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**Building and Managing a Private Practice**

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 Private practice has emerged as one of the most common career paths taken by clinical psychologists. In the American Psychological Association (APA) Division of Clinical Psychology, there has been a significant rise over time in the percentage of psychologists choosing private practice as their primary employment setting (Norcross & Karpiak, 2012). In 1960, 17% of clinical psychologists cited private practice as their primary employment setting, while in 2010 the percentage had jumped to 41%. In a study of APA Division of Psychotherapy members (Norcross & Rogan, 2012), 62% of the respondents cited full-time private practice as their primary employment setting. For those not in full-time practices almost half did engage in part-time practice, on average 10 hours per week, a finding similar to the sample of clinical division members (Norcross & Karpiak, 2012).

 The APA Salary Survey (Finno, Michalski, Hart, Wicherski, & Kohout, 2010) examined employment settings for clinical psychologists involved in the direct delivery of health and mental health services. The majority (57%) of respondents were in private practice, mostly in solo practice (42%) with some in group practices (13%), and a small number in a primary care group practice. The latter number may be expected to rise with changes in our health care delivery system.

 Thus, private practice is a frequent and valued career path for clinical psychologists. Clinicians should be aware that private practice is always evolving. Before WWII there were not many psychologists in private practice. However, for need for meeting the mental health needs of our veteran returning from war led to significant funding for doctoral-level clinicians. While many worked in hospitals and clinics, and the community mental health movement of the 1960s led to many opportunities for psychologists, private practice started to become a viable career path. In the 1970’s and up until the mid-1980’s inclusion of mental health benefits in indemnity insurance plans also bolstered opportunities as many potential clients could now have a significant portion their psychotherapy paid by their employer-based plans. Further, since this was pre-managed care private practitioners could receive their full fees without having to discount them. The mid-1980’s saw the rise of managed care and this has significantly impacted how clinicians have shaped their practice. For the first time those participating on managed care panels saw restrictions on the number of sessions they could see clients, the number of hours they could be reimbursed for psychological testing, and an accountability to a third party on client progress. The important point for private practitioners is how we practiced in 1980 is different from how we practiced in 2000, which will be different from how psychologists will practice in 2020 and beyond. While the particulars will inevitably change, maintaining excellent clinical service, ethical business practices and a willingness to adapt will place psychologists in a strengthened position of building and sustaining a successful practice.

**Developing a Practice**

 All careers have positives and negatives. Whether the path of private practice is the right choice is dependent on many factors, including the need for autonomy, personal and professional values, and personality. It is important to do a self-assessment to determine if private practice is the right choice.

 A recent list of “pros and cons” in the choice of private practice as a career path (Barnett & Musewicz, 2012) is illustrative. The pros include: (a) being your own boss; (b) the ability to decide practice location, hours worked, and area of specialization; (c) potential for high earnings; (d) flexibility, and (e) control over business decisions. The cons include: (a) financial uncertainty with risk of periods of low earnings; (b) responsibility for all expenses and overhead; (c) possible professional isolation for solo practitioners; and (d) responsibility for billing, collecting, insurance, and employee and staff decisions.

Several studies have examined career or job satisfaction of psychologists in private practice. In several studies, private practitioners reported experiencing less job stress, fewer physical problems, and more positive mental health when compared to a sample of psychologists in academia (Boice & Myers, 1987) and less burnout than psychologists working in agencies (Rupert & Morgan, 2005; Rupert & Kent, 2007). Psychologists in solo or group private practice reported a greater sense of personal accomplishment, more sources of satisfaction, fewer sources of stress, and more control at work than respondents in agency settings. In other studies, private practitioners reported high satisfaction ratings on self-perceived level of success, closely followed by flexibility of the job, intellectual stimulation of the work, and their relationships with colleagues (Walfish & Walraven, 2006).

However, this path is not without stressors, as suggested by the “cons.” In an interdisciplinary sample of private practitioners, Walfish and O’Donnell (2007) studied sources of stress for the independent practitioner. The highest levels of stress were found with relationships with managed care companies, emotional demands associated with private practice, and economic uncertainty.

**Deciding Where to Practice**

 When beginning to practice, it is common for clinical psychologists to join an existing group practice. In some circumstances this is necessary when the clinician is not yet licensed and needs supervision to, (1) accumulate the hours of supervised work experience required for licensure, or (2) have a licensed professional take responsibility for their work. Since there is little, if any, formal training on how to operate a private practice during graduate training, psychologists may also want to join a group where billing, collecting, and marketing are provided, as well as policies, procedures and forms in place that provide for legal and ethical practice. In such a setting, a psychologist may be an employee of the group practice, an independent contractor in the group practice, or may rent space and services from the group practice, but is in actuality a solo practitioner.

 Some psychologists bypass the group practice route and either open their own solo practices or find other clinicians to share space and services but are not in a group practice per se. In the latter circumstances it is important to communicate to the public that, while sharing space with other clinicians, the individuals actually each have private practices. This reduces the vicarious liability (Woody, 2013) of being responsible for the work and behavior of the other clinicians who share the office space.

 In business there is an adage, “Location, location, location” when considering opening a new establishment. The same principle holds true for a psychology practice. Just as a restaurateur wants to open where there is a large pool of potential customers, it is important for psychologists to choose a practice setting where there is visibility, easy access, and a large pool of potential clients. For this reason psychologists may consider co-locating a practice in a primary care clinic or medical specialty clinic. Physicians control (and direct) the care of a large number of potential clients. Many articles can be helpful in considering integrating mental health care within a medical practice (e.g., Kelly & Coons, 2012; Coons and Gabis, 2010).

