THE BUSINESS OF PRIVATE PRACTICE IN PSYCHOLOGY IN THE DAY AND AGE OF THE AFFORDABLE CARE ACT

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Abstract

The business of private psychological practice historically has involved both skill in providing therapeutic care and financial acumen. The complexities of the current healthcare system in America have made the dilemma of providing quality treatment and managing business for financial sustainability nearly untenable. The implementation of the Patient Protection and Affordable Care Act (ACA) in 2010 brought more than 28 million previously uninsured individuals into the healthcare system. At the same time, the ACA added greater complexity to the healthcare system. The dilemma of providing quality treatment and maintaining financial viability has never been more challenging for mental health professionals serving in private practice. The author of this qualitative study examined how the current healthcare environment has impacted three different practices. The present study examined how the climate of the mental healthcare world has impacted the mission and financial sustainability of three practices as a result of the ACA and other factors.

Keywords: mission, business plan, private practice, Affordable Care Act,

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Chapter 1

Business of Psychology

A Brief History of Mental Healthcare Business in America

In a summation of the history of mental healthcare in America, Mechanic & Olfson (2015) said "the development of our mental health system is as much a story about finances and payment as it is a tale of the evolution of new treatments" (p. 6.3). As one reviews the research, it is clear that this statement applies as much at a macro level concerning the history of mental healthcare (Mechanic & Olfson, 2015; Rozensky, 2013; Nordal, 2012) as it does on a micro level of the individual clinics (Meyers, 2014; Legge, 2015; Shallcross, 2016). Concerning the challenges with finances and treatment, the big picture of the history of mental healthcare in America in many ways parallels the history and struggles of each individual private practice.

Since at least the middle of the 20th century, there has been a struggle to determine who is responsible for healthcare. Families, government (both state and federal), and other community agencies all have roles in healthcare. The roles and responsibilities of agencies providing healthcare (family, government, or otherwise) can overlap or conflict. There are also many instances when healthcare is gravely lacking (Mechanic & Olfson, 2015). Recognizing the large numbers of veterans with psychiatric disorders, the federal government brought the structure of the military into the healthcare system to organize care for the veterans and their families after World War II. In addition, with employment increasing rapidly, insurance companies took the opportunity to sell their services to employers, who in turn made health insurance a benefit to employees. In 1965, the government introduced and supported Medicare and Medicaid to

care for the elderly and the disabled (Mendelberg, 2014). In an attempt to reduce costs and provide accountability, managed care organizations were created (HMO Act, 1973). The transition from pay for services insurance with freedom to choose providers to managed care programs was slow at first. In 1988, 73% of employees had insurance that allowed them to choose their provider, and 27% were in health maintenance organizations (HMOs) or preferred provider organizations (PPOs) that directed participants to particular providers and specific treatment options. By 2001, 95% of the people with insurance were in HMO or PPO plans (Centers for Medicare and Medicaid Services, 2003). This managed care initially appeared to be an improvement (reducing healthcare costs), but the reality turned out to be that the managed care organizations reaped large profits, spent less money on services, limited patient access to treatment, and lowered payment to providers (Gasquoine, 2010).

As dysfunctional and inequitable as the managed care system has been, those individuals and their families whose services were covered were fortunate (Mendelberg, 2014). The less fortunate were those whom Medicare or Medicaid covered, whose options for services and providers were severely limited by: 1) the low provider reimbursement rates, 2) the cumbersome and costly administrative processes, and 3) the chronicity and acuity of a higher percentage of patients (Mendelberg, 2014; Goodheart, 2010). The least fortunate were those without any insurance coverage. In 2010, 48.6 million Americans were without insurance coverage (U.S. Census Bureau, 2015).

Today, the healthcare world, of which the independent practice of psychology is an integral component, is undergoing substantial change (Nordal, 2012; Rozensky, 2011). Practitioners are becoming more aware of the economic issues that affect their practice

(Goodheart, 2010). However, as a result of the recent changes in the healthcare world, due in large part to the Patient Protection and Affordable Care Act (ACA, 2010), treatment and finances are very much in flux. The changes that the ACA has implemented will not be completely implemented until 2018. There are political factions contesting multiple components of the ACA. The magnitude of the issues is yet to fully manifest. Large entities from a variety of industries are involved with the change, such as insurance companies and the American Medical Association. A few of the major issues are the coding of services for billing, the responsibilities of primary care physicians, and reimbursement rates. The healthcare world and its patients will not fully realize the impact of the legislation for many years (Mechanic, 2015).

Mental Health in America

In 2014, the National Survey on Drug Use Health (NSDUH) reported that approximately 18.1 percent of all adults aged 18 or older had "any" mental illness (AMI) in the United States. Any mental illness is defined as any mental, behavioral, or emotional disorder that meets the criteria from the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV; the American Psychiatric Association [APA], 2000) excluding developmental and substance use disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; National Institute for Mental Health [NIMH], 2016). Eighteen-point one percent represents approximately 43.6 million adults aged 18 or older that were diagnosed with any mental illness in 2014 (SAMSHA, 2014; NIMH, 2016). The NSDUH does not have a number for AMI for adolescence in 2014; however, they report that in 2014, 11.4 percent of adolescents aged 12 to 17 had a Major Depressive Episode (MDE) during the past 12 months. This represents approximately 2.8

million adolescents. MDE is defined using the diagnostic criteria from DSM-IV. The percentage of adults having an MDE in this same time frame was 6.6 % of adults aged 18 or older, representing some 15.7 million adults (SAMSHA, 2014). The percentage for adolescents experiencing an MDE is 73% higher than the percentage of adults experiencing an MDE during this same time frame. It is the result of figures such as these that prompt action such as the Patient Protection and Affordable Care Act was necessary.

Patient Protection and Affordable Care Act

In an examination of the state of healthcare and the needs of the people, Nordal (2012) wrote:

> The United States' fragmented and uncoordinated system of healthcare delivery, an increase in the number of individuals with chronic illnesses, poorer population health outcomes as compared with other developed nations, escalating costs of healthcare, and the large number of uninsured Americans necessitated sweeping reform in the financing and delivery of healthcare. To address these issues, Congress passed the Patient Protection and Affordable Care Act (ACA, 2010) with the goal of improving health outcomes for all Americans by increasing access to higher quality and more efficient care, while reducing the growth rate of healthcare costs (p. 535).

The scope of this study precludes an extensive examination of the ACA. For the purpose of this research, it is important to look at how and why the ACA will impact the private practitioner, for, as Nordal (2012) goes on to say, "the ACA of 2010 will unquestionably be the largest driver of change in our healthcare delivery system for the foreseeable future" (p. 537).

The provisions of the ACA offer opportunities to insure nearly 60 million previously uninsured or underinsured people (Mechanic, 2012). Mental healthcare professionals are reimbursed for previously unreimbursed services, can treat clients with pre-existing conditions, can integrate care with new information technology tools and treatment teams, and can embrace brain trusts of multiple disciplines in tackling complex chronic comorbidities. In addition, mental healthcare professionals will be able to utilize evidence-based interventions and provide a high level of accountability within and across diverse professional fields (Mechanic, 2012, Beronio, Glied, & Frank, 2014). Mental healthcare professionals are also supportive of the ACA because there are millions of uninsured people that will now be able to receive services. However, many issues are still unresolved. These include authorization for treatment, limitations on services provided, the administrative process for payment, and the establishing of the criteria for evidence-based interventions (Mendelberg, 2014, Flaskerud, 2014).

The ACA legislates a healthcare system transformation that will include the integration of behavioral healthcare into primary care settings. It is not clear what role psychologists will have in this unfolding and evolving integrated system (Nordal, 2012). A small percentage of clinics have begun the integration process with ACA grants funding their work (Norcross, 2016). This integration is different from multidisciplinary teams, where professionals from different fields are co-located and able to consult on patient care. Interdisciplinary or integrated care models include professionals of diverse fields collaborating on all components of patient care: physical, mental, or behavioral, and even social or familial issues (Kelly & Coons, 2012). There are many advantages to these models, the specifics of which are beyond the scope of this study. At the same time,

there are two significant unknown issues. The first issue is, how will insurance companies compensate professionals in an integrated behavioral clinic setting? Secondly, how is the insurance coding for services rendered established to pay the providers of varying professional fields? These issues are critical to the sustainability of a practice. At this point in time, private practices have barely begun to feel the impact of the move toward integrated behavioral clinics. There is no current research available reflecting the impact of integration on the viability of private practice.

The ACA will one day may require therapy to be evidence-based treatment (EBT). The timeline for this component of the plan is a hotly contested issue (Mendelberg, 2014). There is a tremendous debate about the ability to identify a treatment or therapy as evidence-based because there are so many other factors to consider, and the treatment modality is a minor contributor. For example, one could easily imagine that an exceptional therapist delivering a non-EBT treatment plan would be more effective than a mediocre therapist delivering an EBT treatment plan (Duncan, Miller, Wampold, & Hubble, 2010). Thus, therapist competency is likely a stronger predictor of treatment outcome than therapy modality. Currently, there is not enough research to definitively state this one way or the other (Budd & Hughes, 2009). The EBT requirement will mandate the private practitioner to identify the listing of EBTs and confirm if the treatment they are delivering qualifies. Otherwise, they would be disqualified from receiving payment or required to deliver an approved treatment modality.

The ACA provides coverage and treatment for mental health and substance use disorders at an unprecedented level (Beronio, Glied, & Frank, 2014). The percentage of

people with mental illness and substance abuse disorders is much higher among the previously uninsured, so their coverage through the ACA is particularly significant (Mendelberg, 2014; Cantor, Monheit, DeLia, & Lloyd, 2012). These clients could be a significant percentage of the caseload of a private practitioner. However, there are multiple factors that impact the attainment of psychotherapy for these potential clients. The reason for this is that with managed care, there have been financial incentives that favor the use of psychotropic drug prescriptions over psychological therapies for the treatment of mental disorders (Gasquoine, 2010). Research, however, shows that drugs are sometimes less effective than psychotherapy (Gasquoine, 2010, Mechanic, 2012). In addition, managed care has placed an emphasis on short-term psychotherapeutic approaches, with the primary emphasis being on symptom reduction and functional adaptation within parameters of the disorder (Gasquoine, 2010). Free market enterprise mandates that insurance companies remain diligent at reducing the expenses of treatment. History shows they apply pressure to treat clients with pharmaceutical solutions rather than engage with a private mental healthcare practitioner (Gasquoine, 2010). Although research shows psychotherapy is frequently more effective, and in the long term, less expensive than short term interventions or pharmaceutical solutions, the insurance companies' strategy of encouraging the prescription of short psychotropic drugs has been utilized to reduce the cost of treatment (Mendelberg, 2014). This issue only expands with the new population that the ACA covers because the ACA still utilizes insurance companies as providers (Gasquoine, 2010, Mechanic, 2012). If insurance companies and HMOs continue to exert such influence, psychotherapists may not see any increase in client load, even though a greater population in need is now covered.

Business Issues for the Private Practitioner Related to the ACA

In order to prepare for handling ACA insured clients, professionals will need continuing education to better understand what is permissible, how billing is processed, and how much reimbursement can be expected (Rozensky, Celano, & Kaslow, 2013). In their study, Rozensky, Celano, and Kaslow (2013) presented four topics in which professionals must become proficient to be successful in this age of the ACA: "1) Interprofessionalism; 2) Workforce and practice settings; 3) Financial accountability, evidence, and healthcare cost offset, and 4) Professional accountability (specialization, accreditation, identity, autonomy, and advocacy)" (p. 163). Clearly, the ACA places a tremendous amount of new work and responsibility on private practitioners to engage in to sustain their business going forward.

As a result of managed care, psychotherapy reimbursement rates for psychologists have seen a 30% decrease over the last 15 years, if inflation is factored into the equation (Cooper, 2011). The reimbursement rates and coding categories from ACA insurers are similar to Medicare and Medicaid, but they are more complex because they are bundled with other integrated care. In some states, managed care reimbursement rates have been negotiated down so far that Medicare and Medicaid rates are higher than private insurers' rates (Nordal, 2012). Further education is necessary for private practitioners to be able to embrace the ACA system. Graduate courses on the subjects are being developed across the nation to better prepare and equip future psychologists, but this work is in its infancy (Hoerger, 2015). Psychologists have been opting out of managed care over the last decade (Gasquoine, 2010). The pressures of reduced reimbursement rates, and now further work to understand and qualify for reimbursement within the framework of the

ACA, could be so overwhelming that psychologists might opt out of serving this population altogether.

Professional therapeutic skills and empathy are clearly insufficient to sustain a psychological practice in the complex world of healthcare in which we live. Many psychologists have little interest or capacity for formal training in business, healthcare financing, and all the other issues the ACA legislates (Meyers, 2014). According to Goodheart (2010), "psychologists need a greater focus on economics to practice ethically, appropriately, and successfully within U.S. healthcare systems that are a rapidly changing patchwork of public and private financing models under great financial pressure" (p. 189). In order to build and sustain a private practice, specific healthcare business acumen and knowledge of treatment efficacy are critical. This is an enormous challenge for people who have entered the field primarily for service-oriented reasons, as opposed to business-oriented motivations (Huynh & Rhodes, 2011). In 2011, Huynh and Rhodes found that of students who were pursuing a career as a psychologist, a significant number of them were motivated "by positive, satisfying experiences they had in helping roles, experiences which for some demonstrated their personal suitability for the profession" (p. 64). However, issues such as turbulent financial conditions, a changing healthcare system, broad business and economic knowledge, and administrative bureaucracy are topics more aligned with business, accounting, and public administration than the helping profession (Mendelberg, 2014, Goodheart, 2010).

Private Psychological Practices

In spite of the changes in treatment options, lower and restricted insurance coverage, and low governmental reimbursement, private psychological practice continues

to be one of the most common career paths that clinical psychologists take. Many practitioners find the business management aspect of private practice to be challenging. However, the recent economic downturn has prompted many practitioners to consider diversification in their practices because they are experiencing higher no-show rates, fewer new clients, and increased demand for negotiated fees (Colburn, 2013). Nevertheless, the American Psychological Association (APA) Division of Clinical Psychology has noted a significant rise over time in the percentage of psychologists choosing private practice as their primary employment setting (Norcross & Rogan, 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. In another report, more than half of psychologists who deliver health services are primarily independent practitioners, according to the data from the American Psychological Association Practice Organizations Center for Workforce Studies (APAPC, 2016a). Although financial reimbursement rates for psychotherapy have decreased over the last 15 years, the work for attaining reimbursement has increased. Even with the state of the mental healthcare in great transition, the appeal of private practice is as strong today as ever (Norcross & Rogan, 2012).

Advantages and disadvantages of private practice. The advantages of having a private practice are both numerous and straightforward. The primary advantage is the freedom to be the principal decision-maker (APAPO, 2016b). Some of the major critical decisions involved are: work location, work hours, fees to charge, clientele and specific

disorders, treatment modality and theoretical approach, and a clear choice to work with a particular client or not (Harrington, 2013; Brennan, 2013). The therapist gets to choose which clients they will work with, which treatment plan and therapeutic modality they will utilize, how much they will be compensated for the work, and what schedule they will have.

The advantages need to be weighed against the disadvantages (APAPC, 2016b): 1) complete responsibility for all financial matters (overhead, insurance policies, furnishings, equipment, continuing education, fees for extra services such as billing, accounting, and administrative work), and 2) inconsistent revenue streams. Additional challenges are the 1) financial barriers for uninsured or under-resourced clients to access service, 2) ethical and legal standard of care maintenance, and 3) marketing (Harrington, 2013; Brennan, 2013). In addition to the disadvantages listed for being in private practice, there is an increasing number of clients with greater awareness of what might be available in therapy (APAPC, 2016c). These clients seek better service and more competence from providers without increased financial outlay (APAPC, 2016c). This requires the private practitioner to seek out education as well as consultation to ensure the quality of the service provided is continually improving (APAPC, 2016b). The ACA, with its emphasis on accountability, induces providers to work together to diagnose and plan for treatment (Klingaman et al., 2015). Unless the private practitioner is working in a specialized collaborative group practice, any shared decision making of diagnosis and treatment is exclusively dependent on the client and the therapist. Without taking further time and expense to find someone, the practitioner may be unable to find anyone else

with whom to collaborate. This can be a very difficult issue when dealing with clients with personality disorders or comorbid pathologies (Klingaman et al., 2015).

