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Presentation made to the Pacific Northwest Neuropsychological Society

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Learning Objectives

As a result of attending this presentation, participants will be able to:

1. Discuss implications of health reform legislation on maintaining a high-quality professional practice in accordance with ethical and regulatory standards.

2. Describe how the APA ethics code applies to the business aspects of neuropsychology.

3. Develop billing, coding, and documentation systems in healthcare delivery systems that are compliant with professional ethical standards and regulatory standards.

4. Use the information to adapt clinical and professional activities to meet changes in healthcare policy in a proactive manner.
Policy on Ethics Course Guidelines {Summarized}:

Ethics Course Guidelines for Psychologists and Providers:
(1) Material suitable for CE credit is that which reflects on the directives of the TSBEP and/or the guidelines established by APA, NASP, or other organizations of professional psychologists. Courses that focus on bases for ethical decision making and/or problem-solving with diverse groups, contexts and situations are particularly relevant to this category of CE.

(2) Professional Ethics concerns conduct and practice when engaged in professional work… ethical boundaries are established in order to regulate practice in a way that is acceptable to its incumbents.

(3) Codes of Ethics are concerned with a range of issues designed to set out the ideals and responsibilities of the profession. Ethics requirements are intended to provide assistance in determining appropriate decision-making and behavior, improve consistency, and provide a minimum acceptable level of practice.
HEALTHCARE IN THE U.S.

A Brief Look at Where We Are and Where We Are Going

A special thanks to Charles Callahan for his contributions to this section.
“Demography, Economy, Technology”

- **First Curve**
  - Established way
  - Current $$
  - Slowing in long run
  - *Fee for Service*

- **Second Curve**
  - Radically new way
  - Source of future $$
  - Explosive in long run with long tail
  - *Fee for Health*

*Ian Morrison, Healthcare Economist/Futurist (1996)*
Chart 7.1: U.S. Population Trends and Projections by Age, 1980 – 2050(1)


(1) Years 2010 through 2050 are projections. Projections are based on 2000 source.

Number of Medicare Beneficiaries Soars Beginning in 2010

Source: HCFA, 2000; Census Bureau 2001
International Comparison of Spending on Health, 1980–2008

Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

Source: OECD Health Data 2010 (June 2010).
U.S. Healthcare Economy

Times More Expensive than in 1970

- NHE per Capita: Health care spending in 2004 was 17.6 times 1970 levels.
- CPI: Consumer prices in 2004, as measured by CPI, were 4.6 times 1970 levels.

Budget Shares:
- Federal: 32.0%
- State and Local: 19.2%
- Private: 54.8%

Medicare and Medicaid enacted in 1965.
Sources of National Health Spending, 2008

- Private health insurance: 34%
- Medicare: 20%
- Medicaid (federal and state): 15%
- Other private funds: 7%
- Other federal: 6%
- Other state and local: 6%
- Consumer out-of-pocket: 12%

FIGURE V

U.S. Health Care Spending

Out-of-Pocket 13%
Private Insurers/Employers 42%
Government 45%

Health Care Expenditures by Source of Funds Through the Decades

Share of Disposable Personal Income Spent On:

Private vs. Government Share of Health Expenditures

- Private: Businesses and Households: 68% in 1987, 55% in 2010
- Government: 32% in 1987, 45% in 2010

Produced by: Veronique de Rugy, Mercatus Center at George Mason University
Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1988 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

(1) Includes Medicaid Disproportionate Share payments.
### Exhibit ES-1. Overall Ranking

<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>1.00-2.33</th>
<th>2.34-4.66</th>
<th>4.67-7.00</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL RANKING (2010)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Care</td>
<td>4</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Effective Care</td>
<td>2</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Safe Care</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Access</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Cost-Related Problem</td>
<td>6</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Efficiency</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Equity</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Long, Healthy, Productive Lives</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Health Expenditures/Capita, 2007</td>
<td><strong>$3,357</strong></td>
<td><strong>$3,895</strong></td>
<td><strong>$3,588</strong></td>
</tr>
</tbody>
</table>

Note: * Estimate, Expenditures shown in SUS PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).
Figure 1: Medicare spending and quality of care by state, 2001
Is the current system sustainable?