Locating your practice with or in a medical office has numerous advantages. A child psychologist might rent space in a busy pediatric clinic. A neuropsychologist should rent space in a neurology or rehabilitation medicine practice. Such co-location is a “win-win” for physicians who are looking for consultation or treatment of the mental health needs of their patients and, in addition, earn rental income. For the psychologist such a co-location provides access to a large number of potential clients and the opportunity to practice in their specialty area.

**What Services to Provide**

 It is easy for most psychologists to say that they provide individual, couple, family or group psychotherapy and psychological testing. The harder question to answer is to which populations and under what circumstances. In other words, should they be generalists or develop a specialty? The answer may in part depend on geography. If practicing in a rural area, the psychologist must be a generalist (and have access to consultation from specialists outside of the geographic area). Some psychologists work in areas where they are the only psychologist in a 50 – 100 mile radius. They do not have the luxury of saying, “Let me refer you to my colleague down the street who specializes in your problem.”

 For psychologists working in reasonably populated areas developing one or two specialty areas is recommended. One advantage of being a clinical psychologist is the large number of specialty areas in demand and clients willing to pay fee for service. Also recommended is selecting becoming a local expert in that specialized practice area. This requires practitioners to “brand themselves” in the community (Verhaagen, 2010). That is, to be known to the point that when someone is looking for a practitioner in that specialty area the psychologist will be quickly identified as “the go to person.” This may include: (a) presenting workshops on the topic for professionals, and if appropriate the public; (b) writing articles in professional and lay publications; and (c) being available to the local media to discuss the specialty area.

The identification of two specialty areas is recommended for a couple of reasons. First, diversity in professional activities increases the likelihood that the psychologist will not “burnout” or become bored. Second, environmental circumstances (e.g., changes in insurance laws, downturns in a specific sector of the local economy, the awarding of a contract to another private practitioner) may have a swift and significant impact on the demand for the specialty service. There are scenarios in which a thriving practice was decimated in 30 days by an internal policy change by an insurance company. While there may be times of economic boom, it is not wise to put “all eggs in one niche basket.”

 The often-spoken fear is that if psychologists have a specialty area they will never receive general referrals for clinical care. This has not proven to be the case. Rather, by establishing oneself as an expert, gatekeepers and the referring community will often inquire about the psychologist’s ability to provide care to other types of clients and for other disorders. Excellence in clinical care and excellence in customer service will eventually lead to a full practice.

 Indeed, we and others (e.g., Walfish & Barnett, 2009) suggest that psychologists embrace and perform a multitude of professional activities for which their extensive doctoral-training has prepared them. These skills include psychotherapy, assessment, consultation, supervision, administration, writing, teaching, research, and development of products. Psychologists who use most of the tools in their toolbox, rather than an isolated and narrow set of tools, will develop sustained, successful practices. Clinical psychology in private practice is way more than performing psychotherapy.

**Developing Referral Partners**

 When we, the authors, first entered practice and approached physicians to be referral sources for them, we often felt as though we were “begging for business.” The relationship appeared to be unidirectional (with the occasional exception of sending the physicians a referral). It quickly became apparent that the relationships were indeed bi-directional.

The psychologists were pleased to see the physicians’ patients, and the physicians in turn were “relieved and grateful” that their patients had access to quality mental health services. A large percentage of the patients had psychosomatic illnesses, a number were noncompliant with their medical regimens, and some were “breaking down and crying” in the physicians’ offices. The physicians felt ill-equipped to deal with the behavioral health and emotional issues and were happy to refer their patients to someone with whom they had a working relationship and about whom they felt confident regarding clinical skills. Again, it was a “win-win’ situation.

 For these reasons, the term “referral sources” has been abandoned and replaced with the term “referral partners” (Kase, 2011). That is, psychologists serve individuals and the people/companies/government entities that need services to be provided for their patient. Given the psychologists’ skill, they can help those in need of their services, both the referral partners and the patient/clients referred. Thus, relationships with referral partners are bi-directional as in a partnership with those making the referral.

**Marketing**

Most clinical psychologists are uncomfortable with the term “marketing.” There are several reasons why psychologists do not like marketing, such as a fear of seeming unprofessional, a lack of knowledge about marketing, and not knowing how to “speak the language” of potential clients and referral partners (Stout & Grand, 2005). Consequently, psychologists often become avoidant about marketing their services. This is unfortunate because, unless there is something quite remarkable about clinicians or their services, little business will come their way. Indeed, some talented clinicians are so avoidant of marketing that either their practices close or they join group practices that provide the marketing for them, usually at a high price. (Several articles, books, and websites present helpful marketing primer for private practitioners (e.g., Kase, 2005; probably include another here).