American Psychological Association Practice Central

The Practice Central website of the American Psychological Association (APAPC) provides extensive instruction for psychologists to build and maintain a private practice in the United States of America (APAPC, 2016b). The consistent message from the website is that it is not enough for a psychologist to provide excellent treatment (APAPC, 2016c). In order to sustain a viable practice, the practitioner must personally lead the way in adapting services provided, engaging in marketing, and building and managing their practice. According to Walfish, "besides entering a difficult economy and lacking community connections, chances are you haven't yet acquired crucial financial and marketing acumen. Grad school teaches you how to be a good clinician, but no one teaches you how to run the business side of a practice" (as cited in DeAngelis, 2011, p. 40). "The healthcare system's growing complexity increases the need for practitioners to be familiar with business concepts," says David Ballard, PsyD, MBA, assistant executive director for corporate relations and business strategy for the APA Practice Organization (APAPC, 2016b, p. 1). Psychologists functioning in today's complex environment must build their knowledge bases and learn how to put business concepts into practice.

One component of addressing the business side of practice is developing a mission or value statement for the practice. This mission is identifying target clientele, treatment modality, and the rationale behind the choices (DeAngelis, 2011). Most graduate schools cover these issues well as far as they relate to the populations of clients, common pathologies, theoretical orientations, and treatment modalities (Rozensky, 2014,

APAPC, 2016b). These subjects are the components psychologists understand and are the central reasons they were drawn into the field (Huynh & Rhodes, 2011). Establishing a clear purpose upon which the practice is grounded will help drive the decisions involved when it comes to the financial aspects of the business (APAPC, 2016b).

The APAPC recognizes that the mental healthcare environment of today makes establishing and maintaining a private practice much more difficult than it was 15 or 20 years ago (APAPC, 2016d). For this reason, there was a review of APA private practitioners across the country, and the APAPC found that those private practitioners experiencing ongoing success had several things in common. The characteristics that the APAPC identified as common in successful practices were:

1. Creatively apply focus of practice toward a niche.
2. Develop and maintain flexibility working with the changes in the healthcare system.
3. Actively engage in the business aspect of the practice (APAPC, 2016d).

These common characteristics reinforce the theme presented earlier: our national healthcare system is as much about finances as it is about treatment, and this same truth exists at the micro level of the individual practice.

Business plan for success. There are many distractions when running a private practice, and as Morris (2000) notes, “like many psychologists, I'm so interested in helping people that it's easy to do things that aren't good for my business, I can't emphasize enough how important having a business plan has been in terms of reminding me that I'm running a small business" (as cited by Clay, 2000 p. 48). On the APAPC website, there are more than 24 articles on establishing a business plan to build a private

psychological practice such as eight listed in this study, (APAPC, 2016b-i). There are no articles listed in which a business plan is deemed an unnecessary component for establishing a private practice. Clearly, a written business plan is the recommended approach for the establishment of a successful private practice (APAPC, 2016e).

To develop the business plan, it is recommended that psychologists reach out to experts in accounting, taxes, and mental healthcare law, as well as practitioners who have worked through the process (APAPC, 2016e). Walfish (2011) states, "…don't just go on the experience of one person who is terribly successful or one person who is all gloom and doom…," and "the more private practitioners you can talk to in the beginning, the more accurate your knowledge base will be" (as cited in DeAngelis, 2011, p. 40). In this turbulent climate of mental healthcare, private practices established with the noblest of intentions and strong therapeutic skills, but without business skills are at risk of losing sustainability (APAPC, 2016B). Stout stated, "when you take the trouble of creating a business plan, it helps you flesh out answers to questions like how much money you need, what your costs are, what the money will go for, when you'll break even and when you'll make a profit" (as cited by Clay, 2000, p. 48).

Components of a business plan. The APAPC establishes that the development of a business plan begins with an overview of what the practice is about (APAPC, 2016b). The plan will include a summary of the purpose for existence or mission. The mission will communicate the core values that drive the practice (APAPC, 2016e). The business plan will include the logistics of the practice as well as the target population (APAPC, 2016c). The plan will also include the services provided, clients served, and ways the practice measures success (APAPC, 2016d). In addition to being a compass for the

direction of the practice, the business plan can help to communicate to others the services the practice offers. Communicating the services provided is particularly important as it relates to referrals for the practice, and to support from other professionals with clients who are beyond the scope of the practice (APAPC, 2016f).

Most the rest of the business plan details the financial issues involved in determining whether a practice will succeed or not. These include an examination of the environment, a plan for marketing, and the tracking and managing of finances (APAPC, 2016d). Psychological practices take place within the context of their society. An environmental analysis for the business plan is necessary for looking at the immediate society in which the practice is to be established to determine how it may be impacted by the service. This analysis will include socio-economic issues, legislative and regulatory issues, and demographics (APAPC, 2016e).

The tracking and managing of the financing component involves projections of income and balance statements, cash flow analysis, and short term and long term capital requirements. It is vital to have a clear understanding of projected revenue and expenses. The Practice Finance section of the APAPC website provides financial instruments and ratios to track financial progress. These tools provide financial data to track performance to ensure a stable financial future (APAPC, 2016g). The dynamic that this study examines is, how do the financial realities resulting from the ACA era affect the mission, (i.e. the focus and function) of the practice?

Marketing mandatory for success: the necessary evil? A major component of a business plan is a solid marketing strategy (APAPC, 2016h). There are more than 20 articles on the APAPC website on how to perform successful marketing (APAPC, 2016f,

2016h). Many counselors bristle at the concept of marketing and sales because they have a hard time juxtaposing life-altering treatment with the collection of money. As Legge says, "we're socialized in the helping professions to think that helping others and making lots of money are contradictory" (as cited by Shallcross, 2016, p. 3).

The emphasis in successful marketing as consultant David P. Diana (2016) communicates is on sharing, "why you do what you do as a counselor, offering potential clients a mission and a story which they might connect" (as cited by Shallcross, 2016, p. 5). In this situation, Diana (2016) states, "when your values and purpose match up with a group of people with similar values and purpose, then you have found your audience" (as cited by Shallcross, 2016, p. 5). The audiences therapists are connecting with are both clients and other professionals who are looking for professionals of similar ilk when they need a referral (Shallcross, 2016, APAPC, 2016f).

Successful marketing implemented with integrity may be the difference between fulfilling a mission while attaining financial sustainability and going out of business.

As Legge (psychologist and business coach) stated concerning her clients:

> [They] have expressed frustration that she can't show them how to make a comfortable living working exclusively with individuals and families with low incomes. In that instance, she might tell counselors that although some of their practice can be dedicated to working with that client population, they also have a responsibility to supplement that with higher-paying work so they can stay in business for all their clients.
>
> (as cited by Shallcross, 2016, p. 19)

This is the dilemma many psychologists must face in the climate that current healthcare economics renders. How do psychologists within private practices balance their mission of providing care to particular clientele with the financial requirements needed for sustainability?

There are numerous studies that reveal the transition of private practitioners from one type of practice to another (for example, from private practice therapy to a consulting business). In these instances, the practitioner essentially rips up the initial mission and creates a new beginning (Colburn 2010, Belar, 2003, Nessman, 2014). Research that demonstrated the evolution of business plans and mission without having to overhaul the entire thrust of the initial practice was unable to be found. One focus of this study is whether practitioners have experienced the transition of a mission to remain financially viable.

Rationale and Purpose of the Study

Historically, the financial aspects of running a private psychological practice have been a big challenge. Governmental programs and policies, as well as insurance organizations, have contributed to this challenge. People pursuing psychological private practice are frequently more service-oriented than economic-oriented (Huynh & Rhodes 2011). Psychologists and mental healthcare workers have much more interest and experience in the treatment of people than the financial aspects involved in sustaining a practice. Nevertheless, even with these difficulties, the largest percentage of people in psychological practice continues to be those in private practice.

The ACA has enabled an unprecedented number of people, a group with a higher prevalence of mental illness, to attain mental healthcare (Mechanic, 2012). At the same

time, the ACA requires an extraordinary level of education, accountability, and administrative processes for practitioners to provide services. In addition, all of this is required at a lower reimbursement rate for the services provided. The practical realities presently necessary to maintain financial sustainability may be overwhelming for practitioners who are primarily service-oriented in their motivation, talent, and focus.

The APA acknowledges this reality and understands the economic difficulties and administrative challenges involved (APAPC, 2016b). The APA has developed a support structure for psychologists to initiate and engage in private practice. A major component of this support is for practitioners to develop and follow a business plan for their practice. A central element of the business plan is the mission that defines the purpose and the focus of the practice. The focus of this study was how this mission evolved as the clinician faced the business demands of the current mental healthcare world. There is only anecdotal information of practitioners wrestling with the mandate to change their mission to sustain business viability. The newness of the ACA would partially explain the dearth of information on the effect of these issues on private practitioners. However, there were no peer-reviewed or systematic studies examining this dilemma, or the impact of the dilemma on the practitioners themselves.

The author of this study set out to identify and understand the experience of private psychology practitioners in America. The issue studied, with the current mental healthcare system, how did the practitioner experience the evolution of their mission to maintain their financial sustainability? For example, a practitioner enters the mental healthcare field with a passionate drive to help underserved populations in the U.S. Then this individual learns of the education necessary to serve people whom ACA insurance

providers cover, as well as the claims process difficulties and low reimbursement rates (Mendelberg, 2014). The clinician comes to realize that they cannot stay in business under their mission as it stands. The dearth of practitioners available for clients whom the ACA covers attests to the prevalence of this scenario (Goldman & Karakus, 2014). What happened to the practitioners in this situation? Did they make compromises with their mission? Did they change their financial expectations? If so, how did that feel to them? How did they process through this transition on a personal and professional level?

Research Question

The purpose of the study was to qualitatively observe and understand the direct experience (referred to as the lived experience) of mental health professionals in private practice. The lived experience of the mental health counselors or psychologists was examined with respect to how their mission integrated with the financial reality of today's world.

The research questions of this study were as follows:

1. How have the focus and function of private psychological practices and their financial goals and requirements been impacted, considering the changes in mental healthcare because of the ACA?
2. How have financial circumstances created by the healthcare system affected the missions of psychological practices?

Chapter 2

The American Psychological Association provides information and instruction for people to establish a successful private practice in the mental health field (APAPC, 2016e). The information addresses such issues as development of a business plan, selecting a niche, and marketing. A component missing in the information is the personal experience of people practicing according to their principles in the current climate of mental healthcare, as well as experiences of financial turmoil. This focus of this study was to attain such information.

In the following sections, a description of the fundamental worldview and research design will be presented. In addition, the research questions guiding the study will be provided. Population characteristics, sampling and recruitment procedures, and data collection methods will also be described. Finally, data analysis procedures, including establishment of validity, credibility, reliability, and protection of participants, will be explained.

Philosophical Worldview

The study was conducted using a Pragmatist Philosophical Worldview to attain real-world, practice-oriented results. The Pragmatist Philosophical Worldview is about determining what works and identifying available solutions for a problem (Creswell, 2014). Furthermore, pragmatism allows for more than one solution to a problem. The emphasis of this study was to see how psychologists in private practice are meeting the mental healthcare needs of the multitudes in America requiring treatment. Creswell (2014) states, "Pragmatists agree research always occurs in social, historical, political, and other contexts" (p. 11). The healthcare system in the United States is continually

evolving in an attempt to meet the needs of its people. The United States federal government has attempted to bring wholesale changes to healthcare through the ACA, which is having and will continue to have an enormous impact on the entire mental healthcare field (ACA, 2010; Mendelberg, 2014; Mechanic, 2012). For example, a large part of the impact relates to very pragmatic issues such as how many hours practitioners need tor the education necessary to process the administrative requirements that the ACA mandates, as well as how much reimbursement practitioners will receive. This study looked at how practitioners are responding to the type of issues initiated or intensified by the ACA.

Purpose Overview

The focus of this research was to identify what private practitioners are doing to meet the mental healthcare needs of clients in their community at this time in history, given the challenges of the current healthcare environment. The study observed the evolution, if any, of the mission of the practitioner as their expectations and plans potentially conflicted with financial obligations and pressures. The pragmatic worldview offers an excellent perspective by which to observe this process and evolution. The purpose of this study was to explore the impact of current financial challenges, and substantial change from ACA-driven healthcare, on the mission, function, and focus of private psychological practice.

Research Design and Methodology

A qualitative comparative case study was the methodology utilized in this research study. The unit of analysis is what defines a qualitative case study (Merriam & Tisdale, 2016). The units of analysis in this study were three specific private practices.

The researcher was the key component for bringing forth evidence through data collection and analysis, which then provided a thorough and rich portrayal of the experience of the subjects. Qualitative case studies, according to Merriam and Tisdale (2016) are about "the search for meaning and understanding" (p. 37). The researcher ascertains understanding and meaning from the evidence attained. The author of this study sought to identify and understand how private practitioners are experiencing the impact of financial constraints on the reason for their practice existing. The aim of this study was to attain a rich description of the evolution of the practice as theory (mission) met reality (financial realities).

A qualitative study is particularly useful when it is difficult to separate the impact of the variables affecting the case, and the context in which the variables exist. In this case, for example, it was interesting to see the dynamic interplay between the financial challenges and clinical goals and aspirations. A quantitative study would typically make a judgment about the efficacy of the practice or some component of the services provided. However, qualitative methods enable an exploration into how participants exist in their real-world environment: not only what they think and feel, but also what their experiences mean and how they understand them (Merriam & Tisdale, 2016). The author of this study focused on how the participants are meeting the personal and mental health needs of their clients, while making a viable living managing a small business. The focus of the present research was to understand participants' experiences through their viewpoints; therefore, a variety of approaches were utilized to reveal information about their experiences (Creswell, 2014). These approaches are addressed in the data collection process and procedures section of the study.

The missions and subsequent business plans of the practitioners provide a picture of the clinical and financial benchmarks that the owners or directors of the clinic have established. As previously mentioned, a quantitative study would be objectively measuring the efficacy of the clinic or some component of the services provided. In contrast, qualitative methodology research focuses on the personal impact on the lives of the participants. For example, the financial reality may lead to significant adjustments in a mission. The qualitative research process in this study included identifying the original intentions and plans of the practitioners. Secondarily, information was collected to look at the results that the practitioners have attained, and these results were compared with their initial intentions.

Case studies allow for the purposeful, in-depth analysis of a subject with clearly established limits on time and activity (Creswell, 2014). Qualitative case studies involve the researcher obtaining detailed data collection from a variety of different sources and methodologies, such as observations and interviews, and audiovisual as well as printed materials (Merriam & Tisdale, 2016). In contrast to other qualitative research methods, case studies involve research questions directly related to the end product; they gain qualitative data that is more concrete, contextual, and generalizable to other studies (Merriam & Tisdale, 2016).

Population and Sample

The participants in this qualitative research study were three different private counseling practices from the greater Seattle metropolitan area (King County). In particular, the three practices were in the eastern region of King County, which is an area with a higher socioeconomic population (King County, 2016). A critical component of

the author of the study was to communicate directly with the people who established and managed the business plan. It was also important to communicate with a person that has knowledge of the initial mission, as well as the current mission, to be able to identify any evolution throughout the history of the practice as it related to clinical and financial goals and benchmarks. For this reason, community mental health clinics, clinics within a hospital setting, and corporate-structured clinics supervised by a board of directors were precluded from the study.

An initial email invitation to participate in the study was sent to clinics meeting the criteria of the study listed in the preceding paragraph (see Appendix A). The participants in the study were selected from those who responded to the email. The participants were then contacted in-person and provided with a consent form that was reviewed with them verbally (see Appendix B). The participants were given the opportunity to ask questions and gain clarification on all procedures and purposes before we began the study.

The three clinics studied differed in business structure. The first clinic (referred to as Clinic 1 going forward in this paper), has multiple sites and approximately 30 therapists. The owner has hired multiple employees to handle non-therapeutic responsibilities such as marketing, billing, and scheduling. The second clinic (referred to as Clinic 2 going forward), has one site with five therapists. The owner subcontracts billing services. The third clinic (referred to as Clinic 3 going forward), has the owner/therapist in one site. This therapist does her own billing and booking. She is completely responsible for everything to do with her business. Each of the three participants of the study was the owner of the clinic.