- Obvious gaps in quality and desired outcome
- Soaring costs with decreasing efficiency, quality, and outcome highlight the need for change
- Multiple attempts for change over the years, with little success – largely due to political factors (on both sides)
- “Transformation” has been suggested, and ultimately passed…
  - Patient Protection and Affordable Care Act was signed into law in 2010 after a very long political battle
    - Do the ends justify the means?
    - Is the new system sustainable?

Time will tell.....
- Extend coverage to 32 million individuals
- Expanded Medicaid eligibility, insurance reforms, and an individual insurance mandate
- Key cost savings provisions implemented 2014 and beyond
- Streamline Bureaucracy (?!?!)
- No majority can repeal aging population
1,968 New and Expanded HHS Secretarial Powers In the Health Reform Law

- Title I: Health Insurance Coverage
- Title II: Government Programs
- Title III: Health Care Delivery
- Title IV: Chronic Disease and Public Health
- Title V: Health Care Workforce
- Title VI: Transparency and Program Integrity
- Title VII: Access to Medical Therapies
- Title VIII: Long-Term Care CLASS Act
- Title IX: Revenue Provisions
- Title X: Medicaid, CHIP, Women’s Health, Indian Health
- Health Care and Education Affordability Reconciliation Act
- See pdf
Implementation Time Line

- See timeline pdf
Implementation Time Line

- Health reform is a dynamic process
- Continual changes scheduled on the basis of the law – Be prepared!
- Continual changes to the changes
  - Pending litigation
    - Recent SCOTUS ruling did not settle the issue and may have complicated it further
  - New litigation
  - Societal changes
  - Economic realities
  - Political changes (November(s); HHS Sec’y Power)
  - States and Medicaid Expansion
  - Others
Proposed Implications of Health Reform

↑ ACCESS and QUALITY while ↓ COST

1. Negative sum outcomes-focused reimbursement (Darwinian Economics)
2. Decreased inpatient revenue will drive operational efficiency redesign
3. Bundled payments across extended (acute to post-acute) care episodes
4. Rewards primary care focus on population health and chronic disease management
Proposed Implications of Health Reform

5. Total cost management supplants fee for service incentives ("fee for health")
6. Providers will maintain tighter and fewer affiliations across delivery system
7. Focus on functional vertical integration between systems and physicians
8. Information technology-driven care as a competitive differentiator

Health Care Advisory Board (www.advisory.com)
Further Implications

9. Principle of Insurance
   - Wealthy pay for the Poor
   - Young Pay for the Old
   - Healthy pay for the Sick
   - Non-utilizers pay for the Utilizers
   - Low performers pay for high performers (VBP)

10. Technology, evidence, incentives, and transparency will wring out waste

11. Personal responsibility for health behaviors?
   - More changes on the political horizon (e.g., NY)
Willingness of Healthier and Wealthier to Subsidize Care for Sicker and Poorer is Weakening

Harris Survey question: Do you agree or disagree?
The higher someone’s income is, the more he or she should expect to pay in taxes to cover the cost of people who are less well off and are heavy users of medical services.

Chart 4.1: Percentage of Hospitals with Negative Total and Operating Margins, 1995 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.
PPACA Spring Loads Broad Implementation of New Payment Models

Provider Cost Accountability

Episodic Costs

Total costs

- Prospective Payment System
- Pay-for-Performance
- Hospital-Physician Bundling
- Episodic Bundling
- Shared Savings Model/ACO
- Capitation
THE NEW MODELS OF HEALTHCARE DELIVERY
THE NEW MODELS OF HEALTHCARE DELIVERY

Fee For Health Vs Fee For Service

- Patient-Centered Medical Home

- Accountable Care Organization (ACO)

- Global Payment Systems

- Alternative Quality Contract (ACQ)
Patient-Centered Medical Home (PCMH)

- A team based health care delivery model led by a physician that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes and quality while reducing costs.

- Goals are to improve patient and doctor relationships and access, coordination of care, prevention, quality, and safety.

- Moves decision making regarding services and utilization to the providers as opposed to the payor.

- Facilitates partnerships between individual patients and their physicians.