 In contemporary practice it is important for psychologists to utilize the Internet as part of their marketing strategy. A website is a way of introducing the psychologist to a potential client or referral partner. Strategies for utilizing a website for marketing purposes include increasing traffic (e.g., potential clients) to a website, how to convert visitors into clients, and ten mistakes often made in Internet marketing that reduces the effectiveness of the strategy (Bavonese, 2012). An online presence allows the psychologist to better brand themselves as an expert. These strategies include maintaining a blog, using social media outlets, and leaving a “footprint” on the web to increase traffic to the site (Wallin, 2012)

**Managed Care vs. Fee-for-Service Practice**

 The decision to participate on managed care insurance panels or to solely maintain a fee-for-service (out-of-network) practice can be complicated. Part of the decision depends on geography and the economy of the area in which psychologists practice. In lightly populated areas, or where the number of jobs is concentrated in a particular company, it is difficult to completely stay off of managed care panels. While there may be some fee-for-service activities, psychologists can provide (e.g., forensic services, services to government entities), most potential clients in these locales will want their health insurance to pay the largest part (if not the entire part) of their mental health care.

 Part of the decision about managed care participation may be based on the values of the psychologist. There are some private practitioners who do not want to restrict their service provision only to those who can afford to pay out of pocket. While psychologists who have a fee-for-service practice can provide *pro bono* or lowered fees on a case-by-case basis, they tend not to see many clients who have lesser financial means.

Of course, a psychologist can develop a hybrid practice. In such a model, some services are paid for by participating in a limited number of insurance panels, while other services are paid for by the client or a different type of third-party, such as a government entity (e.g., Social Security Administration, Juvenile Court) or business (e.g., fitness for duty evaluations, pre-employment screenings).
 Early career psychologists often believe they have no choice but to join as many insurance panels as possible in order to get their practices off the ground. There is some advantage to this decision as a practice building strategy (depending on the provider density of the area) as often the result is a full practice relatively quickly (viz., 9-12 months). However, if this is the only practice building strategy, then the psychologist’s caseload will be full, but of relatively low paying clients. This is due to the deep discounts (50% or more of usual and customary fees) accepted for services for the privilege of being on the insurance panel. In that instance, the psychologist becomes dependent on the insurance carrier. It is rare, in our experience that insurance carriers will raise their fees (one panel is known to have the same reimbursement rates as 25 years ago) and therefore it is difficult for psychologists to raise their incomes over time. Worse yet, there have been cases in which insurance carriers have reduced their fees to psychologists with only sixty days’ notice in which to adapt to the change. The greater the proportion of the practitioners’ income that is earned from insurance carriers, the more dependent the psychologists is on the good-will of the carrier.

 If psychologists are willing to use their entire skill set in practice, there are many opportunities to develop a practice that does not involve participating on insurance panels. Strategies for doing so have been the subject of books such as *Breaking Free of Managed Care* (Ackley, 1997)*, Saying Good-Bye to Managed Care* (Haber, Rodino & Lipner, 2008), and *Earning a Living Outside of* Managed *Care: 50 Ways to Expand Your Practice* (Walfish, 2010)*.*

 Three surveys (two with psychologists and one with clinical social workers) have been conducted identifying practice activities of private practitioners that fall outside the purview of managed care (Le & Walfish, 2007; Walfish, 2001, 2011). . In these surveys hundreds of revenue-generating practice activities were identified. They ranged from only being a small portion of the clinician’s practice to being the entire focus of the practice. The practice activities fell into the following general categories: Business Psychology; Consultation to Organizations; Fee-for-Service; Forensic Psychology; Group Therapy; Health Psychology; Psychoeducational Services; Services to Government; Teaching and Supervision; and Miscellaneous. When considering income-producing strategies, psychologists should not solely think about the degree they have earned, but rather the skill sets that they possess (Plante,1996). It is clear from the literature and experience that psychologists open and creative with their skills can earn a substantial percentage of their professional fees outside of managed care.

**Diversity Opportunities in Practice**

 The changing demographics of the United States unquestionably impact the clients we see in our practices, or services that may need to be provided in our communities. Changes are mostly seen in urban areas, but affect clinicians in suburban and some rural areas as well, where there has been an influx of immigrants. In addition to changes in racial and ethnic diversity, there is also growth in the number of individuals who are sexually diverse (e.g., gay, lesbian, bisexual, transgendered, transsexual, polyamorous) and we have an evolving definition as to what it means to be a family (Haldeman, 2012). We are no longer a country composed primarily of nuclear Caucasian families with a mother, father, and 2.5 children.

 The changing demographics bring challenges to clinicians. It is important to become multiculturally competent, in providing assessment and psychotherapy services. Many gaps in clinicians’ education and training can compromise competent provision of services to diverse groups (Metzker, Nadkarni and Cornish, 2014). It is incumbent upon psychologists to seek out opportunities for continuing education and case consultation to become multiculturally competent.

 The challenges raised by the changing demographics also present opportunities for clinical practice (e.g., conducting parenting groups for gay and lesbian couples raising children). There are a large number of teenagers grappling with being bicultural who may be in need of either individual and/or family therapy There is a growing need for psychologists to conduct immigration evaluations (Kamoo, 2011) for asylum applications. With the rise in the number of states legalizing gay marriage, premarital therapy for same-sex couples (Whitton & Buzella, 2012) is a service that clinicians could provide in their practices. With increasing rates of interracial marriage, workshops for parents on raising a biracial child. Building a practice is not simply a question of whether or not it can be successful. Rather, it is a question of doing so carefully and strategically.

**Managing a Practice**

 Excellence in practice management usually goes hand-in-hand with excellence in clinical care. In order to deliver such care one has to practice in a business manner that can sustain a high level of service delivery. If the business aspect is threatening and anxiety producing for the professional, one can readily anticipate the negative impact it will have on the delivery of service to the client. Whether psychologists are in solo practice or a large group practice, in full-time or part-time practice, a for-profit or not-for-profit entity, they are in a service business. Common principles have been shown to be valuable for running successful practices. Many of the principles below are common in the business arena and are readily applicable to a private practice, whether it be full-time or part-time.