Data Collection Process and Procedures.

A variety of methods were utilized to gather data, which provided a multi-faceted picture of the practices. The data collection process included semi-structured one-on-one interviews, participant observation, field notes, and document analysis (Merriam & Tisdale, 2016).

Semi-structured interviews. Each participant was interviewed personally in an audio-recorded one-on-one interview for ninety minutes (see Appendix C). The transcription of this interview is included as Appendix D. The semi-structured interviews included open-ended questions, flexible in their wording and order, for the purpose of attaining an understanding of the experience of those in private practice. The interview provided an opportunity for me to respond in the moment to the subjects and their situations as they developed throughout the interview process (Creswell, 2014; Merriam & Tisdale, 2016).

There was a variety of formats used in the data collection. Participants were questioned about the following: their knowledge of their business plan and mission; the evolution of the mission (formal and informal); the process of managing potentially conflicting goals (clinical and financial); and their thoughts and feelings as related to the process in the maturation of their business. Relevant demographic and background information was gathered (see Appendix C). Follow-up or clarifying questions were used to ensure understanding of participant experiences (Creswell, 2014; Merriam & Tisdale, 2016).

Field notes. After each interview, field notes were captured that provided descriptions of the setting, social interaction, countenance, and demeanor of the

participant, as well as nonverbal information (Mack et al., 2005). The observation of the participant expanded understanding of the cultural, social, and economic reality in which the participant lives (Mack, Woodson, MacQueen, Guest, & Namey, 2005). Observation provides information that an interview question might miss. Listening to an answer to a research question only from an audio recording precludes valuable information attained in facial expression and body language. The field notes included such observations (Mack et al., 2005). Another component of the field notes is my own experience, feelings, reflections, interpretations, overall impression, and working hypotheses about the experience of the participants, as well as their lived experiences as private practitioners (Mack et al., 2005).

Written document analysis. Written information about each practice was collected prior to the scheduled interview. The documents were everything from brochures, websites, fliers, and other documents related to the purpose and services that the practice provides. Written documents provide researchers with the actual language and wording of the participants (Creswell, 2014). An analysis of the documents was conducted to obtain a conception of the participants' intended mission or focus and functions. The analysis included an examination of the production of text, sights, sounds, and messages that represent the context of the practice (Creswell, 2014). Specifically, the documents under study provided information about the culture of the setting, as these documents were created within and for the culture (Merriam & Tisdale, 2016). The documents are a written representation of the values and services of the clinicians. The documents provided at least a segment of the mission for the practice. A document analysis provided the opportunity to synthesize the main themes that participants plan for

their clients to experience. The analysis of the documents provided a comparison between the spoken word of the participants and the observational information obtained.

Procedure. The data collection process began with the conducting of audio-recorded one-on-one interviews with each owner or clinical director of the practices. The interviews were about 90 minutes in duration. In addition to the interview, I engaged in participant observation, captured field notes, and collected documents not previously collected for analysis throughout the entire site visit.

Data Analysis Process and Procedures.

Once the data from the interviews, observations, field notes, and documentation were compiled, they were analyzed to identify specific themes concerning the evolution of the mission of the private practice as the business sustainability processes manifested in the current healthcare environment. The recordings from the interviews were transcribed verbatim.

Coding was conducted using the constant comparative method. This methodology compared the tangible collected data with the concepts expressed. It was a review and comparison between what the participants said and what manifested in print and practice--the spoken perspective versus the observed perspective (Merriam and Tisdell, 2016). This initial process is called open coding. The categorized data from open coding was then processed using an analytical or axial coding process. This particular coding process engaged interpretation of the data as well as an examination of the meaning of the data. Interpretation describes what the data says, whereas reflection during this process of analysis speculates on what the data means (Merriam and Tisdell, 2016).

The data (field notes, transcriptions, and document analysis) will be reviewed and coded. The study employed Tesch's systematic process of collecting, categorizing, coding, and analyzing data, which is comprised of two stages of analysis (Tesch, 1990). The first was the within-case analysis, in which the data analysis and coding process was completed for each one of the three cases individually. Once the within-case analysis was completed, cross-case analysis was initiated. This process included a compare and contrast process that described the analysis, with the final explanation applicable to all three cases. When there was a common thread of themes across cases, it led to one conclusion, whereas a lack of common themes, led to a different conclusion (Mack et al. 2005, Merriam & Tisdell, 2016). For example, if all three cases had to change their mission as a result of financial constraints, and the process elicited a strong emotional response, this led to one conclusion.

Credibility, Validity, and Reliability.

Researcher bias and assumptions. I am a psychology graduate student working in a private practice as an intern. My responsibilities include performing intake of new clients, which includes the financial obligations they must meet to contract for the services the practice offers. I am very conscious of the need for mental healthcare for many individuals, couples and families in low-income households and have a desire to provide service for members of this population. I am aware of the dilemma many practitioners experience concerning their desire to provide service for this population, and the very real financial needs regarding the sustainability for the practice.

Qualitative research methodology, including the interview process, includes a potential for bias. Participants may have a hard time communicating their lived

experiences or may be less insightful concerning their beliefs and perceptions because of the personal nature of the interaction with interviewer (Creswell, 2014). These limitations were addressed through rapport building with the participants to help them feel comfortable, and the use of semi-structured interview questions to examine their experiences while allowing the flexibility to pursue information leads (Creswell, 2014). In addition, to reduce potential anxiety, I reviewed the major points of the ACA legislation and briefly communicated the resulting pressure that many practitioners experience. I communicated an understanding of the difficulties of practice sustainability, such as reduced reimbursements from insurance providers and governmental agencies such as Medicaid and Medicare.

In this study, I attempted to capture how participants had come to understand the balance of their mission within the context of business sustainability. In general, it is impossible to prove an objective truth with a measurable cause and effect explanation (Creswell, 2014). Areas as complex as human emotional reactions, adjustments of intentions, and directives related to moral dilemmas are so dynamic and multidimensional that human beings directly observing and analyzing may provide a better description of reality than a data collection instrument would. Utilizing rigorous methodology in the process was a key component to of the study to ensure that the observation, collection, and analysis had validity. One such example was coding data the same way with each clinic (Merriam & Tisdell, 2016).

Internal validity. Merriam & Tisdell (2016) state there "will be multiple constructions of how people have experienced a particular phenomenon, how they have made meaning of their lives, or how they have come to understand certain processes" (p.

242). Triangulation was the primary strategy employed to ensure internal validity. Multiple methods utilized in the collection of data (in other words, field notes, interviews, and document analysis) provided the means to compare for uniformity in analysis. A comparison of the analysis from the field notes, written documents, and interviews frequently identified common themes from different sources. The comparison from multiple sources demonstrated consistency in the data and thus supported internal validity. Member checks and respondent validation was a second strategy utilized to ensure internal validity. The premise of member checks is that preliminary findings and initial analysis was shared with the participants to confirm that the direction of the data analysis was consistent with their points of view (Creswell, 2014). The member checks took place in a follow up discussion with the participants after the initial data analysis was completed, and prior to defense of the dissertation.

External validity. The large quantity of richly descriptive data obtained from three separate case studies provided a strong level of external validity. This along with the multiple methods utilized in collection and analysis provided the basis from which the findings were extrapolated to similar populations (Merriam & Tisdell, 2016; Patton, 2015).

Protection of Human Subjects.

The study methodology adhered to the procedures of Northwest University's Institutional Review Board to protect the confidentiality and interests of the participants. The participants were presented with a consent form containing information about the study and purpose, commitment required, potential risks, and the criteria for participation (see Appendix B). The informed consent process provided an opportunity for the

participants to ask questions and develop trust with me, and thus assisted in the interview and observation process (Merriam & Tisdell, 2016).

Summary

The current study employed a qualitative research methodology from a pragmatic worldview perspective. The study focused on attaining an understanding of the lived experience of private practice mental healthcare providers facing the challenges that the current healthcare environment presents.

The research design was that of a comparative case study with three different practitioners leading a psychological practice. Each case involved observational data, audio recorded semi-structured interviews, document analysis, and field notes, all for the purpose of understanding the practitioners' experiences. All the coded data was examined for emergent themes relating to the practitioners experiencing the maturation of their practice as the circumstances of the current healthcare system and economics of today impact the practitioners. The crux of the circumstances is that significant time is needed to fulfill the requirements that the health care system mandates, and time is directly related to finances.

As a psychology graduate student, I have interaction with a segment of the culture involved in mental healthcare. This gives me a perspective into the dynamic interplay between helping people and juggling the sustainability of the business, as it relates to those involved in the field. Validity was established through triangulation of the rich descriptive data from multiple modalities (document analysis, field notes, and interviews), as well as participant validation via member checking. Reliability was

established via coding of transcribed interviews. External validity was reinforced utilizing cross-checking and comparative analysis of the three different clinics.

As a result, the lived experience of the integration of mission with the financial parameters in these private psychological practices was elucidated.

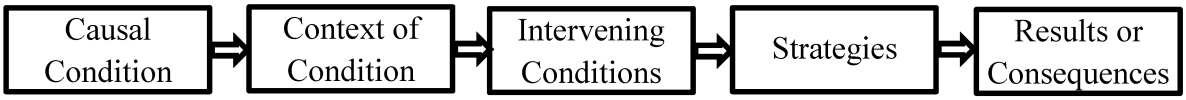
Chapter 3

Data Analysis

Process. Transcripts from interviews, website content, field notes, and pre-existing documents from three different private counseling practices were content-analyzed using a two-stage process of data analysis (Tesch, 1990). The first stage was the coding of all content from each individual clinic. This open coding was the process of examining text from the different sources of data and developing salient categories. There was an application of labels to the phenomena found in the data, which was part of the process of creating the categories. The categories and the data found within were compared and contrasted with other data in other categories. This process provided an opportunity to examine the consistency in content and theme across multiple presentations from one source. The second stage of analysis was axial coding, in which the data from all categories were examined for any relationships and connections that existed. Axial coding is more than describing content and combining the content into categories; it is a reflection and interpretation of the content for understanding. This process was done for all three clinics, and then across all three clinics.

The axial coding process looked for the causal conditions that created the categories. The causal conditions were examined within the context of the environment of the conditions (e.g., the need to produce an income within a geographical area). These conditions led to the intervening conditions in response to the context, the strategy and actions taken, and finally, the resulting current reality. See the example from this study below in Diagram 1.

Diagram 1: Conceptual Process Utilized for Axial Coding with Example



Some of the categories established by coding were partially pre-determined due to the semi-structured interview questions (Appendix C). The initial question was: what were you setting out to do when you opened your practice? In other words, what was the mission of your practice? The second directive of the semi-structured interview was: describe the business plan you had when you started your practice. These questions created the overarching constructs of *mission* and *business plan*. There were other emergent categories from the data, as well as these overarching constructs. There were no limits on the identification of categories during the analysis of the data. Categories or themes were identified by the frequency of the ideas and the consistency of the categories across clinics. The additional constructs that emerged from the data included *financial issues*, *legal issues*, and *business structure*.

The semi-structured interview questionnaire was designed to elicit responses to the research questions of this study. The first of the two research questions is below. The second question will be addressed later in the paper. Research question 1:

> How have the focus and function of private psychological practices and their financial goals and requirements been impacted, considering the changes in mental healthcare because of the ACA?

Focus and function of the practice

The presentation of the findings in this first section is designed to address the first research question. The principal focus of each of the three practices was to stay in

business for the long term, whereas other clinicians may have a primary focus of helping people, no matter the cost. The primary focus of these business people was to succeed in business. Helping people would not happen long term if they could not stay in business. Each clinic owner had performed a budget forecast and concluded that their clinics could not service ACA, Medicaid, or Medicare insured clients and accomplish their primary focus of financial viability. The reimbursement rates for these programs are too low, and the process for receiving it too bureaucratic, to be economically feasible for all three clinics.

The three clinics of the study differed in business structure. The first clinic (Clinic 1) has multiple sites and approximately 30 therapists. The owner has hired multiple employees to handle non-therapeutic responsibilities such as marketing, billing, and scheduling. The second clinic (Clinic 2) has one site with multiple therapists. The owner subcontracts billing services. The third clinic (Clinic 3) has one therapist in one site. This therapist does her own billing and booking. She is completely responsible for everything to do with her business. Each of the three participants of the study was the owner of the clinic.

Each clinic demonstrated consistency in their content across multiple data sources. The content from the website, interview, field notes of observations, and preexisting documentation was consistent. There were no conflicting or contradictory information within clinics from the multiple data sources. Coding data resulted in the creation of the same categories across all three clinics. The only distinct difference in coding between the clinics was with Clinic 3. Coding of the relationship between onsite therapists did not manifest with this clinic because there was only one therapist involved.

The final categories from analysis were *mission, business plan*, *business structure*, *financial issues*, and *legal issues* with multiple issues coded for each category.

Business plan. Business plans for all three clinics had several similarities. All three owners located their practice near their homes, in a higher socioeconomic demographic. Most potential clients would have access to and utilize the Internet to screen and identify a therapist that matched their need. Therefore, each owner understood the need for an online presence that included biographies, pathologies treated, and therapeutic approach. All three owners utilized a variety of Internet directories for referrals, such as the Psychology Today website. Additionally, all three clinicians chose a strategic location for their clinic for their geographical convenience, client accessibility, and visibility.

One major difference with Clinic 1 was the owner's perceived need for an aggressive online presence. Aggressive online presence means when a web search is performed, his clinic shows up at the top of the list. This clinician stated that he could not envision anyone spending less than $5,000 to $6,000 a month for this aggressive online presence. He reported spending nearly 4 times that amount ($20,000-$24,000), for his online presence every month. The business plan for this clinician is to continue to build and expand the network of clinics that his company services. This clinician reiterated several times how competitive the industry is, and that the competition would continue to increase because of the number of practitioners graduating every year from at least five different graduate schools in the Seattle area alone.

The owners of Clinics 2 and 3 both stated they felt no need to further expand their marketing, as their caseloads are almost always full. The owner of Clinic 2 mentioned

that when a new therapist joins, their caseloads build quite quickly as well. These clinicians spend less than $100 a month for their online presence.

The owner of Clinic 3 stated she has no desire to expand to include other therapists. She is in a region with numerous healthcare offices with other clinicians in the vicinity. This practitioner is in her mid-sixties and mentioned that she greatly values her freedom and the simplicity of the organization of her practice.

The themes from the data coding for the *business plan* category are found in Table 1. Quotes from each clinic are included when applicable.

Table 1:

Business plan: business precepts for practice success

Visibility and location is strategic: Attributed to Clinics 1, 2, & 3

- Clinic 1: "Each office is located in a vibrant area, featuring plenty of places to linger before or after your session, including restaurants, coffee shops and parks. Each office has a few free parking spots as well as ample street parking allowing your time with us at (*Name of Clinic*) Counseling to be a convenient and pleasant experience"
- Clinic 2: "And I happened to come across this space and I signed a lease because it's such a great space and there is just not a lot of practitioners up here."
- Clinic 3: I've lived in and around XXXXXX in one form or another. So, close to home, not a big commute, make life easy" "I had visited a gal here and I liked the nice little space"

Website marketing is critical:

- Clinic 1: "If you're looking for professional Christian counseling and/or psychiatric care that respects your faith and values, then we're glad you found us. We are an association of licensed professionals who are experienced in helping people of all ages find healing for a wide-variety of struggles."
- Clinic 2: "…we would offer them, (*therapists joining the group)* a website presence."
- Clinic 3: "Because I didn't take insurance, I took whoever showed. But they tended to come initially because of my website. And my website spoke about being at the crossroads," *(crossroads meaning those struggling with life transitions).*

Utilize Internet directory:

- Clinic 1: *In response to addressing the need to utilize multiple directories for web presence, Clinic 1 owner said*, "so it's highly competitive in this industry, the counseling industry in the online space. Right? We are competing with Psychology Today and Therapise and these national companies."
- Clinic 2: "a referral from the Gottman website or something"

Clinic 3: "It's another website of directories. I belong to 2 directories." *(Each quote represents data demonstrating their commitment to Internet directories)*
Multiple therapists: Clinic 1: "We are an association of licensed professionals" Clinic 2: "(Name of clinic) is a team of independently-contracted professional mental health providers"
Overall marketing strategy: Clinic 2: (Do you have a need for further marketing?) Answer: "it's just not a need. If I were to market, I don't have the people for them." Clinic 3: "my caseload is typically 90-100% filled"
Christian orientation for church referrals: Clinic 1: "I wanted to identify myself publicly. I wanted to just be as clear as I could out of the gates, so that specifically church people would feel comfortable coming in. And pastors were going to be okay, this is somebody that is going to be overt out there."
Biographies are online for all therapists: (*Quotes unavailable due to confidentiality*)

Business structure. The business structure was purposeful for each clinician. At Clinic 1, the individual therapists set their fee and determined their schedule. The owner, as a contracted company, charges a split-fee rate and provides everything the therapists might need; clients, HIPAA compliance, billing, insurance, and everything else necessary for a thriving practice. "What's really important is that they are not our independent contractors, but we are their independent contractors. They are their own independent business and they in a sense contract out a portion of what they are needing which is marketing, back end business support, business coaching, so it's less clinically oriented what I'm providing for the practitioners." According to the owner, there is much less risk with this format. The specific risks he referred to are tax compliance, HIPAA compliance, and malpractice risk. According to this clinician, other business structures open the door for further risk, such as therapist liability. For example, in a traditional

employer/employee structure, a therapist could sue the owner if a client hurts the therapist.