- Care coordination requires additional resources such as health information technology, and appropriately trained staff to provide coordinated care through team-based models.
Accountable Care Organization (ACO)

- First described in 2006 and defined by CMS as "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."

- Similar to the Health Maintenance Organization (HMO) model of healthcare delivery.

- Still focuses on a strong primary care team as the center of service delivery and decision making with networks of providers in PCMH-like relationships.

- Seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

- The ACO is accountable to the patients and the third-party payor for the quality, appropriateness, and efficiency of the health care provided.

- The ACA allows for rewards to ACOs with a share in the cost savings resulting from improved quality and reduced costs.
Accountable Care Organization (ACO)

- Less overhead than the PCMH model and a greater ability to serve larger populations and more in-depth services (hospitalization/specialties)

- Larger budgets to allow for greater capital improvements and infrastructure

- Cost savings across a broader “system” or “organization” to reduce duplication and waste (Darwinian Economics)

- One sided “Shared Savings” model - Providers do not directly bear risk

- ACO places a degree of financial responsibility on the providers in hopes of improving care management and limiting unnecessary expenditures while continuing to provide patients freedom to select their medical services.
The success of the ACO model in fostering clinical excellence while simultaneously controlling costs depends on its ability to “incentivize hospitals, physicians, post-acute care facilities, and other providers involved to form linkages and facilitate coordination of care delivery.”

By increasing care coordination, ACOs strive to help reduce unnecessary medical care and improve health outcomes, leading to a decrease in utilization of acute care services.

Increased transparency as the ACO knows exactly what each doctor is doing.

According to CMS estimates, ACO implementation as described in the ACA is estimated to lead to a estimated median savings of $470 million from 2012–2015.

- CBO has since questioned these numbers.
Accountable Care Organization (ACO)

- Reimbursements are tied to reduction in the total cost of care for the patient population provided that quality markers are met.

- Quality measures are defined in a variety of areas, with specific markers for:
  - Patient/caregiver experience
  - Care coordination and safety
  - Preventative health
  - Specific at-risk/high risk populations (e.g., diabetes, heart disease)
Accountable Care Organization (ACO)

- Who Gets The Incentives?
  - MD, DO, PA, NP, & CNS

- Who is missing??????
  - Other professionals may join groups as “participants”
  - Pending efforts to classify psychologists as equal to physicians in this regard, but still pending
  - Not related to medical staff membership, but this certainly wouldn’t hurt
Global Payment Systems

- Increased opportunity to control spending
- Shared savings if spending is below the pre-specified budget
- Shared accountability for deficits if spending exceeds the budget
  - This downside risk helps control spending by providers
- Two-sided system in terms of risk rather than one
Alternative Quality Contract (AQC)

- Model of healthcare implemented in 2009 in Massachusetts by BCBS as a new approach to aligning payor and provider incentives, focusing on quality and cost containment.

- Features a global payment and pay for performance model

- Includes performance incentives, plus design features intended to lower the cost of care over time.

- Provider groups in the AQC system assume accountability for spending, similar to ACOs that bear financial risk.

- Groups are eligible to receive bonuses for “quality” and cost savings.
Three main features that distinguish it from fee-for-service models:

1. Physician groups, or hospital systems, enter into 5 year global budget contracts
   - Baseline budgets and increases are based on negotiations with BCBS
   - Budget covers the entire continuum of care including outpt, inpt, rehab, long-term care, prescriptions, etc
   - Organization is responsible for all services including specialties
Three main features that distinguish it from fee-for-service models:

2. AQC groups are eligible for Pay-for-Performance bonuses up to 10% of their budgets
   - Larger than typical P4P bonuses
   - Identified measures of quality and performance or “gates”

3. AQC groups receive tech support from BCBS including reports on spending, utilization, and quality to assist in budget management.
Alternative Quality Contract (AQC)

Health Care Spending and Quality in Year 1 of the Alternative Quality Contract


Alternative Quality Contract (AQC)

- Compared average spending for seven provider organizations
- Analyzed 2006 – 2009 claims for @400K enrollees whose PCPs were in the ACQ system and for @ 1.4 mill enrollees not in the ACQ system
- Average spending increased for enrollees in both groups in 2009, but the increase was smaller for the AQC group (1.9% less per quarter)
Alternative Quality Contract (AQC)