**Setting a Vision and Core Values**

 The oft-cited writings of Collins (2001; Collins & Porras, 1996) highlight the need for “vision” in a successful business entity. Vision is comprised of: (a) what the business stands for; (b) why it exists, and (c) what the business aspires to become. An easy way to concretize the term “vision” is to ask, “What is my major reason for being in practice?” A clear vision helps guide one’s decision-making and define core values. These values then must get communicated to staff, clients, and the community.

When examining websites of different practices, one often sees that the practice provides individual, couple, and family therapies to children, adolescents and adults. While it describes what the practice does and with whom, it does not describe why they do it or their passion for the work. An alternative description might be, "To help my [our] clients see the best sides of themselves in order to live more full and joyful lives." This of course could be contrasted with an alternative description such as, "To help my [our] clients reduce the pain and interference from anxiety, depression, and trauma.” Each of these descriptions, if they serve as a vision for the practice, becomes guide the focus and direction of the practice, and even perhaps the treatment provided to clients.

 Likewise, the values that psychologists set for their practice go a long way to inform how they do business, and the decisions they make. One of the authors was invited to a dinner meeting with colleagues from another practice who were considering a practice merger. At the end of the dinner, the partners from the other practice started to split their share of the dinner cost down to the nearest dollar. This level of “fairness” seemed incompatible with a value of openness and give-and-take. This value was an important one and therefore the merger discussions did not go forward. Psychologists may think of their vision as the ultimate destination set for their practice and their values as the guiding principles for reaching that destination.

 The implementation of a business’s core values get translated into principles that inform day-to-day decisions and related behaviors (Covey, 1992). Even the acceptance or refusal of referral can relate to the key principles that define a practice. If the key principle is production, the referral that is close to the fringe of one's competence is likely to be accepted. However, if the key principle is doing what is best for the patient, then the same referral is likely to be respectfully declined and redirected to a specialist in the community.

Verhaagen and Gaskill (2014) provide an excellent example of building a successful group practice (e.g., more than 30 clinicians who have full caseloads none of them participate on a managed care plan) that evolves out of their values and vision. The values of FIRE (Fun, Innovation, Relationship, and Excellence) influences all aspects of their successful practice.

Similarly, hiring and staff decisions will be impacted by the guiding principles that psychologists adopt to manage their practice. If psychologists are looking to hire someone and pay the least they can, they will in all likelihood interview accordingly, and conduct aggressive negotiations. They may also realize far greater turnover and possibly have staff that resent the workplace. On the other hand, if the guiding principle is to have a reasonable arrangement that feels equitable to both practice owner and employee, a different hiring and practice culture will likely be established.

Beyond vision and core values, a number of skill sets central to practice management. These include hiring staff, developing office policies, collecting and analyzing practice metrics, managing finances, using advisors, and complying with ethical and regulatory matters.

**Hiring Staff**

Hiring staff is by far one of the most difficult and important tasks related to practice management. Staff represents the practice owners and what the practice stands for to the community. At the same time, the practice owners are fully responsible for the actions of the clinical and administrative staff. Consider that when owners hire staff they are making a decision that can be valued at tens of thousands of dollars per year (the cost of salary and benefits).

Yet hiring decisions are often subjective and based on a relatively small amount of data. Moreover, this is a decision that automatically renews and, except in rather extraordinary circumstances, is difficult to easily undo. It is a decision that is made after usually just one to two hours (or less) of exposure to the applicant. Many other far less expensive decisions are made with far more time, thought and care.

Interviewing with care, assessing skills, and carefully checking references can be crucial to help avoid a hiring mistake. Such mistakes are often a result of being impressed by the applicant's credentials or personality style, or being fearful that the "right person" might not come along, rather than doing full “due diligence.” Taking good care to have a “right hire” will save the stress and costs of rushing into the decision. Never hire someone out of desperation. It only increases the likelihood of a “bad hire.”

**Developing Office Policies and Procedures**

 Whether in solo or group practice, policies and procedures are essential to good management, avoiding chaos, and avoiding the possibility of inadvertent ethical transgressions (Barnett, Zimmerman, Walfish, 2014). It is vitally important to protect confidentiality, bring consistency to practice, and avoid misunderstandings among staff, clients in the management of the practice. Policies and procedures should be in writing, referenced in employee agreements, and available to patients as appropriate (e.g., HIPPA and privacy statements).

 Policies relate to financial management, employee behavior (such as securing the office and records, ethical behavior), and incentive compensation. They also can relate to clinical issues such as explaining and obtaining informed consent and the handling of emergencies. If either the business or services of a practice are faulty, the practice, staff and clients might be placed in jeopardy.

**Analyzing Practice Metrics**

Metrics are equivalent to taking the pulse of a business. Many psychologists know little about the overall health of their practice from a numerical standpoint. Metrics are generally not complicated and do not require an advanced degree in business, economics, accounting, or finance. Rather, they require regular data collection and rudimentary analysis.

The tables below comprise a “dashboard” for a mental health practice. Notice how the information is straight forward, relates to generation of new business (finding), the overall financial status of the business (minding), and the level of service delivery (grinding). Of course, the information that would be pertinent to each practice would vary, and psychologists should customize the tables accordingly to fit the needs of their setting.