The business structure of Clinic 2 involves a split fee arrangement for the associate therapist. This business structure also includes a leased space agreement for fully licensed therapists at a fixed rate. The owner does not have in-house billing or employees. Licensed therapists are responsible for their own billing and administrative needs. The therapists receive website presence and referrals from owner. This arrangement meets many criteria for the mission of the owner. The need to establish a livable income, minimize risk exposure for taxes and employee liability, and create a community of therapists in an equitable relationship fulfills most of the mission for this owner. However, she has not arrived at a structure that meets her desire for more management of the clinic, and fewer therapy sessions for herself, with income remaining at least at the current level.

For Clinic 3, the structure was a single therapist at a single location, with all services including billing being the complete responsibility of the owner. This structure enabled her to achieve the mission of generating a livable income and providing the maximum amount of freedom, which were the two most significant criteria of her mission.

Details for the *Business structure* of each clinic are found in Table 2.

Table 2:

Business structure

	Number of Therapists	Number of Sites	Marketing	Back office Support
Clinic 1	Multiple	Multiple	Extensive	Full
Clinic 2	Multiple	Single	Limited	Limited
Clinic 3	Single	Single	Extensive	Full

Financial considerations. All three clinics have been able to meet their top financial priorities: earn a livable income and build the practice without debt. Financial decisions have mostly been based on profitability, but not entirely. The owner of Clinic 1 intimated that being on insurance panels may impact or influence the commitment to being an overtly Christian organization. His concern is that insurance companies could potentially deny or restrict reimbursement based on the religious component of the therapy. For example, if evidence-based therapy (EBT), becomes the criteria for insurance reimbursement, demonstrating a religious component of the therapy may preclude coverage for a Clinic 1 treatment plan. The owner of Clinic 2 accepts numerous insurance companies because an outside service, which charges 8% of the therapy rate, processes all her billing. The owner of Clinic 3 only takes Premera insurance because the administrative difficulties and reimbursement rates for other insurance companies take too much of her time, and thus are not cost effective. She has a full caseload with private pay and Premera.

Each of the three clinics has, at most, one or two people at a discounted rate. All three earn over $100,000 annually from their therapy fees. The owner of Clinic 2 feels she is at a crossroads with her practice. Financially, for the practice to be cost effective and accomplish her mission of more management and less therapy, she believes she must invest money in hiring employees to bring billing and other back office services in-house. At this point in her life, while she is transitioning from four teenagers in her home to an empty nest, she cannot determine if this financial commitment is something she is ready to make.

The themes from the data coding for *Financial considerations* category are found in Table 3.

Table 3:

Financial considerations: financial precepts for practice success

Minimization of debt:

- Clinic 1: "So the goal is being fiscally responsible, not having to get any venture capital, so that we are not tied to any external sources of funding. That has always been a value, sort of bootstrap it."
- Clinic 2: "I feel like there is a couple of things, the risk holds me back and the financial piece, I need money to grow; attorneys are terribly expensive and my final three kids graduate next year so I have had that piece."
- Clinic 3: "My mission was to go immediately into private practice…..I had to start earning money and paying financial aid."

Payment options

Private pay only:

- Clinic 1: "no insurance contracts. It's all private pay. I don't want to deal with insurance. It's a nightmare. Also, I do think that over time being able to practice as a Christian practitioner is going to get tighter and tighter and I think there are going to be more restraints from managed care. So, I'd rather create a structure for practitioners who are really interested in practicing as Christian practitioners that is going to be sustainable.

Premera insurance only taken: Clinic 3 only

- Clinic 3: "It probably takes me about 20 minutes to do my Premera billing. I have 15 people, 12 people, easy half hour. It's just boom, boom, boom, boom. It takes longer to do Regence but soon I'll be off that."

Several insurance providers accepted:

- Clinic 2: Our counselors are in-network providers for most major health insurance companies, including but not limited to: Blue Cross/Blue Shield - Blue Card Plans (Not Boeing), First Choice, Group Health, Premera Blue Cross, Regence (Not Boeing), Lifewise of WA, Lifewise of OR, United Behavioral Health

Provision for sliding fees:(maximum 2)

- Clinic 1: "I don't do sliding scales. I have one patient right now who I've just been working at for years who I keep at the original, but I instead, I'm either going to do pro bono, charge them nothing, or it's going to be my regular fee for service."
- Clinic 2: "we will see some people, a certain number of clients for private pay on a sliding scale, but we just don't deal with Apple. It's more just like client load and I think I have 2 clients right now. One is a client I have seen for like 4 years. He has followed me every place I've been. He drives from Everett, so it's just a little bit of sliding scale."
- Clinic 3: "I decided I would only do 2 of my clients on a sliding scale so I could afford to exist."

Focus on financial growth:

Clinic 1: "I'm seeing 25, 26, 27 clients a week, my fee is $200 an hour so I'm looking at what, $225? *(thousand)*. I don't pay anything into the entity unless I have to fund." (*Fund meaning as an owner, pay out of pocket expenses to expand*).

Clinic 2: I would love to make over a 100 this year, I would love to head in that direction. (direction of some therapist making anywhere from 150,000 to $300,000 a year)

Clinic 3: "And I have hovered, it is going to be about 120. (thousand this year). I made a note here that I took two weeks off in 2015. But I'm going to try and do but it's probably going to be around 120."

Legal issues. Clinics 1 and 2 had similar concerns with legalities all related to working with other therapists. These issues did not apply to Clinic 3, and her only legal issue was being HIPAA compliant. Most of these issues are publicly displayed on the Clinic 3 website, (e.g. consent to treat forms and rights and responsibilities of clients). These items are reviewed with her clients in their first session.

Clinics 1 and 2 were concerned about having therapists that felt equitably compensated for the services they exchanged with the owners of the clinics. Both owners understand the regulations and taxes the government has implemented have made it very difficult to maintain a split fee contract labor agreement with therapists rather than an employer/employee relationship. In addition, they communicated a need to be vigilant with HIPAA compliance as it relates to the therapists because of the risk factor involved if the therapists neglect or abuse the laws or guidelines.

The overriding principle driving each clinician was the viability of their business providing therapy for clients. All other criteria for their missions are secondary to this overriding principle. Everything involved in the mission, business plan, and structure of each clinic was subject to this overriding principle.

The themes from the data coding for the *Legal issues* category are found in Table 4. Quotes from each clinic are included when applicable.

Table 4

Legal issues

Internal company relationships Clinics 1: "yes, the federal government made a shift a couple of years back that resulted in us flipping our business relationship with practitioners. So, now we are their independent contractors. Yeah, and making that flip was probably about $20,000 in legal fees." Clinic 2: "labor and industries are really cracking down on, and they will err in favor of, this is an employer/employee relationship, then you guys owe us taxes now. It's huge, right now and I don't know what that would mean." "So, risk management, as far as HIPAA, as far as not getting in trouble with labor and industries, or wanting to keep the relationships less complicated, not an employer/employee all of that and how to define that and how to truly delineate these challenges, that's what it has become for me."
HIPAA compliance: Clinic 1: part of the backend business support the independent therapists contract with the owner of Clinic 1 has to do with: "making sure things are HIPAA compliant" Clinic 2: "I guess the risk piece is pertaining to clients and HIPAA, and wanting to make sure that we are following those rules. I found out at this workshop that I should be having a policies and procedures manual for HIPAA in place, so I've got to hire an attorney to do that, because I can't write that. We need to have a risk management assessment plan in place that if we get audited they see that. I mean all of these things really complicate things running a group practice. And there are a lot of groups that are just flying by the seat of their pants and not doing any of this."
Legal and equitable relationship with therapists: Clinics 1 & 2 Clinic 1: "I'm interested in working with people who are interested in taking a little bit more risk and having more ownership, that way. In order to do that, they end up generating more revenue, as long as they can produce and I don't set their fees, they set their fees" Clinic 2: The following quote illustrates the challenge the owner experiences providing equitable support for the therapists. "I'm not going to have you sign a year lease, I want you here because you want to be here and if it's not working then we will chat." "…And anyhow I decided that with a couple of groups getting into trouble with the independent contractor or employee, …this is a lot of risk, too, I'm just going to kind of move to an office share agreement, and so that's where I have moved to with therapists that are fully licensed."
Avoidance of supervision role: Clinic 1: "I'm a Washington state supervisor but I haven't currently taken on any supervisees. A big part of that is energy wise and adding more liability onto my practice. I don't supervise within my group, and the main reason for that would be dual relationship.

Clinic 2: "I don't want to deal with the whole supervision thing. Besides that whole realization, like supervising XXXXXX and that whole employer/employee relationship. I realized that for me to supervise an associate as part of our group, it would be an issue, not so much as the dual relationship but because it could be viewed as more on the level of looking like an employer/employee relationship, so I said absolutely not."
Labor and industries and tax compliance: Clinic 2: "labor and industries are really cracking down on, and they will error in favor of, this is an employer/employee relationship, then you guys owe us taxes now."

The mission of the practice

The second research question of the study addressed the issue of finances and mission.

How have financial circumstances created by the healthcare system affected the missions of psychological practices?

Mission. The stated mission of each clinic was very broad. Each clinician clearly stated their intention of establishing a financially viable counseling business. This expectation and intent was prioritized above all other aspects of the mission, as well as the business plan. It was their plan to build a practice that would sustain a livable income in the geographical area where they resided: the eastside of the Puget Sound area. The *Mission* category has been broken down into three subcategories for fuller explanation. The subcategories are financial viability, target population, and work/life balance.

Financial viability: All three owners had referral information for low or no-cost counseling agencies to provide for individuals unable to afford their services. This is an example of the difficult position the current healthcare system places on caregivers. There are people that want help from these clinicians, and the clinicians want to help them. However, the healthcare system has no means to enable these clients to choose the caregiver based on their needs or desires, but only on what coverage they have. Many

people cannot afford $500 to $800 a month for therapy. This is the range these clinicians charge for a weekly therapy. The healthcare system and the economic realities of the Puget Sound area preclude many clients from receiving help from these clinics. The owner of Clinic 3 shared the distress she felt about this issue, remarking, "I went out of my way to find the agencies, give them the names and numbers, so even though I'd never hear from them again—it's so easy to get lost in that world, so I had a little Word sheet of different agencies that I could say, 'here, let me send you some info,' and I'd have the contact number and a little information about the population they take." The healthcare system has indirectly impacted these clinicians mandating a need to pursue a practice in an area where clients can afford their services. The themes from the data coding for the *Mission*: financial viability category are found in Table 5. Quotes from each clinic are included when applicable.

Table 5: *Mission: Financial viability*
Earn a livable income for the Eastside of Seattle long termed (Clinic 1,2 & 3)
Clinic 1, "the goal is being fiscally responsible" Clinic 2, "this would be a good career, something I could step into and make a decent amount right away." Clinic 3: "I had to start earning money and paying financial aid."

Target population. Initially, the target population of each clinic was anybody that came to the clinic. As the owner of Clinic 3 said, "I didn't take insurance, so I took whoever showed." As their caseload and thus their financial stability increased, their population became more focused. The therapists of Clinics 1 and 2 work with all ages of clients although the owners themselves only see adults. The owner of Clinic 3 only works with adults.

The owner of Clinic 1 targets a Christian population as the major focus of his mission as well as business plan. He wants to provide service as a Christian clinic, overtly communicating that the clinic was established on Biblical principles. The owner said, "Now what that doesn't mean is that I'm sitting there with chapter and verse with patients all day, but you got to have something to help make sense of why things are the way they are." This was a unique mission attribute from the other two clinics. It is also a part of his business plan, as he has intentionally marketed to Christian churches so pastors could refer people to his clinic, and Christian clients would have greater comfort going to the clinic. The owner of Clinic 1 stated "I really feel called to step into that gap between the church and the psych field," and "I wanted to provide professional Christian counseling." Clinic 1 advertises that all their counselors are Christian counselors, but they do not preclude non-Christians as clients.

Life and work balance. All three clinicians discussed the desire to have freedom to provide the type of therapy they choose, to the clients they choose, for the rates they choose, on the schedule that they choose. Freedom to maintain a balance between work and personal life was important to each clinician. As each clinician has seen their revenue increase over time, options and freedom of choice have increased.

Finally, as it relates to mission, Clinics 1 and 2 have the desire to cultivate a community of mature therapists that enjoy a group practice. The motivations for this mission include self-care, development of skills, and increased revenue opportunities. The themes from the data coding for the *Mission*: Life/Work Balance category are found in Table 7.

Quotes from each clinic are included when applicable.

Table 7:

Mission: Life/Work Balance

Life/work balance as a mission:

Clinic 1: "I think practitioners, people in general, want it both ways, right? they want the flexibility but they also want as much revenue as possible."

Clinic 2: "This would be a good career, something I could step into and make a decent amount right away, schedule my own hours, work around the kids, right? and grow." "I don't want to be gone every day from 8 to 5 if I don't choose to be"

Clinic 3: "I wanted a private practice for the freedom. "I don't have to explain anything to anybody about anything that I do" It also probably pertains to how I run my schedule. In terms of my own personal performance. I don't start seeing clients until 12 noon. I'm not a pleasant person before noon. I would not be personally fulfilled, (laughing). Nor would I be in any shape to cope with somebody else's stuff."

Community of therapists:

Clinic 1: "I have always loved creating community for people. And so, helping practitioners not be so isolated in this field is super important to me,"

Clinic 2: "(Name of clinic) Counseling is a team of independently-contracted professional mental health providers"

Chapter 4
Discussion

The results of this study reinforce the belief that providing quality healthcare is fundamentally connected to challenging business realities (Mechanic & Olfson, 2015). This rings true on the national level as well as at the local, individual practice level. The prevailing difficulties experienced by the clinicians included in the study were not related to therapy but were financial and legal in nature. At the date of this writing, the media are communicating the reality of a new United States Presidential administration and the potential impact it will have on the healthcare system, specifically the ACA. There will likely be significant change to the ACA, as this storyline from the Atlantic indicates that "President Trump is intent on repealing Obamacare" (Newkirk, 2017). Our national healthcare system is struggling to create coverage that is affordable for all, at the same time, the business issues of private psychotherapy practice remain the major focus of the owners of the three clinics of this study as opposed to the pressure of treatment efficacy.

The subjects of this study expressed confidence and competence in treatment modalities and treatment efficacy and reported their challenges were legal and financial in nature. There are multiple sources of risk in owning and managing a private practice. According to the data from this study, the risks that take the most time and focus are HIPAA compliance, the Department of Labor and Industries statutes, financial obligations for taxes, and potential penalties. These were the issues troubling the owners rather than questions such as, "Are we reducing the suffering of our clients?" And, "Is this therapy more effective for this client than another?" The clinicians did not express a single concern regarding the efficacy of their therapeutic services. As an example of the hierarchy of training needs, the owner of Clinic 1 has a *mandatory* biweekly business

meeting and an *optional* study group where case consultation is encouraged. The business meetings are about business skills such as how to make sure the patient will book sessions. This is not to denigrate the motives of these clinicians in any way. Each clinician communicated a level of compassion toward their clients to this author. The message from the above examples is that the business aspects of private practice are more difficult to manage and train for than patient care.

