure: this structure is in need of significant reform (Kathol, Butler, McAlpine, & Kane, 2010; Mauch, Kautz, & Smith, 2008). Mental health services are paid for differently than physical health services. As a consequence, a "two-pots -of-money" phenomenon occurs such that payments for mental health services and for physical health services are kept in separate pots. This approach does not promote nor enhance integration. Further, the payment paradigm often relegates psychologists to provide only "mental health" services rather than pay them for treating other aspects of the person's health not covered under a mental health code. While health and behavior assessment codes are one way to begin to allow psychologists to work on non-mental health conditions (e.g. diabetes, hypertension), the codes have limitations and may not be a long term solution for financially sustaining integrated behavioral health (Kessler, 2008).

Dr. Matranga: For the psychologist or group practice that might want to negotiate a contract or other arrangement with a hospital or similar large entity, what considerations or resources come to mind?

We have written about this quite a bit so I have attached two articles that may (or may not) help [to be posted on MePA web site in Members' section].

Also, here are some resources:

One stop:

http://integrationacademy.ahrq.gov/

Case study:

http://www.advancingcaretogether.org/

Webinars:

http://www.youtube.com/channel/UCGCWmd6TZpKZ6SCzR3zOcjA

State example:

http://coloradosim.org/

MePA Happenings

Bangor Area Women in Psycchology recently met at the home of Beth Bohnet. (front Lto R Cherylk Pelletier PhD, Lenore Tiping PhD, Sandy Coleman, PhD. Back (l to r) Beth Bohnet, PhD, Diana Prescott, PhD, Jeanne Forland, Jeanine Crockett PhD, Diane Tennies, PhD and Reessa Greenberg,

THE MAINE PSYCHOLOGICAL ASSOCIATION

P.O. Box 5435
69 Sewall St.
Augusta Maine 04332
621-0732 Fax 622-6228
1/800-287-5065
Mepaaug@aol.com

Webpages:www.mepa.org

Newsletter Editor:
Laura Slap-Shelton, PsyD
laura.slap@gmail.com

Executive Director:Sheila Comerford
mepaaug@aol.com

Save the Date!

MePA Fall Conference

Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders

Friday, Oct. 25, 2013

Speaker: David Barlow, PhD ABPP

More Information to follow!