Examination of Table 1 informs psychologists that the practice is growing in numbers of referrals. There have been strong increases. Note how by converting the annualized figures to monthly averages one can look at the current year as it compares to the last two full years. This allows one to discern what is happening to the practice over time. Here you can see that, compared to the last year, the monthly referrals from schools have declined. This could indicate a need to reinvest in the relationship with schools as a referral partner if this is central to the vision of the practice. Also note how the category “Other” might need to be further differentiated by alternative descriptors, as that category is almost tied for the strongest source of referrals in the current year. 

Table 2 presents a Profit and Loss Statement for the practice. The data suggest an especially strong increase in the current year as it relates to income. At the same time, there is significant decline in expenses (i.e., Rent Paid) as a result of the clinician moving into a home office. Notice how the combination of more income and less expense compounds the impact on the total Net income. 

Table 3 presents a Sample Accounts Receivable statement. The data suggest that last year there was a substantial reduction in overall accounts receivable. While during the current year there continues to be some decline, it is not as strong as during the prior year. However, on close examination there is a change in the pattern of monies owed in that more money is outstanding in the <=30 Days row. This can mean that even though there is not significantly less money outstanding this year, there is a greater likelihood of collecting what is outstanding since it is more current. In this practice there was an increased emphasis on collections this past year. The data suggest that the new procedures are “paying off” as there are less aged outstanding monies.



Table 4 examines the payor mix in terms of insurance-based fees collected vs. private pay fee sources. The gradual increase in private payors is notable in the table (an increase over two years, consistent with the goals of the practice to rely less on insurance-based clients as a revenue source). A relatively modest percentage increase in private pay income translates into substantial dollars (e.g., when comparing last year to the Current Year).

 Metrics can help psychologists see what is happening in their practices and help avoid making decisions that feel right, but may be misguided. These and other tables can be customized by psychologists for their management information system hold a great deal of information on just one sheet of paper.

**Managing Finances**

 While there are many principles and approaches to financial management, a few key concepts can go a long way in building and managing a successful practice.

**Forecasting and budgeting.** Forecasting income by psychologist and expenses can better evaluate the profit and expense centers. This can lead to decisions about where to best allocate resources and where not to do so. For example, one of the authors (JZ) in an early phase of serving as a practice management consultant heard from the practice owner, “I need help in getting my people to go out and market the practice.” However, when we examined the financial data (especially the costs associated with each clinician) it was apparent that the last thing that was needed was marketing. The practice was losing money on each unit of service provided! Bringing in more referrals would hasten the decline of the practice. Instead, a serious discussion was needed about how the practice might be restructured to stop the financial hemorrhaging and focus on developing profitable services.

Examining anticipated income and expenses can help make decisions in an informed manner. Budgets are in essence educated guesses and can help avoid excess expenditures. Budgets can inform through the fiscal year whether the psychologists are on track or not, and whether there is an area which varies from the initial expectation. Many financial software programs will enable psychologists to keep budgets as well as run various reports showing Profit and Loss (across various categories) as well as Balance Sheets (showing the balances of various accounts). They can also help analyze trends across months, quarters or years.

**Reading all contracts carefully.** As business owners, psychologists will be in the position to sign contracts. Office space, equipment leases, managed care contracts, employee agreements, cleaning services, alarm services, and lines of credit are but a handful of the legal agreements that may require the owner’s signature. The person or company seeking the signature may act as if all the fine print is just pro-forma and urge a quick signing of what looks like an agreement that require a lot of time to read. It *is* worth the time. The agreements are indeed legal contracts, and psychologists will likely be held to them even if they did not realize what they were signing or the implications thereof. An example of office space rental included surcharges called “triple-net” which resulted in a $1,000 per month surcharge to a practice (Walfish & Barnett, 2009). This came as a great (or not so great) surprise as the practice owners did not understand this section of the lease. It can be invaluable to get legal input from an attorney with whom there is an on-going relationship.

**Investing in the practice as if it were someone else’s business.**  Imagine investing annual overhead each year in someone else’s practice. Now multiply that amount by 25, 30 or even 40 years (i.e., the length of time a psychologist may be in practice). Over time that is a sizable investment. What due diligence would you perform investing that amount of money in someone else’s business? Your business deserves the same consideration. Too often psychologists are haphazard with their own practice. One’s own practice should be given the respect it deserves as a business.

**Building in checks and balances.** Hire good staff; keep a careful eye on the business and try to have good oversight. Errors will still occur. Psychologists may make errors. Staff may err. They also may betray your trust. Checks and balances can go a long way towards saving psychologists from headaches and serious financial losses. Develop ways of double-checking the work and the financial transactions of staff. Reconcile bank statements. Do not have the same person oversee accounts payable and accounts receivable (unless it is you). In one case, a psychologist was the victim of embezzlement of over $100,000 by a staff member

**Making money (or saving money) by standing still:** There are a number of circumstances where one can impact the bottom line of the business in a substantial way by making one phone call or a minor change in procedures. For example, renegotiating phone rates, subletting the office the day(s) the psychologist is not there, changing billing services, changing computer technicians or web design services may net hundreds or even thousands of dollars per year. The savings go straight to net compensation, that is, how much money earned from the practice.

**Using Advisors**

Developing a cadre of advisors can go a long way towards avoiding the potholes others have previously fallen.