Based on the results of this study, one could conclude that the success of the private counseling practice in the Puget Sound area today is challenging because of the business knowledge and experience required. This is not to say mediocre therapeutic service is sufficient for the practice to thrive as long as there is sufficient business acumen. The study simply demonstrated that the challenges that these clinicians voiced were not related to therapeutic skill or psychological knowledge in treating the clients. The challenges they struggle with are legal and business oriented in nature.

The Financial Constraints of Private Practice

The reality of the healthcare system and the economic condition in the Puget Sound area preclude ACA clients from receiving treatment from these three clinicians. The financial reality is that they could not stay in business if they treated more than one or two clients at a less than full fee rate. The cost of living in the Puget Sound area, risk management requirements, stringent HIPAA compliance processes, low reimbursement rates, and bureaucratic processes of insurance providers shaped the business plan of the clinicians. Although there are more potential clients whom the ACA has newly insured, the bureaucratic processes to receive reimbursement have increased. Patients and practitioners heavily experience the business axiom “time is money” when sitting on hold

for 30 to 45 minutes to be able to speak with a representative from an insurance company. Even if the process were streamlined, low reimbursement rates from the insurance of Medicare, Medicaid, and ACA clients prevent these clinicians from generating enough revenue for financial viability. In addition, one of the clinicians reported that if he were to take on one of these clients, their needs are not merely therapeutic. This population also typically needs case management for issues such as employment, housing, legal issues, educational needs, and physical health issues. These issues are not covered under any treatment code and are therefore not billable. Even if the reimbursement rates and process were cost effective, the other needs of the client would mandate exclusion from the caseload. The ACA does not specifically address these issues. These issues precede the ACA, but the percentage of ACA insured clients needing more comprehensive care is much larger than the private insurance clients. The potential treatment population that all three subjects in this study target was based upon the budget forecasts of the clinics, not their desire or mission to help a particular population. The clinicians almost exclusively have clients who can pay their full fee, or who have private insurance. From the perspective of these clinicians, the current healthcare system climate forces private practitioners to choose between serving a higher socioeconomic group or being financially insolvent. When asked how to help the underserved, particularly those from a lower socioeconomic group, the response from the owner of Clinic 1 was, "Here's how it's funded: [therapists who serve these populations] have a spouse that takes care of them. That's really how it's done. It's really a side deal, a ministry."

The current state of economics in the healthcare field in Puget Sound forces private practitioners to make a choice of lifestyle. If the practitioners choose to provide

service for ACA or Medicare covered patients, they limit their financial opportunities. The owner of Clinic 1 said, "It's going to be pretty tough if someone is billing less than $150,000 a year to live in this area and have any retirement or buy a home." If his assessment is true, clinicians serving low-income clientele will likely have financial limitations, unless they have another revenue source.

Private Practice Models

The study results demonstrated success with three different private practice models. The aspects of each model are distinct and provide an opportunity to match personal preferences for those interested in private practice. Clinic 1 is overtly Christian, with a community of therapists and the owner providing comprehensive support to everyone for a fee. Clinic 2 provided much more autonomy for the owner and the therapists; therapists essentially rent a room and some services for a fee, and yet the group dynamic is available should the therapists have the need or desire to engage. Clinic 3 was a completely one-person operation in every facet of the practice. Unique attributes and challenges exist in each model.

Study Limitations

Study assumptions. The assumption of the author was that the clinicians who were the subjects of this study would be servicing some clients insured through the Affordable Care Act. The expectation was these clients would create a reduction on the budget because of the high processing time to receive reimbursement and low reimbursement rates. The hypothetical reduced budget would cause the practitioners to change their mission, (e.g. no longer helping clients from a lower socioeconomic status), to remain in business. The budgetary mandate to eliminate ACA clients from their

caseload would create distress in the clinicians. In this scenario, the study would have been a study of how did this transition happen, (the change to the mission and business plan), and how the practitioner personally experienced that change.

The business acumen of all three subjects in the study enabled them to establish a successful business plan from the beginning which precluded the ACA-insured clients. As a result, the assumptions of the author did not apply to the three clinics of this study. The practitioners did not experience distress due to these changes because the changes to the mission or business plan did not exist. According to the APAPC (2016e), most practitioners are far less knowledgeable about business than the subjects in this study. A study of clinicians who started with ACA clientele and had to adjust their caseload would be worthy to investigate.

All three clinics have been in business for nearly 10 years. The owner of Clinic 1 spoke of the competitiveness of the industry numerous times during the interview. This belief speaks to the financial commitment ($5,000 to $6,000 weekly) to maintain internet traffic on his website. He deems it a high priority to maintain high visibility on web searches, and the cost for that is significant. The other two clinics are much smaller operations, and their caseloads are much easier to keep their census full. Therefore, they deem further marketing unnecessary. One of their primary explanations for this is referrals from other clients. For example, the owner of Clinic 2 repeated her lack of concern for marketing, stating, "I wasn't worried about getting clients; if you do good work, you will have clients." The landscape today for starting a counseling private practice is probably considerably different from when these clinicians began their practices, due to the increased number of clinicians in the marketplace. A study similar to

this study with clinicians just starting a practice would be a strong addition to the research.

Diversity of clinicians. The clinicians of the study had some common attributes which may have contributed to the success of their practice. The business experience of the clinicians, as well as their age, may have played a factor in their therapeutic competence and confidence. In addition, the clinicians were all Caucasians. One clinician was a male in his late thirties, the second was a female in her early forties, and the third was a female in her mid-sixties. If the same questions from this study were asked of a recent graduate student in counseling or psychology, in his or her mid-twenties, from a diverse culture, with minimal business or therapeutic experience, who was starting a private practice, the resulting data could be vastly different from the three clinicians of this study.

Therapeutic skills. This study did not measure therapeutic performance. It is possible that the three owners of the clinics in this study are exceptional therapists, and that their therapeutic skills may keep their caseload full and have more to do with their success than their business acumen. A similar study which factors in therapeutic skills would be a valuable addition to the literature.

Future Directions and Recommendations

The extensive business experience and knowledge of the clinicians in the study compelled them to have a mission, business plan, and business structure, which precluded benevolent humanitarian directives as a top priority. In their formulation of potential target populations to treat, they balanced their two primary objectives—financial viability and service. All three clinicians identified financial viability as most critical. They each

identified community mental health agencies available to low-income and underserved clients and underscored the harsh economic realities of the industry in Seattle, partially because of the high cost of living.

A study in the lower socioeconomic areas of the Puget Sound area could give an idea of how challenging it is to successfully sustain a private practice in lower income areas. There may be a need for vastly different structures, expectations, and arrangements made for viability. Is there a budget forecast possible with ACA insurance reimbursement rates to sustain a private practice in a low-income neighborhood? It seems a study addressing this issue would be a valuable addition to the literature on the business of private practice.

A study of private practice clinics that have started in the last year would be important to determine if the marketplace is as competitive as the participants believe. Some salient questions to consider are:

1. Has the competition increased to the degree that it requires $5,000 to $6,000 a month to attract enough inquiries on the Internet to procure a caseload, as the owner of Clinic 1 believes for a startup practice for one or two therapists.
2. What is the financial investment necessary to establish the business structure of the practice to meet Labor and Industries guidelines?
3. What does it take to gain momentum in attaining referrals?
4. How much time investment is there in marketing, researching legal structures and HIPAA compliance?

The clinicians in this study had the luxury of gaining market share prior to experiencing the current complexities of HIPAA compliance and Labor and Industries restrictions as well as less competition. This will not be the case for new practitioners. These issues would be important for people wanting to start a private practice in the business climate today.

Closing Remarks

The growing population and the stress of living in a populated and expensive environment will sustain the need for therapists. How quickly the market is saturated with therapists is a thought-provoking question. It can be speculated based on the view of the national picture, as well as the local picture, that competent therapists will need significant business acumen to succeed in a private practice.

References

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association.

American Psychological Association Practice Organization (2016a). *APA member profiles*. Retrieved from http://www.apa.org/workforce/publications/15-member/index.aspx?tab=2

American Psychological Association Practice Organization (2016b). *Putting business into practice*. Retrieved from http://www.apapracticecentral.org/business/management/tips/secure/business.aspx

American Psychological Association Practice Organization (2016c). *Tools for identifying and understanding your target clientele*. Retrieved from http://www.apapracticecentral.org/business/marketing/target-client.aspx

American Psychological Association Practice Organization (2016d). *A foundation upon which to build your practice.* Retrieved from http://www.apapracticecentral.org/business/

American Psychological Association Practice Organization (2016e). *Your business plan: steps for success.* Retrieved from http://www.apapracticecentral.org/business/ http://www.apapracticecentral.org/business/management/index.aspx?_ga=1.33681 12.1247761391.1464977421

American Psychological Association Practice Organization (2016f). *Networking: are you connected?* Retrieved from http://www.apapracticecentral.org/business/marketing/building/secure/networking.aspx

American Psychological Association Practice Organization (2016g). *Give your practice a financial checkup.* Retrieved from http://www.apapracticecentral.org/business/finances/checkup.aspx

American Psychological Association Practice Organization (2016h). *10 low-cost ways to market your practice.* Retrieved from http://www.apapracticecentral.org/business/marketing/building/secure/low-cost.aspx

American Psychological Association Practice Organization (2016i). *Choosing the best legal structure for your professional practice*. Retrieved from http://www.apapracticecentral.org/business/alternative/index.aspx

Budd, R. & Hughes, I. (2009). The Dodo Bird verdict: controversial, inevitable, and important: a commentary on 30 years of meta-analyses. *Clinical Psychology and Psychotherapy, 16,* 510-522. DOI: 10.1002/cpp.648

Beronio, K., Glied, S., & Frank, R. (2014). How the affordable care act and mental health parity and addiction equity act greatly expand coverage of behavioral healthcare. *Journal of Behavioral Health Services & Research, 41*(4), 410–428. DOI: 10.1007/s11414-014-9412-0

Brennan, C. (2013). Ensuring ethical practice: Guidelines for mental health counselors in private practice. *Journal of Mental Health Counseling, 35*(3), 245-261.

Business Insider (2016). RANKED: The economies of all 50 US states and Washington, DC, from worst to best. Retrieved from http://www.businessinsider.com/state-economy-ranking-q4-2015-2016-1.

Cantor, J.C., Monheit, A.C., DeLia, D., & Lloyd, K. (2012). Early Impact of the Affordable Care Act on Health Insurance Coverage of Young Adults. *Health Research and Educational Trust, 47*(5), 1773-1790. DOI: 10.1111/j.1475-6773.2012.01458.x

Center for Disease Control and Prevention (2011). Mental illness surveillance among adults in the United States. *Morbidity and Mortality Weekly Report* 60, 1-32.

Centers for Medicare & Medicaid Services. (2003). *Healthcare industry market update: Managed care*. Baltimore, MD: Cent. Medicare Medicaid Serv. http://www.cms.hhs.gov//Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CapMarketUpdates/Downloads/CMS-Mkt-Update-Managed-Care-03242003.pdf.

Clay, R. A. (2000). Why every private practitioner needs a business plan: A blueprint can help you monitor your practice's health and make your dreams reality. *Monitor on Psychology, 31*(6), 48. Retrieved from http://www.apa.org/monitor/jun00/plan.aspx

Colburn, A. (2013). Endless possibilities: diversifying service options in private practice. *Journal of Mental Health Counseling, 35*(3), 198-210.

Cooper, C. (2011, May/June). Should psychologists plan for the future? *The North Carolina Psychologist, 63,* 8–10.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches, 4th edition.* Los Angeles, CA; Sage Publications, Ltd.

DeAngelis, T. (2011). Are you really ready for private practice? *gradPsych, 9*(4), 40. Retrieved from http://www.apa.org/gradpsych/2011/11/private-practice.aspx

Duncan, B., Miller, S., Wampold, B., & Hubble, M. (2010). *The heart and soul of change: Delivering what works in therapy. Second edition.* Washington, D.C. American Psychological Association.

Flaskerud, J. H. (2014). Mental healthcare, the affordable care act, and Medicaid expansion. *Issues in Mental Health Nursing*, 35, 558–561. DOI: 10.3109/01612840.2013.869844

Gasquoine, P. G. (2010). Comparison of public/private health care insurance parameters for independent psychological practice. *Professional Psychology: Research and Practice, 41*(4), 319-324

Goldman, H. H. & Karakus, M. C., 2014. Do not turn out the lights on the public mental health system when the ACA is fully implemented. *Journal of Behavioral Health Services & Research, 41*(4), 429-433.

Goodheart, C. D., 2010. Economics and Psychology Practice: What We Need To Know and Why. *Professional Psychology: Research and Practice, 41*(3), 189-195. DOI: 10.1037/a0019498

Harrington, J.A., 2013. Contemporary issues in private practice: spotlight on the self-employed mental health counselor. *Journal of Mental Health Counseling, 35*(3), 189-197.

Hoerger, M. (2015). Educating the psychology workforce in the age of the Affordable Care Act: a graduate course modeled after the priorities of the Patient-Centered Outcomes Research Institute (PCORI). *Training and Education in Professional Psychology 9*(4), 309–314. http://dx.doi.org/10.1037/tep0000094

Huynh, L & Rhodes, P. (2011). Why do people choose to become psychologists? A narrative inquiry. *Psychology Teaching Review, 17*(2), 64-70.

Kelly, J. F., & Coons, H. L. (2012). Integrated healthcare and professional psychology: Is the setting right for you? *Professional Psychology: Research and Practice, 43*(6), 586–595, DOI: 10.1037/a0030090

King County Government demographics:retrieved from http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/documents/maps/MedianIncome.ashx?la=en

Klingaman, E. A., Medoff, D. R., Park, S. G., Brown, C. H., Fang, L., Dixon, L. B., . . . Kreyenbuhl, J. A. (2015). Consumer satisfaction with psychiatric services: the role of shared decision making and the therapeutic relationship. *Psychiatric Rehabilitation Journal 38*(3), 242–248. DOI.org/10.1037/prj0000114

Mack, N., Woodson, C., MacQueen, K. M., Guest, G., & Namey, E. (2005). *Qualitative research methods: A data collector's field guide*. Research Triangle Park, NC, Family Health International.

Mechanic, D. 2012. Seizing opportunities under the affordable care act for transforming the mental and behavioral health system. *Health Affairs, 31*(2,), 376-382. DOI: 10.1377/hlthaff.2011.0623

Mechanic, D. & Olfson, M. (2015). The relevance of the affordable care act for improving mental healthcare. *Annual Review of Clinical Psychology 12:6.1-6.28*, DOI: 10.1146/annurev-clinpsy-021815-092936

Mendelberg, H. E. (2014). The integration of professional values and market demands: a practice model. *The Psychologist-Manager Journal, 17*(3), 159–177, DOI.org/10.1037/mgr0000018

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative Research: A guide to design and implementation, 4th edition.* San Francisco, CA, Jossey-Bass.

Meyers, L. (2014). Look before you leap. Retrieved from http://ct.counseling.org/2014/11/look-before-you-leap/

National Institute of Mental Health (2016). Any mental illness among U.S. adults. Retrieved from (http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml).

Newkirk, V. R. (2017, January 24). The Trump administration's first blow to Obamacare. *The Atlantic.* Retrieved from https://www.theatlantic.com/politics/archive/2017/01/the-trump-administrations-first-blow-to-obamacare/514103/

Norcross, J. C., & Rogan, J. D. (2013). Psychologists conducting psychotherapy in 2012: current practices and historical trends among division 29 members. *Psychotherapy 50*(4), 490-495 DOI: 10.1037/a0033512

Nordal, K. C. (2012). Healthcare reform: Implications for independent practice. *Professional Psychology: Research and Practice, 43*(6), 535-544. DOI: 10.1037/a0029603

Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

Patton, M. Q. (2015). *Qualitative research and evaluation methods, 4th edition.* Thousand Oaks, CA, Sage Publications.

Rozensky, R. H. (2013). A brief review of the implications of the affordable care act for the practice of psychology. *Journal of Psychology and Christianity, 32*(4), 352-357.