- Conclusions
  - The AQC system was associated with modest slowing of spending growth and improved quality of care in 2009.
  - Savings were achieved through changes in referral patterns rather than changes in utilization.
  - Savings derived largely from:
    - Shifts in outpatient care toward facilities with lower fees
    - Lower expenditures for procedures, imaging, and testing
    - A reduction in spending for enrollees with the highest expected spending
A Thought Experiment Proposed
By Karen Postal, Ph.D., ABPP

Presented At The AACN Annual Meeting
Earlier This Month In Seattle, WA
PCP refers to neurologist

You.

Neurologist refers to:

$ of You + neurologist +

PCP

ACO

You.
PCP refers to another neurologist.

Neurologist refers to:

neurologist+

PCP

ACO

Neurologist refers to:
PCP refers to:

Only $ of PCP

ACO
Your contribution

Reducing Costs

Improving quality measures
Fundamental shift in our professional identity

What is the diagnosis?

How can cognitive & psych data be used to improve health and reduce cost?
How many neuropsychologists….

- Treat medication non-compliance as a crisis?

- Utilize psychological and cognitive data to develop an action plan to address their major health issues?
  - Diabetes action plan: blood monitoring and diet
  - Heart disease action plan: exercise
  - Asthma management (often family systems intervention)

- Focus on recommendations and interventions as much as assessment
PCP refers to:

PCP+ Neuropsych
Cost saving

Neuropsychology
Thanks to Karen Postal for the excellent Thought Experiment
Where is Neuropsychology in the Health Care Reform/P4P/Outcomes Measurement Game?

- Sitting on the sidelines?
- Playing a reserve role?
- Playing on special teams?
- Playing a utility/supportive role?
- Skilled position (e.g., quarterback, receiver, running back)?
- Assistant Coach?
- Coordinator?
- Head Coach?
- General Manager?
- Owner?
It Is Time To Get In The Game....
Business Ethics in Clinical Neuropsychology

The Application of the APA Ethics Code to the Changes in Healthcare Delivery
What about the business of healthcare?

- Particularly in light of ongoing healthcare reforms…

- Business Profitability vs Quality Patient Care vs Both

- Can they all be accomplished???
Ethics Defined

- A system of moral principles: the ethics of a culture

- The rules of conduct recognized in respect to a particular class of human actions or a particular group, culture, etc.: medical ethics; Christian ethics.

- An Individual’s moral principles

- The branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions.
Business Ethics

- A form of applied ethics or professional ethics that examines ethical principles and moral or ethical problems that arise in a business environment.

- Applies to all aspects of business conduct and is relevant to the conduct of individuals and entire organizations.

- Ethical questions range from practical, narrowly defined issues, such as a company's obligation to be honest with its customers, to broader social and philosophical questions, such as a company's responsibility to preserve the environment, protect employee rights, and contribute to community/society.

- Many ethical conflicts develop from conflicts between the differing interests of company owners and their workers, customers, and surrounding community.
Medical Ethics

- A system of moral principles that apply values and judgments to the practice of medicine.

- Six of the values that commonly apply to medical ethics discussions are:
  - **Autonomy** - the patient has the right to refuse or choose their treatment
  - **Beneficence** - a practitioner should act in the best interest of the patient.
  - **Non-maleficence** - "first, do no harm"
  - **Justice** - concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality).
  - **Respect for persons** - the patient (and the person treating the patient) have the right to be treated with dignity.
  - **Truthfulness and honesty** - the concept of informed consent
So what about psychology and neuropsychology…

- Consider the APA Ethical Guidelines in the context of healthcare reform and your own business…
Purpose of Business

But first…

What is the purpose of business in Neuropsychology?

- To help patients and caregivers?
- To contribute to the science - research/knowledge base?
- To train future professionals in the field?
- To enhance the reputation/value of the discipline?
- To add value to our respective places of employment?
- To earn money to sustain the practice?
- To earn extra money to obtain my own needs, wants, and desires?

Why do we do what we do?