**Legal.**Develop a strong and long-lasting relationship with an attorney who can give input when there are questions. This is not just when trouble arises, but rather to help avoid situations that can lead to trouble. Such an attorney or firm should have a number of skill sets (not just mental health issues). Psychologists will likely need legal input to help with office space, collection questions, developing staff contracts, as well as a host of issues specifically around mental health practice (e.g., confidentiality, statutory issues, depositions and subpoenas).

**Accounting and financial planning.** Tax planning, following IRS regulations, and financial planning are some of the functions a good accountant can provide. However the accountant can also be an advisor with regard to business decisions that may impact cash flow, credit ratings, impact of pricing and compensation structures. That is, how much one charges for services or how much (and how) employees are paid for services. Many practices make decisions that “sounded good at the time” only to find later that there has been a major negative impact on cash flow from which they then have to recover. While some accountants are financial planning specialists, psychologists might also seek out a Certified Financial Planner who can help with investments, personal financial management, and retirement planning. In private practice, psychologists fund their own retirement, as there are no pensions provided or matching 401k plans offered by an employer.

**Insurance broker.**“They just want to sell me something. Why should I bet against myself? I don’t really need to worry about that.” These are common reactions to thinking about paying more insurance premiums. However, getting sound advice about insurance can avoid excessive liability. For example, often there is a negligible cost to having malpractice insurance that covers complaints to the licensing authority (as opposed to solely civil claims). Once the insurance is needed, it is too late, if it is not already in place. Similarly a good insurance advisor may help with the intricacies and best values of different policies that may be available (e.g., health, life, disability, long-term care, office premises. business interruption) and help recognize when the least or most expensive policy may not truly be the best. .

**Senior mental health private practitioner.**Other professional advisors will provide consultation from their perspective, but not necessarily view the landscape from the vantage point of a mental health professional. Sometimes the advice of a senior colleague can be quite helpful. For example, if a psychologist is thinking of using a billing service, the attorney can go over the contract and make sure the legal interests are protected. The accountant can offer advice about the impact of the fee structure and collections rates on cash flow. However, neither might be considering whether there is a HIPAA Business Associate Agreement in place with the billing service, or what happens to financial records should the contract with the service not be renewed. Here a senior mental health clinician advisor can help with how the service will actually be implemented, its impact on billing and collecting, and on how it will integrate into the overall management of the practice. In essence, the advisor can be key in helping address matters relating to the business of practice, ethics, and the factors unique to a mental health practice.

**Complying with Ethical, Contractual, and Regulatory Matters**

Years ago, good practice meant providing quality services consistent with ethical standards. However, in recent years ethical dilemmas have become more complex (e.g., the use of the internet, electronic health records and communications, social media) and regulatory compliance has become more onerous (e.g., hiring someone as sub-contractor, pursuing an unpaid bill, seeing someone who does not want to use their insurance benefits when the provider is on their health insurance).

A myriad of compliance issues relate to hiring, managing and discharging staff. There are questions that cannot legally be asked on an interview and the years of simply saying, “You are fired” are considered to be something of the past. Engaging in best practices means being aware of the potential problems as they apply to the practice. The consequences of missteps can be substantial and are not necessarily something for which a psychologists can be protected by malpractice insurance, corporate status or claims of ignorance. In many areas, professional standards of care have been developed. The practice’s policies and procedures will be evaluated against these standards if there is a problem or complaint. For example, if HIPAA requires that there is a written log of activities to ensure security, and there is a complaint and resulting investigation, that log will need to be produced (not made up on the spot).

Managed care contracts provide their own level of complexity. Psychologists often admit to not reading the extensive and long contracts that they sign. They later are surprised to find that the compensation rate is low, they may not be reimbursed, cannot bill the client for uncovered services (such as a missed appointment), and cannot “sign off” as if they saw the patient when another professional (and even possibly an unlicensed) staff person saw the client. These contracts are indeed legal agreements and can lead to claims of fraud against a psychologist who has not read them carefully (before signing) and followed them consistently (Barnett & Walfish, 2011). Psychologists may be guilty of fraud by their not understanding their contracts or being knowledgeable about proper billing procedures.

**Closing a Practice**

 A private practice has to end at some point in time. It may end due to a voluntary or involuntary disruption in practice. A voluntary disruption is when the clinician decides they no longer want to practice. This could be because they are choosing to relocate, choosing to retire, go on a sabbatical, or deciding they prefer a different career path rather than private practice. An involuntary disruption of private practice usually occurs when a major life event renders the clinician unable to practice. This could be due to illness, an accident, or as an extreme example due to death. Just because we are mental health professionals does not mean we are immune from catastrophic life events.

 Ethically psychologists must plan for any interruption in their ability to provide services. Standard 3.12, “Interruption of Psychological Services” states, “Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation or retirement.” While a somewhat misleading term because it is not a legal term nor is it in all cases legally binding, the psychologist must construct a “Professional Will” as a directive as to what should take place in the event of the inability to practice. The failure to adequately plan how the psychologist is going to leave a practice may have a negative impact on patients and create a liability risk (Barnett, 1997). Regarding ethical and/or requirements it should be noted that “Many states have adopted the APA Ethics Code or similar ethical standards in laws or regulations governing the professional conduct of psychologists” (p. 12; APA Practice Organization, 2014). Thus having a Professional Will is considered a standard of practice.