Rozensky, R. H. (2014). Implications of the Affordable Care Act for education and training in professional psychology. *Training and Education in Professional Psychology, 8*(2), 83-94. DOI: 10.1037/tep0000021

Rozensky, R. H., Celano, M., & Kaslow, N. (2013). Implications of the Affordable Care Act for the Practice of Family Psychology. *Couple and Family Psychology: Research and Practice 2*(3), 163–178. DOI: 10.1037/cfp0000009

Shallcross, L. (2016). Becoming your own boss. Retrieved from http://ct.counseling.org/2016/01/becoming-your-own-boss/

Substance Abuse and Mental Health Services Administration (SAMHSA). 2014. *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.* Rockville, MD: Office of Applied Studies, SAMHSA. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. New York: Routledge-Falmer.

Torrance, H. (2012). Triangulation, respondent validation and democratic participation in mixed methods research. *Journal of Mixed Methods Research, 6*(2), 111-123. DOI: 10.1177/1558689812437185.

U.S. Census Bureau. (2015). *Income, poverty, and health insurance coverage, 2015*. Retrieved from http://www.census.gov/hhes/www/hlthins/data/incpovhlth

Appendix A

Invitation to Participate Email

Appendix A

Invitation to Participate Email

Exploring the Business of Mental Health Private Practice
Private Practice Email Invitation
Psyc 8021 Doctoral Dissertation Northwest University
Bob Smith

Dear Clinician

You are invited to participate in a dissertation study conducted by a psychology student in the doctoral counseling program at Northwest University. The purpose of this study is to explore the challenges of running a private practice. It will involve an audiotaped interview and a 30 minute follow up meeting to review of the results in which you will able to clarify any information presented. You will be in control of information you offer.

If you are interested, please examine the attached document, (Appendix B) sign the document and send to this email address, Robert.Smith12 @Northwestu.edu. In addition, you can call me directly at 269-432-3262.

Thank you for your time and interest.

Robert Smith

Appendix B

Informed Consent Form

Appendix B

Informed Consent Form

Exploring the Business of Mental Health Private Practice
Consent Form
PSYC 8021 Doctoral Dissertation, Northwest University
Bob Smith

You are invited to participate in this dissertation study conducted by a psychology student in the doctoral counseling program at Northwest University. The purpose of this study is to explore the challenges of running a private practice today. The following information is provided to help you make an informed decision about whether to participate.

Participation in this study will involve a 90-minute audiotaped interview at the beginning of the study and a 30-minute review of the results in which you will able to clarify any information presented. You may refuse to answer any questions you wish, without explanation or negative consequences. First, you will complete a short pre-screen questionnaire. Secondly, if you are eligible for the study, you will participate in the face-to-face interview. At a later date, approximately 4 months, you will participate in the review of a summary of your interview. All meetings will be held in a private room at your place of business for the interview.

There are minimal risks associated with this study. The risks might include mild discomfort or embarrassment due to the nature of the interview questions about your practice. The benefit of taking part in this study is the opportunity to participate in the research process as a research subject. If at any time, you would like someone to talk to about any feelings or thoughts that arise during your participation, please let me know.

Your participation in this study is voluntary. You are free to decide not to participate in this study, not to answer any questions you wish, or to withdraw at any time. There will be no negative consequences for you if you refuse to participate. You may refuse to answer any questions asked. Please note that this study is being conducted for scholarly purposes only.

If you choose to participate, all identifiable information will be treated confidentially. Your responses will be organized and tracked using an identification code rather than your name. A key linking participant identity with identification codes will be kept in a locked cabinet separate from your responses and accessed only by the study's investigators. The study results obtained may be published in psychology journals or

presented at psychology conventions but will not include identifying information. All data will be stored in a locked file cabinet within a secure office located in the Northwest University College of Social and Behavioral Sciences building. All data forms will be destroyed by October 9, 2022.

If you have any questions about this study, please contact Bob Smith at Robert.Smith12@Northwestu.edu. If you have further questions, please contact my faculty advisor, Dr. Leihua Edstrom, at Leihua.edstrom@northwestu.edu or 425-889-5367. You may also contact the Chair of the Northwest University Institutional Review Board, Dr. Molly Quick, at irb@northwestu.edu or 425-889-5763.

Thank you for your consideration of this request.

Researcher Signature:_____ Date:_____

Participant Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Primary Researcher:

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Appendix C

Semi-Structured Interview Questions

Appendix C

Semi-Structured Interview Questions

Exploring the Business of Mental Health Private Practice
Interview Guide for Private Practice Management Interview
Psyc 8021 Doctoral Dissertation Northwest University
Bob Smith

For Researcher Only

1. What were you setting out to do when you opened your practice? What was your mission starting out?
    a. If you didn't have a formal one, based on your interests and direction, what would you describe your informal mission?
2. Describe the business plan you had when you started your practice.
3. What is the population for which the practice was established to serve?
    a. What particular pathologies or disorders of that population did intend to specialize in?
    b. What preferred treatment plan or therapy modality did you plan to start with?
4. From the perspective of your mission, how do you determine your success or progress? What clinical benchmarks do you utilize to identify progress in what you set out to do? This could apply to your patients or your practice overall.
5. Identify the general financial goals needed to keep the doors open.
    a. What was your plan or expectation or hope regarding your personal income from the practice?
    b. What has your experience been regarding the plan or expectations?
    c. What adjustments, if any have you had to make in regards to finances?

i. Rates? Up or down, sliding scale?

ii. Panels?

iii. Population served? (Medicaid, Medicare, etc.)

iv. Services offered?

6. As you gained experience in the business and financial aspects of being in practice, what adjustments, if any, have you made to your mission?
    a. What issues prompted these adjustments?

In the event of an apparent incongruity between mission and observed practice activities: Prior to asking question 7: This activity confuses me; how does this activity reflect your mission?

7. Describe how your mission reflects what your practice actually is and does?
    a. As you continue in your practice, what changes, if any, do you anticipate in your mission?
    b. Why?

Appendix D

Transcriptions of Interviews

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Clinic 1 Transcription

Bob: I saw from your website that you started counseling in 2005, but when did you start in this format at your own clinic?

So, 2005 I graduated, my private practice is (left blank) Counseling Professional Therapy.

B: And that was started in 2005?

Yep, and I started here in Bothell and in Green Lake, split my time,

B: Right from the beginning?

Well, I started at Green Lake and maybe 6 months later I started here in Bothell as well.

B: Okay, and what were you starting out to do when you opened the doors in those two places, what was your mission?

I wanted to provide professional Christian counseling to both of those locations. I was a new practitioner, back then I was 30 years old. So, I kind of had that new practitioner experience of not having any professional experience and yet I need to see clients in order to get that experience. So, I sent my résumé out to about 20 different companies. I got one call from family services, got into the interview you know, I sealed the deal but they were paying me $10 per session when patients showed, as an extern. But they would provide free supervision, so that kind of got me on my way toward working on my license, 6 months after being there, my own private practice started building enough where I said, hey this is me driving down to Renton from Bothell in this 405 traffic with patients not showing and things like that for ten bucks an hour, I ended that.

B: Other than Christian, did you have a particular population, pathology or disorder, any specific kind of demographics?

Not really, I went to XXXXXXXXXXX graduate school, now (XXXXXXXX school of theology) huge emphasis on abuse and issues of abuse. I pursued XXX XXXXXXX, cause I just heard that he was great in the field, he was the man and I moved out here from New Hampshire. I had read a couple of books by him and I said, hey if I'm going to go somewhere, let's give it a shot here and I went through it in a couple of years so But so, no major focus, I initially wanted to do marriage and family work, but after my internship with Compass Health, working with kids, I just, I hadn't had any specific training in working with kids so it felt a little bit more like daycare.

B: Children in particular?

Yeah, Children in particular, and most of the work ended up being with the parents but the way their structure was set up you're actually sitting there with the kids playing and I had no formal training in play therapy and things like that so real interested in helping couples, helping couples around. I think most of the couples I've been working with are issues of infidelity of some type.

B: So even before you had gotten into your own private practice you had already kind of steered away from family therapy to primarily marriage and individual therapy?

Yes, so I started out 18 plus right out of the gate,

B: Oh, is that right yeah? Could you comment on the particular focus on Christians?

For me, my background I was with youth with a mission for six years and along the way I was doing a lot of lay counseling. I realized, we'd get speakers that would come in that were professionally trained. I'd just soak it up so, that's what I wanted more of. In terms

of Christian focus, I noticed in my missionary experience, you kind of got two groups of people, you got the evangelists and then you got those who are more interested in discipleship and I was much more interested in discipleship. I realized there is a gap between the church and the psych field, and so I said, you know what I really feel like I'm called to step into that gap. But in order to that I need to get professionally trained.

B: Could you tell me now, not about the mission but a little bit more about your business plan?

Do you mean how it has evolved?

B: What it was when you began and how it has evolved?

A gentleman and I, started a handshake partnership whose name is XXXXXX XXXXXX back in the day, we were in a men's group together and we did a private practice course with Susan Hall about 11 years ago, how to start a private practice, we did that, she had some office space that she was subletting out for 300 bucks a month. So, he calls me and he's like hey there's this office space here in Green Lake here, you want to share something and I said sure, $150 a month I can cover that, furnish it, and so from the get go we were really clear, you can either be a Christian that is a counselor or you can be a Christian counselor in terms of how I wanted to identify myself publicly. I wanted to just be as clear as I could out of the gates, so that specifically church people would feel comfortable coming in. And pastors were going to be okay, this is somebody that is going to be overt out there. Now what that doesn't mean is that I'm sitting there with chapter and verse with patients all day. I had an undergraduate in Biblical studies so that helps, I have an interest there but I would say most of the time, I think doing that has given me a little bit more freedom in bringing in some of that direction. Saying hey would you like to

pray about that, at least being able to offer. Because the marketing is clear, the disclosure statement is clear, and I'm clear. So that keeps my patients from feeling like there's a bait and switch happening and that just keeps it clean for me.

B: With your business plan, really talking about your expectations, your financial expectations, your clientele that you are serving, how has that evolved over time? Your financial goals, your financial plans, your financial expectations?

So, the goal is being fiscally responsible, not having to get any venture capital, so that we are not tied to any external sources of funding. That has always been a value, sort of bootstrap it. In terms of, somebody told me, right out the gates, look if you got into this field because you want to make a lot of money, that's not going to happen. And that's totally true, this is a service industry, insurance and its caps on fees for service, so a moderate level psychotherapist is going to make $116 an hour with Premera with a Masters degree and an excellent psychotherapist is going to make $116 an hour capped. So, there's a problem in the industry there. Right because it's not based on how effective someone is although some managed care they look at how quickly you can help someone but not necessarily how well you help someone. So, in terms of finances, I think my goals have been, I want to create a space that where there is enough margin for the practitioners that I'm working with so that we can think creatively, so that we can do research, so that we can experiment with things, so that ultimately we can do some ministry together as well. But we are a fee for service business, out of the profits then we are in a position to do more giving. So being really clean about that on the front end.

B: I hope you know, I just don't want you in anyway to be defensive, because making money is perfectly okay with me.

Yeah, because otherwise we might as well go in the ministry and volunteer. I've done that

B: Now specifically about your business plan, you said something about you would have money for research and a variety of different things, and you wouldn't need venture capital and those types of things. Is there,… I have three specific clients I'm working with, one is a one-person shop, does everything. One of them is multiple therapists in one location and then you have quite a different model, can you tell me the thought process and the business plan for this multiple sites business plan.

10:25 Yes, so the back end, there is a couple factors here, 1) we have the liability of being in healthcare, 2) there is liability around housing, having office space, signing leases, and there is also there is liability from clientele, if things go wrong.

B: What was the first liability you were talking about, I thought that was the liability with the clients.

So being in healthcare, if I'm an employer, of a healthcare provider, I hold some liability for that healthcare provider's health and safety,

B: So, like their safety if something happens with them on the job, *(like a client hurts them)* you're liable for that,

Right I'm liable for that.

B: On the other hand, if the clientele, if they're getting bad service from one of your therapists,

Right! What we are currently doing is, we service practitioners. So, we have a business relationship with them, where we are their independent contractor essentially, business to business relationship. They all have their own businesses. I think we have 30

practitioners right now so, they all have their own businesses and we service their business for a percentage of their gross that is variable according to use and longevity and term of contract and all of that.

B: So, you contract with each person and then essentially, dependent upon their performance, and all of those types of things, you structure your contract with them.

Yeah, what's really important is they are not our independent contractors, but we are their independent contractors. They are their own independent business and they in a sense contract out a portion of what they are needing which is marketing, back end business support, business coaching, so it's less clinically oriented what I'm providing for the practitioners.

B: Do you have things like non-compete clauses, if somebody signs on with you, after a period of time, their census is completely full, their jammed, can they separate from you and go on their own so to speak,

Yup, it depends on the term of their contract. So, we can do an open ended, we do a three-year term, we do a four-year term, and then there is different milestones that they can reach where they get a larger percentage based on the length of the relationship, what they are billing, all of that kind of thing.

B: Where did you come up with that idea?

Some trial and error, we do have a business coach, which we have had for years, and I think he posited this idea one day and we said, you know what, okay that may work. Even losing some really excellent practitioners, we had just gone through a season of like, oh gosh, what's going on, and trying to regroup and figure out what was needed and so through some of the exit interviews, got really, yeah, I think practitioners, people in

general, want it both ways, right? they want the flexibility but they also want as much revenue as possible.

So, the employee model they get very little flexibility but they have very little liability and lots of stability. And I'm much more entrepreneurial, I'm interested in working with people who are interested in taking a little bit more risk and having more ownership, that way. In order to do that, they end up generating more revenue, as long as they can produce and I don't set their fees, they set their fees.

B: How do you, a couple of questions, how do you establish benchmarks, both from the financial perspective as well as from the clinical perspective?

Nothing clinical.

B: So, you don't care about longevity or

It's not that I don't care, I just don't have control over it. And yeah, we keep track of attrition rates, and all of those things but trying to make sense of what those mean, is very challenging.

B: When you say all of those things, what type of things are you referring to?

Attrition rates, price per session, where leads come from, a ton of data, it's a ton.

B: Somebody, someday will figure out what you can do with that to help you be more refined in what service your providing and how to develop it?

My job is to connect excellent practitioners with clients that are looking. That's my job. And if I do that, I've got a business.

B: Financial benchmarks?

I have no Financial benchmarks for my practitioners, every practitioner gets x amount of office space and they are free to fill them, office space is very inexpensive compared to

running the rest of the business. Office space is at 12% of total expenses. So, the expensive parts are building the back-end business support and marketing structure.

B: What is that back-end business support you are referring to?

Phone support, scheduling, reporting, we maintain, we manage the financial tracking sheets, help practitioners with taxes, with making sure things are HIPAA compliant, their disclosure statements, any changes they need to be doing within any of those, they just submit a service request and our team takes care of servicing their business that way.

B: As far as like dividing your time up, there is business, there is therapy, there is coaching, all of those things, how do you? Do you have any kind of, "I'm going to spend a third of my time here, I'm going to spend a third of my time there, and long term what do you hope to do?

There is more complexity in that question. So, I see about 25 patients a week right now. Which is down from the mid-30's for the first six or seven years of my practice. Part of the reason I did so many hours there is XXXXXX and I personally from our own practices, funded getting XXXXX counseling up and running.

I have an agreement with XXXXXX to spend about 20 hours a week of administrative type tasks. Where I am helping our practitioners essentially grow their practices and manage their business. So, we each have a 50-50 labor agreement that way, so he does 20 hours and I do 20 hours. And then I have another entity which is XXXXXXXX XXXXXXXX Counseling which is Eastside corridor, so Bothell, Bellevue Redmond, and Issaquah. And my time, I put time into that above and beyond, so yeah. I don't know. Maybe 60 a week.

B: Long term what do you want to grow to? Do you want to be managing the business primarily, do you want to be more of a therapist?

I love the clinical work. I don't feel like I'm getting close to being done there. I wanted to do, be a psychotherapist since I was 17 years old. I took a psych class in high school and I said this is it, you know. I jumped right out of high school, did an introduction to Biblical counseling school with the University of the Nations. So, I just kind of worked along and I planned on getting my undergrad in counseling psychology but ended up having more credits in Biblical studies. And I'm glad I did, it's been an excellent foundation. Doing this work, hindsight being 20/20, I'm glad I went that way and not just, because I feel like psychotherapy is pretty soft science and you got to have something to help make sense of why things are the way they are.