How do we maintain our ability to do it in the context of healthcare reform and our own ethical guidelines?
Business Role Identification

What is your role in your “business”? 

- Clinician
- Researcher/Scientist
- Supervisor
- Manager/Director of Psychology/Neuropsychology Department
- Hospital/Institutional Administrator
- Executive Leadership

What is your role in healthcare reform? 

- Just related to your practice, discipline, facility, or healthcare in general?
Reasonable defined as “prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.”
APA Ethics Code

General Principles

A. Beneficence and Nonmaleficence
   - Strive to benefit those with whom they work and do no harm

B. Fidelity and Responsibility
   - Establish relationships of trust with those with whom they work
   - Work in the best interest of others and ensure compliance and responsibility in themselves and others
   - Strive to contribute a portion of their professional time for little or no compensation or personal advantage
     - *Pro bono versus professional involvement versus community involvement*

C. Integrity
   - Seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice (*business*) of psychology
   - Psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact.
     - *Billing/coding, business practices, etc.*
APA Ethics Code

■ General Principles

D. Justice

- Recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists.
  
  - Does this apply to access to services and consistency of services based on payor?

E. Respect for People’s Rights and Dignity

- Respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination

- Are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making.

  - Record keeping, HIPPA, and Informed Consent
APA Ethics Code - Standards

Standard 1: Resolving Ethical Issues

- 1.01 – Misuse of Psychologist’s Work
  - This would include misuse/inappropriate use of billing or other professional activities

- 1.02 – Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority
  - About to take center stage with health care reform

- 1.03 – Conflicts Between Ethics and Organizational Demands
  - Professional identification, productivity requirements, charting, test security, records security, and other applications
APA Ethics Code - Standards

Standard 2: Competence

- 2.01 – Boundaries of Competence
  - *Worthy of further discussion…*

- 2.05 – Delegation of Work to Others
  - Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take responsibility to…..
    - *Obvious – Technicians, Trainees, Lower Level Providers*
    - *Subtle – Office/Secretarial Staff, Billing/Coding Staff, Medical Records, etc*

- 2.06 – Personal Problems and Conflicts
  - *Self and staff*
Standard 3: Human Relations

3.05 – Multiple Relationships
- Business versus clinical versus personal relationships
- Institutional relationships
- Multiple roles

3.07 – Third Party Request for Services
- Potential referrals through professional/business relationships (ACO)
- Investors…

3.11 – Psychological Services Delivered to or Through Organizations
- Patient access, types of services, billing practices/expectations, roles in the organization, record keeping, confidentiality and protection of records
- Profit sharing – practice, partnerships, ACO models
Standard 4: Privacy and Confidentiality

- *Main issues relating to business practices pertain to record keeping, confidentiality, and informed consent regarding the limits of confidentiality.*
  - HIPPA
  - EMR
  - Sharing of information
  - Medical versus mental health records
APA Ethics Code - Standards

■ Standard 5: Advertising and Other Public Statements
  ■ 5.01 – Avoidance of False or Deceptive Statements
    ■ Variety of mediums addressed including personal materials such as CV or comments made in public settings
    ■ Includes descriptions of training, degrees, credentials, affiliations, services provided, scientific or clinical basis of services, expected degree of success or improvement, fees, and publications or research findings
    ■ What about specialty distinctions such as Clinical Neuropsychology, Rehabilitation Psychology, Geropsychology?
      ■ TX State Law
  ■ 5.02 – Statements by Others
    ■ Responsibility for public statements or other information provided by others
  ■ 5.05 – Testimonials
    ■ Not solicited from current patients or other persons who might be vulnerable
Use of Specialty Titles

Texas Administrative Code
TEXAS STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS/RULES OF PRACTICE
TITLE 22, PART 21, RULE §465.6

Listings, Public Statements and Advertisements, Solicitations, and Specialty Titles

Specialty Titles. A psychologist may use a specialty title only when one of the following criteria have been met:

1. Doctorate in the area of specialization;
2. Retraining under the APA retraining guidelines of 1977;
3. Documentation that the title has been used for five years and documentation of academic coursework and relevant applied experience, if an individual was matriculated in a doctoral program in psychology in 1977 or before;
4. Certification or approval or specialist status has been granted by a professional, refereed board, provided that the licensee indicates the name of the board which granted the title and that the individual's status with the specialty board is current and in good standing.