 There is no such thing as a standard Professional Will. Rather the important components of such a document have been elaborated upon by ethics experts (Bradley, Hendricks & Kabell, 2012; Pope and Vasquez, 2011). A sample professional will developed by the San Diego Psychological Association is presented by the APA Practice Organization (2014). This document includes four sections. The first section includes essential demographic information, the name of the person appointed as the Professional Executor, and the granting of permission to carry out activities on behalf of the psychologist. The second section identifies the names of attorneys that might be involved in the process, though this is not always applicable. The third section identifies where and how the Professional Executor may access information relevant to carrying out their duties. These include how to access client clinical records, psychological test materials, billing records, appointment books and client contact information, passwords to computers and telephone systems, the professional liability insurance policy, and even keys for the office. The final section focuses on how to notify current and past clients, make appropriate referrals, and the transfer of clinical records to a new clinician. This section also includes a statement as to whether or not the Professional Executor will be paid for their services and if so, the rate of payment and payment method. This document takes a lot of forethought and planning on the part of the private practice psychologist.

 The Professional Will is applicable when the psychologist closes their practice due to incapacitation or death. When the psychologist voluntarily decides to leave their practice there are several practical issues to consider, as well as ethical ones. These are presented in Barnett, Zimmerman and Walfish (2014) in greater detail but the main issues will now be summarized.

 If the psychologist is part of a group practice one issue to decide is when to tell your practice partners when you are leaving and to know ahead of time the ramifications of leaving. Questions to consider include: How much advance notification is required in letting the practice know you are leaving? Who owns the records-you or the practice? If you were part of a managed care panel, does that membership follow you into your next practice or do you lose it completely? Did you sign a restrictive covenant (i.e. noncompetition agreement) that prevents you from practicing in a certain geographic area (e.g., 5 miles) for a specified period of time (e.g. 2 years)? How long will a practice continue to collect unpaid balances due from clients? What will the practice tell former clients or prospective clients when they call the practice trying to make an appointment with you? Will you have access to your voicemail box after leaving the practice and for how long?

 You will also have to tell your current clients that you are leaving the practice. When to tell them may depend on your therapeutic orientation. Typically those clinicians with more of a psychoanalytic orientation prefer more time than those with a cognitive-behavior therapy orientation. Does the client prefer to see you up until the time that you leave or since they are going to transfer to another clinician do they prefer to begin with this new person sooner rather than later? Does the client want to transfer to another psychotherapist once your practice is closed? If so, how will it be decided who they will see? It is the clinician’s responsibility to ensure continuity of care for a client who wishes to continue in treatment. Understand that this termination process can be an extremely emotional one, both for the client and for the clinician, especially if a strong therapeutic alliance has been in place. Closing of a practice is ripe territory for transference issues in clients (especially if they have a history of trauma and an insecure attachment style) and for clinicians (especially if they feel responsible for causing pain in their client since they have chosen to leave).

 In some instances a clinician may be able to sell their practice. However, this is quite unusual, especially for a solo practitioner as they tend to have a “personality-based practice” (i.e. the value of the practice is primarily attributed to the skill of the clinician) rather than a “systems-based practice” (where contracts, referral partners, subcontracting psychotherapists will remain in place). Ethical issues are important to consider as a clinician cannot just hand over their client list and every client has to provide consent for the clinician to discuss their case (or even their identity) to a potential buyer (Koocher, 2003; Woody, 1997). In consideration of selling a practice the best interests of your current clients must be paramount. It is often advisable to get input from mentors when constructing a professional will and when considering voluntarily leaving or selling a practice.

**Future Directions**

The future of private practice will be greatly impacted by the forces of the health care system in which it is embedded. The United States government spends a larger portion of its Gross Domestic Product (GDP) on health care than any other country in the world. In 2010 health care costs reached $2.6 trillion or 17.6% of GDP. By 2020, the government is expected to pay 49% of all health care costs and 57% of all mental health costs (Keehan et al., 2011).

While mental health costs are currently only 6% of health care spending (Levit et al., 2008), containing the costs of those services has been the goal of managed behavioral health care organizations (MBHOs) since the late 1970’s. MBHO practices not only held mental health treatment costs flat, but reduced them (Gasquoine, 2010). Psychotherapy rates have been frozen for the last two decades, effectively eroding about 30% of third party reimbursement when inflation is considered (Cooper, 2011). Additionally, there has been a reduction in the percentage of individuals receiving psychotherapy as a first line treatment, and a significant increase in the use of psychotropic medications (Olfson & Marcus, 2010). Current estimates suggest that approximately half of individuals receiving help for behavioral health problems are seen in primary care environments and 48% of all psychotropic medications are prescribed by primary care providers (Kessler et al., 2005).

In addition to these changing practice patterns and declining reimbursement rates, psychologists in private practice have also experienced: (a) increasing costs of doing business; (b) a marketplace with increasing numbers of masters-level mental health providers; (c) growing regulatory demands regarding billing, privacy, confidentiality, patient consent, and record-keeping; (d) increased administrative burden of working with payors, and (e) a lack of negotiation leverage with payors due to anti-trust concerns (Nordal, 2012).