B: Yeah, the plumb line.

Right, the dividing plumb line, so I think the Biblical text helps with some of that.

B: Can you tell me just a little bit about the software, do you use software for you notes, do you use software for you tracking? Some people, like one lady does everything on an Excel spreadsheet. Everything is on one spreadsheet.

Are you talking for my private practice or are you talking as a group?

B: Both,

So, my private practice is Word docs. I make sure it's secured and all of that. For the group, nothing. They can put anything they want into the system, and we have various ways for them to go about doing that. Some only use Therapy tracker or therapynotes. If they are wanting something more structured, our deal is that, their agreement with us is to make sure they are abiding by ethical and legal standards in Washington state.

B: So, you don't have any arrangements for scheduling or are you tracking any of their scheduling or are they managing all of that themselves?

We help them with some of that, but they manage. So, we provide calendars and things like that. We provide contact forms. We provide systems that are going to be able to sync up with their phones and laptops and communicate within the group, under a HIPAA shell.

B: Have you seen your business plan or your mission statement or your mission in general, have you seen them evolve as you have gained more knowledge and experience with the financial challenges or from a compulsion for a particular service that you are providing for your community.

Not too much, surprisingly. I think we started out saying we want to provide, you know, I think everyone is out there is going to want to say, we want to provide excellent therapy. Right? So, I mean, what clientele are you pursuing as a business strategy? We had chosen to go more on the high end of things. Realizing community mental health is there and there are volunteer organizations who are out their pitching for funding. There are places for people to get help. What I am really looking for is the best of the best practitioners. But I have to pay them as the best of the best practitioners.

B: From the beginning, you said the low income; the Medicaid, the Medicare, the Apple care, all of those things, essentially are not going to be clientele we service.

Correct, or that I service. So XXXXXXXX XXXXXXXX counseling and XXXXXXXX XXXXXXXX counseling, no insurance contracts. It's all private pay.

B: Really? Not even Premera.

Not even Premera. Out of network reimbursement, we have another practitioner that I went to school with that and he joined up with our group about five or six years ago, he does have relationships with Premera, Group Health, First Choice and so anyone who is interested in doing insurance work then contracts with his company.

Then he covers expenses for sessions seen and marketing done in business support provided.

B: And then does he get a percentage of the people that are working with him?

Or I get a percentage of what he bills.

B: Why? Just out of curiosity.

There are a number of reasons: 1) I don't want to deal with insurance. It's a nightmare. So also, I do think that over time being able to practice as a Christian practitioner is going to get tighter and tighter and I think there are going to be more restraints from managed care. So, I'd rather create a structure for practitioners who are really interested in practicing as Christian practitioners that is going to be sustainable. So right now, insurance is still workable, plenty of groups do that. I don't want to deal with the admin nightmare. There is also more liability there. Yeah, there is more liability there, so in business I think it's important, you got to look at what's the potential here, but you also have to protect your downside and that's that.

B: Do you have any idea how many clients, can't schedule with any of your therapists because of the finances? Like how many say, do you take Premera and you say, no sorry, and they say oh rats and then they hang up.

We do, we do have practitioners that take Premera, so yeah, they call in and if they are specifically looking for Premera, okay we say these are the practitioners that are out of

network, and you can get a receipt with a procedure code and get reimbursed. And Premera will reimburse. Or here are a few practitioners that are in network with Premera through our affiliate. So yeah, you can work with someone. We are not marketing that we take insurance. And that's a clear distinction.

B: Do you have an idea of what your therapists can earn, if they are fully committed, and they are working full time as a therapist, do you give them a range of what they can anticipate as far as their income is concerned?

We do, it depends on whether they are an associate level practitioner or whether they are licensed or whether they are interested in doing insurance, whether they are doing an open-ended contract, 3 year or 4-year term, and then how much they are capable of billing per hour. On the private pay side. So, there are a lot of factors in there, if they do entirely private pay and they are a licensed practitioner, and they are able to bill, $175, they are going to end up making around $175,000. If they are seeing 25, 26, 27 sessions a week.

B: And that's the revenue they are generating, or that's their income?

That is their take.

B: And do you have people that are seeing that kind of revenue?

We do.

I'm doing just what all of the other practitioners are doing, right? I'm seeing 25, 26, 27 clients a week, my fee is $200 an hour so I'm looking at what, $225,000. I don't pay anything into the entity unless I have to fund. But I'm putting in 25 hours plus a week of my time, which ends up being 30 or 40%. My therapists are getting a better deal than I

am. They really are and I have all of the liability on top of it. So, any of them can jump in, and if they are capable of good work and putting themselves out there.

B: But if you are doing, what is typical, and I don't know what is typical, it's like 35/65 % and if you are doing that with 20 or 30 therapists, that's going to more than cover office space and liability and all of those kinds of things, right?

No, so XXXXXXXX XXXXXXXX counseling is still upside down, with 30 practitioners.

B: Because of what you would be borrowing money from VC's for?

Correct, to pay computer programmers is very expensive.

B: And it's primarily for your website?

That's the biggest expense because the administrative costs, your people to help with scheduling, and things like that, those are your traditional 20 to $25 an hour positions, but developers, if you are talking about marketing and business consultants are like $500 an hour. Those things add up like really quick, so it's highly competitive in this industry.

B: Which industry are you talking about is highly competitive?

The counseling industry in the online space. Right? We are competing with Psychology Today and Therapise and these national companies that have a lot of capital behind them. We have VC behind some of them so.

And then we've got like 5 grad schools in the area graduating people every year, many of whom are wanting to do Christian counseling, but when I jumped in it was like so easy, I mean we just set up Lake Counseling.com, wrote a few words and it was like, Oh! We started getting calls, it's not like that anymore. It's a sea out there. It's very different. I

can't see anyone spending less than $5,000-$6,000 a month and having any chance of getting much business from that.

B: Explain that to me, because like the therapist that is the one stop shop, she pays $10 a month and she is 90-100% census for the last 7 years. Maybe that's because she has been carrying it and she has that many referrals going on, but your saying that if somebody is starting out brand new,

That's right, yeah, because everybody in the beginning has the chicken or the egg problem. So, you got to have a way to get visibility. Sometimes people are great at networking, sometimes people are great at public speaking, or they have published, so they are authors, so they get recognized but most therapists are not in those categories. We are talking about 2 or 3% of therapists who have either those connections or they have the drive to do something like that, but that's not the norm. Most of the time we just like helping people. And then there is the business side of this work.

B: Which is the reason for my dissertation. One of the clinicians that I was speaking to, she's really nervous, she is a business major and then went into therapy after her undergrad, and she is really nervous because she feels like they are really clamping down on the independent contractors and pushing more and more group practices into employer/employee relationships.

Correct, yes, the federal government made a shift a couple of years back that resulted in us flipping our business relationship with practitioners. So, now we are their independent contractors.

B: So, they hire you?

Yup. Yeah, and making that flip was probably about $20,000 in legal fees. So, all of these things stack up so quick.

B: Do you have attorneys and CPA's that you keep on retainer?

We don't need to keep them on retainers but we've worked with them long enough that I just get a bill for $425 an hour.

B: Which will soon will be your therapy fee, huh?

I don't know, I think I'm pushing it at $200 for a Masters level practitioner. There are plenty of practitioners in our group that have lower fees and so if price is an issue, they can meet with somebody else and that's fine. We refer out a ton of people.

B: So, if you were going to give some person advice in regards to business as it relates to running a practice, what are the things that grad school doesn't teach you.

Well, grad school doesn't teach you about the cost of living, to put that in perspective, So I mean that's not the point of grad school, right?

B: The cost of living as it relates to your practice?

The cost of living here in the Greater Seattle area. With your school loans, you take do you want to, are you planning on having kids, are you planning on buying a house in this area, are you planning on retiring? .....We are really not set up in this industry to sustain practitioners as a career. I don't think that, it's going to be pretty tough, if someone is billing less than $150,000 a year to live in this area and have any retirement because we have to pay for our own insurance, we have to pay, taxes are there. Once you start hitting a higher tax bracket, you start paying more money so.

B: One thing that was disturbing to me was the pressure of grad school for both, because I was a TA for the MACP but also in the doctoral was this press to service the

underserved and the multicultural or diverse cultural population, and being as old as I was and having several business ventures that I have done myself, I said, that's a great concept but are you asking the people to essentially work at community mental health or how exactly do you see this being funded as far as people actually making a living and taking care of those people. Here's how it's funded: they have a spouse that takes care of them. That's really how it's done.

B: It's almost like a hobby then?

It is it really is a side deal, a ministry,

B: They don't share that kind of information in the presentation.

They just care about those populations. Well, everybody cares about those populations. I think that is where the church needs to be stepping in more and the state is stepping in more.

B: The problem with that, if I may, is that the church doesn't get mental illness. They want to pray for people, they want to get people into church, they don't understand.

I'm saying that the church should be stepping in, in terms of funding.

B: I see what you're saying, yeah. And funding these people that are professionals that are helping.

Or maybe a portion of their tithes or something like that. But I think most churches look at that and they say, you know what, we could take this $100,000 and we could go overseas with it and we can start 15 churches. They are having to make those decisions, and it's a tough call. And there are needs all over. I think a lot of times the church says okay, well we've got the state that actually is helping people out at some level here. I

mean, it could be that, I mean the fact that any country is providing mental healthcare, is phenomenal like at this point in history.

If someone is charging, here's what I don't think the underprivileged, not only do they take up more time, they take up more resources, so there has to overall be. When I do sliding scale, and I've got somebody in there that is like 30 – 40 dollars, it's not just that hour, it's the problems that go on in their lives, and you almost become a social worker rather than a psychotherapist with that population.

B: with your sliding scale, do you essentially do that on a monthly amount?

I don't do sliding scales. I have one patient right now who I've just been working at for years who I keep at the original, but I instead, I'm either going to do pro bono, charge them nothing, or it's going to be my regular fee for service. And we will just keep it real clean that way, it's either ministry or it's for profit.

B: And how would somebody qualify for pro bono with you?

I'd have to have an opening, somebody would probably have to plead their case, at this point. At this point I'd have to have a patient referral. And then I volunteer at my own church.

B: As a counselor?

As a, not wearing my clinical hat, but they are lay counselors, they are care receivers, and so I help with some training and supervision for their lay counselors.

B: "Church counselors" are kind of scary!?

Yeah, they are working at rebranding the language to like care coach or something like that, which I think is more appropriate at this point and there is a lot less liability as well.

B: I think what you are doing is tremendous. Any thoughts on intensive outpatient or partial hospitalization programs or anything like that, that you have considered or thought about.

Considered most things, right? at this point. I just think, I have always loved creating community for people. And so, helping practitioners not be so isolated in this field is super important to me, while at the same time, blessing their autonomy. Therapists tend to be pretty independent folk, so I think that's where an employee model is tougher. Trying to reign in that independent spirit, doesn't tend to go as well. So, if I can create community.

B: How do you do that?

We have business meetings, we have study groups, things like that where I'm not leading them, but I create a space for them to if they want to participate in them, they are not mandated to be. They are mandated to be in the business meetings but not for the study groups.

B: How frequently do those go on?

Every other week. We meet for a half hour every other week as a group.

B: And that's mandatory?

That's mandatory, yup for the business meeting and then for the study group, that's not mandatory, that's optional. The deal is they record cases preferably video

B: Of clients?

yup and they present to the group. If they are not interested in doing that then they don't need to be part of the group so it's kind of an opt in but what I've seen clinically in terms of being able to grow clinically, video has been the key. I did my first four years of

supervision without video and then worked with Dr. XXXXXXXX doing video and it was a whole different ballgame. I was reporting one thing and other things were actually happening. I had no idea.

B: Can you give me an example?

Sure, it's as basic as hey I think I'm dealing with a Borderline client. Nope, not a borderline client. I did feel infected, but I'm dealing with someone that is actually, has more Narcissistic and sociopathic traits. So being able to have someone else, a group of other clinicians who have more experience get visibility on that case was really helpful. Because then I'm not going to give them mindfulness activities with that patient.

B: And that was something you cultivated with Dr. XXXXXXXX?

David XXXXXXXX

B: And some of your other?

I've had a consult group of my own for about 11 years.

B: And that was just your peers, and supervision was separate.

I met with XXXXXX XXXXXX, my partner, we met with the supervisor for four years. He is excellent at helping practitioners do individual work. I went to a couple of workshops with Dr. XXXXXXXX who focuses on couples work. And when I did that I was like, hey, we went and pitched him and said, hey would you be interested in doing some consulting work with us. So, he wasn't providing supervision, he was consulting with us on cases. He said I can't consult with you unless I can see your work. I'm not interested in self-report, that's a terrible way to do data research. And we said okay, and so then our learning skyrocketed. So, when we built this, I said if we are actually going to

support practitioners get to a higher level and it's not just them self-reporting, we're going to do it this way, and it's not mandatory but it's the best way to learn.

B: Do you do supervision now? Yourself?

No, I'm a Washington state supervisor but I haven't currently taken on any supervisees. A big part of that is energy wise and adding more liability onto my practice. I don't supervise within my group.

B: When you say your group do you mean within your thirty therapists?

Yes, and the main reason for that would be dual relationship. Because I'm really pushing for bottom line and in terms of healthcare, we really need to be pushing for that patient to get better. I think those are in conflict with each other in the industry. So, we have chosen to separate those out and they are free to choose any supervisor they want.

B: When you say that you are pushing for the bottom line with your therapists, what does that sound like? What does that look like?

It means I'm going to be thinking about, I'm not saying that I am overtly pushing, I'm just saying that the nature of the structure would create too much temptation there. I would be thinking about, gosh, can't you string this patient along a little bit more. I think that happens in the industry and so I understand the temptation around finance, I want to stay away from that and create as many safeguards for myself.

B: So, what is like your business meeting like, what are you covering, what are you teaching what are you training? What are you talking about what's your agenda?

Tools, everything from here's, I mean you got a patient that is calling in and they are dealing with X-Y-Z, how do you go about making sure that patient is going to book, is going to continue.

B: So, like administrative efficacy and

Correct, how we service best as we possibly can because as a business owner, I will get a win if we do that. And it's up to the supervisor, the supervisor is primarily focused on patient care.

B: Do you communicate with the supervisors at all?

No, but I would if they reached out, if they said, hey I've got questions about. All of the practitioners if you want to talk about any of our business model, we have a whole trade secrets agreement that basically says don't go out giving the specifics of our business model everywhere because it's a highly competitive industry. If your supervisor wants to know, well feel free to have them talk with us, that way I can be part of the story, because the practitioners don't always understand why we are doing what we are doing and there are too many moving pieces. I'm so vested now, it would be tough to extract myself so part of that is good because it's like all right, I got to keep figuring out a way to make this happen, a lot of work.

Clinic 2 Interview Transcription Part 1

B: Leads me into the very first question, how long have you been a therapist? I've gone over your website and have seen your biography but

I graduated in 2011, so 5 years. 2 years with someone else and 3 years here.

B: How long have you been practicing here? Since the first of the year. Is this the first time that you have been on your own?

That was I think it was September 2015 when I left the last group, and then when I was down on east lake Sammamish but prior to that I was with the group, XXXXXX, XXXXXX, and XXXXXX.

B: Then you went from there to another place on XXXXXXXXXX?

I was, I just went out on my own. Oh okay. Actually, when I got to that location, with the other people that I just mentioned, I left there with the intention of going into 100 per cent private practice. I rented one room from the Yoga center with XXXXXX and XXXXXX. That was it and then they after I had been there XXXXXX started the group after that. XXXXXX started the group and then her and XXXXXX got into it. It was very confusing. I went down there and knew a little of the dynamics there.

B: Has it been the same business format since January or did you change the business format since then?

No, at the last location, which was just a short time. It was just me. Not thinking of a group just, 100 per cent just me. I had been prior to signing at that space keeping my eyes open for another location for bringing in other practitioners. And I happened to come across this space. I had leased that other space already for a year and I wasn't in a position to carry both so the landlord said I could get out of it, if I could find a tenant and

so I went ahead and signed this place because it's such a great space and there is just not a lot of practitioners up here. And I ended up paying for like 4 or 5 months until I finally got a chiropractor who had been working with XXXXXX and XXXXXX and I down on XXXXXX, who is in my space down there.

I started out doing just me, and then when I got here, I wanted to create a space for a group setting. And I'm probably getting ahead of you.