Use of the term "Board Certified" or "Board Approved" or any similar words or phrases calculated to convey the same meaning shall constitute misleading or deceptive advertising, unless the licensee discloses the complete name of the specialty board that conferred the aforementioned specialty title, certification, approval, or specialist status.
APA Ethics Code - Standards

Standard 6: Record Keeping and Fees

6.01 & 6.02 – Documentation, Maintenance, Dissemination, and Disposal of Records
- HIPPA, Paper vs EMR, ROI
- Storage – electronic vs paper, protocols?
- How long?

6.03 – Withholding Records for Payment
- Don’t do it and don’t try to justify it

6.04 – Fees and Financial Arrangements
- Must be specified as early as possible
- Consistent with laws
- Not misrepresented
- Collection agencies
- How do ACO and global payment systems affect this?
APA Ethics Code - Standards

- Standard 6: Record Keeping and Fees
  - 6.06 – Accuracy in Reports to Payors and Funding Sources
    - Accurate/Appropriate Billing and Coding
    - Appropriate documentation
    - Becoming more tedious and increased regulation/audits
    - New health care laws will change the way we do business in this section
      - ACO
      - Bundled Billing
      - Fee for health replacing fee for service
      - Possible move from time based to procedure based billing
APA Ethics Code - Standards

- Standard 7: Education and Training
  - Not applicable to the business ethics discussion aside from appropriate listing.

- Standard 8: Research and Publication
  - Outside of academic settings and grant activities, not applicable to the business ethics content for this presentation.
APA Ethics Code - Standards

Standard 9: Assessment

- In general, this section applies to clinical activities and will not be covered in detail as this applies to business, but a few caveats should be considered:

- 9.04 – Release of Test Data
- 9.07 – Assessment by Unqualified Persons
- 9.08 – Obsolete Tests and Outdated Test Results
- 9.11 – Maintaining Test Security
APA Ethics Code - Standards

Standard 10: Therapy

- Again, this section applies to clinical activities and will not be covered in detail as this applies to business, but a few caveats should be considered:

- 10.01 – Informed Consent
- 10.04 – Providing Therapy to Those Served by Others
- 10.10 – Terminating Therapy
What do we do when we face an ethical dilemma?
Closing Thoughts

Where Does Neuropsychology Need To Go From Here?
Solutions for Neuropsychology

- What we really need.....
Solutions for Neuropsychology

- Reduce “total cost” of production
  - Live on Medicare rates (or less) by 2014
- Match supply with demand
- Cost Containment in Clinical Activities
  - Batteries, reports, testing practices, etc.
  - Consider integrating doctoral and mid-level providers onto care teams with differentiated roles and accountabilities
  - Consider care extenders - don’t compete to do same things that they can do cheaper
  - Use of psychometrists where applicable
  - Use of office staff for high time/low professional requirement activities (e.g., billing, coding, pre-cert)
Solutions for Neuropsychology

- Offer service warranty (i.e. Geisinger)
- EBM interventions for highest cost/poorest outcome diagnoses with highest rates of hospital readmission
- Doctoral psychologists as systems-level measurement scientists and performance improvement specialists
- Engage in EMR and technology initiatives (Outcomes Based Research & Office Processes)
  - Clinical data sharing, self-scheduling, productive use of wait time, behavioral self-monitoring
Solutions for Neuropsychology

- Expand service offerings outside of traditional neuropsychology roles
- Consider medico-legal aspects
- Identify new referral streams in a rational/strategic manner
- Determine your “theory of your business” and market yourself appropriately
  - Low Cost Leader
  - High Quality Differentiation
  - Niche/Focus
  - Morton’s vs McDonald’s
Solutions for Neuropsychology

- Identify and Develop a relationship with local ACO(s)
- Learn how to effectively communicate how Neuropsychological assessments will help lower costs and improve quality
- Move into administrative/leadership roles to maximize your impact in your setting
- Support APA Practice organization/ advocacy for more favorable rules
- Remain active in local, state, regional, and national organizations to increase the volume of our voice
Questions?