On the heels of all of these changes entered the Patient Protection and Affordable Care Act (ACA) of 2010, which will unquestionably be the largest driver of change in our health care system, including behavioral health care, for the foreseeable future. And, given the anticipated eventual increase of up to 52 million individuals in the ranks of the insured beginning in 2014--due to increased access through ACA provisions for Medicaid expansion and Health Insurance Exchanges--(Elmendorf, 2010) there will be an even greater demand for behavioral health care services. The goal of the ACA is to improve health outcomes for all Americans by increasing access to higher quality and more efficient care, while also reducing the growth rate of health care costs (Kaiser Family Foundation, 2011). Provisions in the ACA strongly suggest that institutional-based practices, which have the capability of supporting interprofessional health care teams, are critical to the delivery of more efficient, higher quality, and more cost-effective care (Rozensky, 2011).

As the U.S. health care system continues to evolve and is shaped by the ACA, health care and government policies will promote more collaborative care and integrated practices (Delbanco, 2011). These include: (a) the proposed gradual move away from fee-for-service as we know it today to alternate payment models such as bundled, global or episodic payment models and shared- savings and shared-risk financing models; (b) tying payment to the use of evidence-based practices and outcome measures in an effort to improve patient and population health and (c) the use of electronic health records systems. Health policy experts and health economists believe that integrated health care is the most effective way to bend the cost curve, and governmental policies are lock-step with that thinking.

The ACA encourages the development of Accountable Care Organizations (ACO) and Patient-Centered Medical Homes (PCMH) by making innovation grants available to establish and evaluate these care delivery models. These models focus on comprehensive, integrated, team-based care by a group of providers who are responsible for the health care of a defined patient population, although PCMHs are envisioned as operating on a much smaller scale than an ACO. ACOs may be designed in different ways, but will include at a minimum at least one hospital, primary care physicians, and specialty care providers. ACOs must provide coordinated and well-integrated patient-centered care while promoting value, improving population health, measuring performance, adopting health information technology, and reducing costs (Singer & Shortell, 2011). The new delivery systems are currently being evaluated both by the federal government and private entities and the results are mixed, although there is a sense of promise that the PCMH can both increase the quality of care and reduce costs (Grumbach & Grundy, 2010).

These developing models lend themselves to psychologists currently in solo and group practices through contractual arrangements or through group practices, such as a limited liability company or interprofessional group where psychologists are permitted by state law to have incorporated group practices with other health care professionals, or by participation in more sophisticated models like IPAs. But in addition, if psychologists want a broader health care practice, beyond specialty mental health care, they will need to become familiar with the culture and practices of these kinds of environments. Psychologists will need to cultivate new and expanded skill sets for integrated practice, including brief interventions for mental health and behavioral problems, innovative use of health IT, and comfort with electronic health records systems.

Integral to achieving the ACA’s goals of improved health outcomes is a growing emphasis by public and private sector payors on provider accountability as demonstrated by adherence to evidence-based practices and the use of outcome measures. In an effort to provide guidance to psychologists about evidence-based practices, the APA is currently developing clinical practice guidelines in the areas of depression, PTSD, and obesity. These guidelines will be based upon the scientific and professional knowledge of our discipline and are designed to provide high-quality, evidence-based recommendations for patient care.

Value-based purchasing strategies will continue to put pressure on providers to demonstrate, through quantifiable metrics, the success of their treatment interventions. For some time now, managed behavioral health organizations have encouraged providers to evaluate outcomes. A private sector example is OPTUM, which has encouraged its providers to participate in having their clients complete their Wellness Inventory. A public sector example is the Medicare Physician Quality Reporting System (PQRS), which was introduced in 2007 as an incentive- and penalty-based program in which eligible Medicare providers report quality measures for covered professional services provided to Medicare beneficiaries. Providers who do not report quality measures will be subject to a 2% penalty in their Medicare payments beginning in 2016 (Nordal, 2014). The APA Practice Organization has a number of PQRS resources for practitioners on its Practice Central website.

The common wisdom is that these trends in health care delivery will continue, and small practices that are health care focused and unwilling to reevaluate their practice models will be at a significant disadvantage. Practices that include large numbers of psychologists, and perhaps other mental and behavioral health professionals, for integrated delivery systems will be advantaged. In the future, too, private practices of psychology will likely focus even more on coordination and collaboration with primary care practices and treating the behavioral components of chronic illness. The demand for health service psychologists will be fueled by rising health care costs and greater incidence of chronic illness associated with unhealthy lifestyles that include smoking, alcohol abuse, physical inactivity and obesity. Currently about 75% of all health care dollars are spend on treating chronic illness (Centers for Disease Control and Prevention, 2009), so this is a patient population with whom psychologists should be able to demonstrate the value they can bring to the health care system in terms of both facilitating better patient health outcomes and reducing overall health spending.

Psychologists will need to finance, develop, implement, and maintain the IT and data reporting systems that will be necessary to track information required for the performance-based reimbursement mechanisms of the future. Larger groups of professionals can work collaboratively to achieve quality improvement in their patient care. Consumers, employers, and payors will continue to demand data on provider performance related to adherence to quality outcomes and process measurement, patient satisfaction, and cost of care. Larger integrated groups will probably be favored by payors due to the mix of service, geographic coverage, and simplicity of contracting through one Tax ID number instead of with numerous individual providers. Further, there are negotiating efficiencies with payors when a group of practices, such as an integrated independent provider association (IPA), can share a manger that can analyze and negotiate contracts. In summary, psychology’s survival as a valued discipline in the health care system of the future will depend upon the extent to which psychologists can contribute to the system’s achieving the “triple aim” of the Affordable Care Act: improving the patient experience, improving health outcomes, and bending the cost curve by providing evidence-based, cost-efficient care.

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