B: What was your mission when you were setting up this practice?

I have my mentor named XXXXXX, and she has started a group up in the Bothell area, and I wanted to do something similar here. I actually hired a consultant to do a business plan to help us look at the financial piece and take a look at that and forecasting, hired an attorney to take care of a lot of things like leases and contracts and things like that. I would say that I have very much strayed from that.

B: Is that right?

'Yeah, I still use a lot of the stuff, but yeah I'll let you ask the question otherwise I'll just keep talking.

Bob: So much of this particular research is to take a look at that we have heard so much about how the ACA is driving practices into the integrated care. It has brought in about 30 million potential clients for practitioners. But, both my experience as well as what's going on at XXXXXXXX, and what I see that practitioners are experiencing compared to what we hear in class; I'm not sure that they coincide. I'm trying to understand what is the actual lived experience of people that are there in their own practice. You have a plan and you have the reality of managed care, insurance, and ACA and all of those things which have a tremendous impact on the business plan. A lot of the time what

practitioners set out to do and what they end up doing may have to change as a result of the economy or they just realize what it takes to run their practice is quite different.

B: So, I would like to know what was your plan when you first started out.

Yeah, I actually didn't even consider the managed care act, that piece at all, for me, the business plan it's become more about economics, the financial piece, and rest as far as the financial piece, more so risk management, as far as HIPAA, as far as not getting in trouble with labor and industries, or wanting to keep the relationships less complicated, not an employer/employee all of that and how to define that and how to truly delineate these challenges, that's what it has become for me.

B: So, more therapist to therapist as opposed to therapist with clients, as far as liability is concerned? What do you mean by that?

In regard to risk and the liability, the issue is more working with other therapists, yes! Then with your clients themselves, Yep

B: Was that a result of what you experienced at your previous situation?

More so like I said, my mentor was big on that. Risk and what not, and just wanting it to be important to me, to do things by the book and to keep them legal and to not set myself up for fines or back pays to the state because we don't have a relationship that is defined accordingly between therapists. That was the biggest thing to me. I wasn't worried about clients, about insurance or anything.

B: So, the business plan that you developed with your consultant, what was that like? Can you tell me about that a little bit?

It was basically bringing on other therapists that were interested in being part of a group that see value and benefit in being part of a group, where they would come on and they

would, you know, choose the days they want to work or what not, and we would offer them a website presence, marketing, office, office supplies, all of that in exchange for a fee split according to the agreement. And that we had eventually projected that we would be growing enough to where we would bring the billing piece, which is HUGE, in house, have someone doing that in-house. Right now, I contract that with an outside company for a percentage. And we would grow and grow, and just bring on more administrative help and the accounting piece as we grew. This location, another location, I wasn't really worried about getting clients, I think if you do good work, and you're in a location that is underserved, like Sammamish or Issaquah, the clients are going to find you. That's never been a worry for me.

B: And while you are there, I will ask you about the managed care act. You said it was not something that you considered anyway, can you tell me about that?

So, like, it's kind of the harsh realities of the industry is that I see, and again, this is just my experience, but there are certain groups out there or clinics that will, like the community mental health, where they will draw more of the managed care, like the Washington state Apple care or some of these other plans that we don't accept. We've never been; we just made a decision, not encouraged to necessarily accept those. I don't really get any calls for that, and I have places that I refer them to, but this is more like private insurance in this area, so yeah, I hear these things about managed care and how eventually they may even give certain groups certain amounts of money and say you need to see this many clients or what not but to me that's not really in the near future for me and if it is then, I've always kind of got one foot in a group and one foot out, right now, cause I'm just not sure.

B: What type of group are you referring to? That you have one foot in

You know like a full-on group with other therapists where you start to bring stuff in house and you know, you have made that commitment and um yeah,

I don't know if that's what you meant by managed care, I guess I should ask you what you mean by managed care.

B: Very much so what you have described, so essentially because of your geographical location, you anticipated not serving that type of clientele because there are really not many in this area? There might be some in the low-income housing in the Highlands or a few other places but for the most part, and if they did you would refer them out to community mental health,

Or we will see some people, a certain number of clients for private pay on a sliding scale, but we just don't deal with Apple or sadly enough. I can say this because my husband works there, but I know that Boeing has terrible mental health insurance and I don't accept it, I don't see anyone that has Value Options because figure something, if you feel really strongly about coming in here, you found us, a referral from the Gottman website or something, then we will have to do an out of pocket thing and then you can deal with Value Options, because they reimburse, there is such a discrepancy with what they reimburse and they are just really difficult to work with.

B. Yes, I know about that, I've experienced that.

Yeah, me too, personally and professionally.

B: So, the population that you started to practice with, is it still what you have on your website, what your focus was; families, married couples in particular, and okay, and was

there any particular pathologies or disorders that you were coming together to, "I really like to work with this population, and I really want to?

Now you are talking about just me as an individual therapist?

B: Yes, as well as your practice as you oversee the whole thing, you're going to

Well that's kind of two different things,

B: What I mean by that is I'm assuming that as you bring on therapist, you are identifying what their focus is and what their skills are and what their desires are as far as particular pathologies and disorders and you may have some impact or influence based on what they are doing and whether you want that person or that type of client that would come in.

It was just my intention that, for myself, that's one thing, it's like so, you're asking me if the types of clients have changed? Is that the first part?

B: Well, who you started off to be serving, what pathologies and disorders and populations?

You mean like when I started here or started as a therapist?

B: Since you started here,

Oh, no that hasn't really shifted. You know when I first started here I think I saw a few more adolescents, but I don't see many adolescents now, for a number of reasons,

B: Okay, More adults?

Yeah,

B: Okay. How has your business plan changed from your consultant's direction?

Yeah, well part of that is from my own experience, you know as an independent practitioner, and my own reasons for leaving the various groups I've been with, which all

but the last one, were just very positive, not really, like, appreciating the group setting but not needing it and by needing it, I mean also to increase income, there is only so many clients you can see a week as a therapist, it's pretty fixed, right? so you know, if I was paying 35-40 percent to a group, to do things that I felt I could do on my own no problem, then to me that just didn't make sense.

B: Sure

So I understand therapists that are coming here, and for instance, I will use XXXXXX because she is absolutely fabulous, where she came on and she said, yeah I want to do the percentage for referrals and all that and she got very busy, very fast and she was kind of in the same position and she's like I just, you know she was full and she's fully licensed and so she just says "hey, I don't; I think I'm going to leave." Cause I also made a promise to myself and like the group that if people want to leave, I don't want them to feel like, hey no harm, right? Like we're all adults, a lot of people don't necessarily have that. Anyhow, she left.

What do you mean?

Well, she left kind of the percentage based pretty quickly on and anyone that has come on under that plan, I said "I'm not going to have you sign a year lease I want you here because you want to be here and if it's not working then we will chat. I thought, darn it, this is uh, I get it. Totally get it, I totally understood where she was coming from so that's where I kind of re-evaluated and said. Now Shannon is fully licensed, so there is fully licensed and not fully licensed,

And anyhow I decided that and the whole thing with a couple of groups getting into trouble with the independent contractor or employee and I'm like this is a lot of risk, too,

I'm just going to kind of move to an office share agreement, and so that's where I have moved to with therapists that are fully licensed.

B: So, fully licensed, they essentially pay lease based on the market rate? Or

It's just what I have set, basically, it includes not just like renting out the space, it includes their presence on the website, it includes referrals, all of that

B: So, you want to have mature licensed therapists who feel good about coming here and don't have to give out such a big chunk of their income to get what they think they would be generating on their own. But still, it's worth it to you because you have a group practice, essentially but you also have some added income to what you do as a therapist.

18:30

Right, exactly

B: And you don't have any liability except for whatever clients might do because of issues with the building which you have insurance for.

Exactly, and then I have the associates piece.

B: Right and you are doing them, *(associates)* a favor and

Doing them a favor and a lot of extra work. I'm doing a lot of the paperwork, the billing, and the sorting and all of that. I meet with a CPA each month to sort through all of that to keep track of that for me, for them. Which I don't have to do for, I mean these guys are completely on their own being fully licensed, so,

B: So, they (*licensed therapists*) do all of their own billing,

Oh, they do everything, 100%, so I feel it's mixed. That I'm kind of at this crossroads now, I'm like what the heck am I doing. I'm not sure here, I don't know.

B. It's continuing to evolve,

It's continuing to evolve, like XXXXXX and I were just having a talk about, cause she may leave at the end of her lease, because she does have a year lease. We have an office share agreement. That's by days, it's not like that's her office. She has it for certain days. And it's a flat fee per day. And it's fair, I've researched that and all of that and she feels good about it, so anyhow, but she's going to leave at the end of June. She wants to be completely on her own, she may even do something similar. You know she's being open and honest about that and telling me where she might go and do I want to take a couple of spaces and I'm not sure. I think the next step might be for us to do the billing in house but that's bringing someone on as an employee and do I want that, a) hassle and b) costs, right? How am I going to cover that? I don't know. I'm trying to think to figure this all out right now and I'm almost frozen for the last I'd say month, trying to decide, you know. A lot of the groups in the area, Dayspring down in Issaquah, they just let their therapists know, (that are independent contractors), that you are moving to an employer/employee relationship.

B. Really, do you talk to them as to the understanding as to why they are doing that?

I have not talked to them directly, I've heard this through the grapevine but I know that there have been other groups that have done that, lots of them actually because supposedly, labor and industries are really cracking down on, and they will error in favor of, this is an employer/employee relationship, then you guys owe us taxes now. It's huge, right now and I don't know what that would mean.

B. How do you stay up to speed on what those things are?

Well there's a whole independent contractor manual on the L&I website, which I kind of looked through. I just took a continuing education course which was absolutely fabulous

through Wellspring on risk management. And this is both, I guess the risk piece is pertaining to clients and HIPAA, and wanting to make sure that we are following those rules. I found out at this workshop that I should be having a policies and procedures manual for HIPAA in place, so I've got to hire an attorney to do that, because I can't write that. We need to have a risk management assessment plan in place that if we get audited they see that. I mean all of these things really complicate things running a group practice. And there are a lot of groups that are just flying by the seat of their pants and not doing any of this.

B: Okay as it relates to your financial goals, your general financial goals, what was your plan or expectations or hope regarding your personal income from the practice?

You mean like generally speaking?

B: Or as specific as you are comfortable sharing.

I don't want to get too detailed, a lot of that is very different, regarding the financial piece, when we set out and had the consultant that I hired to write the business plan. It's just not the same.

B: Let me give you a range and maybe that will help you. People that just want to be a therapist and they don't want anything to do with business, but they don't want to be at a community mental health kind of a situation, they are looking at a range of somewhere between like 60-to 80,000 dollars a year they are hoping to get financially. People that are independent, a little bit entrepreneurial, and particularly on the Eastside are looking at somewhere between 90 to 130, 140, 000 a year salary and then the more aggressive that are equal business people as they are therapists are looking at unlimited, anywhere from $150,000 to 3 or 400,000 a year.

I'd like to know what those people are doing.

B. Well you know, they are essentially franchising, they don't have a tremendous risk aversion. I will be talking with one of those people that has multiple franchises as part of my research and I will certainly share what I learn from them with you.

Yeah, I would love to head in that direction.

B. The larger multiple site kind of thing?

Yes, but

B. Yes, I noticed your first degree is in business and marketing.

I know right, I know and I feel like there is a couple of things, the risk holds me back and the financial piece, I need money to grow; attorneys are terribly expensive and my final three kids graduate next year so I have had that piece. For me it's been about, yes, I absolutely need to bring in income to the family, I would love to make over a 100 this year, that would be huge, but also balancing, I'm also a big-time mom now with four teenagers.

B. So you have kind of a pre-career

L: I'm contemplating, I'm re-contemplating.

B: Pre-career total commitment kind of thing and now you are kind of a semi-entrepreneur, therapist, mom kind of a deal. Does that define you at all and the transition you are getting ready to go through?

Yes, and you asked how did you hear about these things and like that's huge too. I know this mentor that I have, I believe she is in the process of franchising, not everybody wants to share all of their information, right, like she actually went down to some place in Arizona to consult with this group that works on like I think the franchise price and all of

this, so it's like diving in and making that commitment. I would really like to, I mean ideally I would like to do less even therapy and more of that piece.

B: The business component?

But it also is important that it's not all consuming, the whole work/life balance, so I feel like some of my goals are conflicting.

B: Could you step out of the therapy altogether? Just to run the business?

Yes,

B: You would like that? What took you into therapy in the first place?

It was a business decision. That's a huge piece of it. Yeah, I have really two of my best friends that are both therapists. They don't know each other, they just, you know happen to be, so I had to step out of the business world entirely when I had four kids in 16 months. So, it wasn't really an option for me to work. But I've always been an excellent worker, a really good student, and the prospect of kind of stepping back into something after 15 years later and what not, I wanted it, I didn't want to go to work, with all due respect, to be a barista like Starbucks or you know a very entry, almost administrative level at a company. It was important to me to kind of, I love the idea of being my own boss, where the harder I work the more I make. Love school, so it was not a big deal for me to go back, even with four small children. I just really enjoy learning. So, I decided, hey this would be a good career, something I could step into and make a decent amount right away, schedule my own hours, work around the kids, right? and grow.

B: So, would it be accurate to say that your initial financial goal/expectation was to be pretty committed but not full-on career while you're a mom and right around low six figures was your hope and probably close to your expectation on a regular basis?

Yes, yup.

B: But post, stay at home mom, or kids at home mom, more along the lines of $250,000 to a half million dollars a year as you develop your business would be your goal?

That would be amazing, yes.

B: Well 10 million dollars a year would be amazing too, but do you see $250,000 to $500,000 as a realistic goal?

I'd like to say I do and I'm willing to put in the work, but I just don't quite know how to go about that. There is a little bit of hesitation, I feel like as your staff your, you know, whether you're financially, you know, what would go into that? Right? It's like, because at a certain point, you can't back out. Right now, I feel like I'm in this safe place where I can say, okay, I'm just going to do my thing and I'm going to be one of those 80-$100 thousand people and that's it. But I'd even consider getting completely out of this. It was like a year maybe two years ago I interviewed and offered a position at an eating recovery center. As a professional relations coordinator, meaning sales basically, kind of hard, it my brain, like I mean doctors and what not, calling on them and entertaining and just making sure that the whole professional community know what the eating recovery center has to offer. It's not because I'm a huge eating recovery specialist or advocate, I just thought that would be so cool, to do that piece and to really grow.

B: And why did you not do it?

They flew me to Denver, offered me the job, offered me more money. Well, a lot of it was the money, they were like, supposedly offering me more and like 80 or 90, plus bonuses or something, but we want you to know that we work so hard, we work every day like 8 am until 6 pm and I'm thinking, I can do the same thing with what I'm doing. I

mean it sounds really fun but I don't want to be gone every day from 8 to 5 if I don't choose to be.

B: Yeah, how much could you make as a therapist if you worked those same hours?

That's what I was thinking, it was kind of like a no-brainer. Right it was like, but there was lots of growth opportunities and bla and I believe that but ultimately.

B: Do you know that show Billionaires?

I love that show,

B: You'd be a perfect psychologists/counselor for people like that in that show.

I know I thought about that too, the closest one, but I want another challenge, that's just who I am, so I don't know what that is or what that would look like, I'm just not sure. I love that show.

B: As far as your rates and the percentage of people that you do sliding scale with and all of that kind of stuff, how do you manage that component? Is it driven by sheer client load or is it driven by your financial expectations and needs?

No, I'm not really good about like setting that and saying this is where I'm going to be. It's more just like client load and I think I have 2 clients right now. One is a client I have seen for like 4 years. He has followed me every place I've been. He drives from Everett, so it's just a little bit of sliding scale.

B: So, when you got out of school, you were working in a group practice then? That was up in Bothell?

It was in Redmond, XXXXXXX counseling, and then I was in Redmond. I went to work for them also saying we weren't allowed as associates to be on Premera so with all of the people that would pay out of pocket so everybody was on a sliding scale. I also said, can I

work upstairs because I want to see what the billing looks like and handling the phones and check insurance. And then my mentor, who is also one of my instructors, also worked there for a short time while she was getting hers, she said, you should come with me because I've got this great. So, I was her first therapist working with her and now she has like 15 people with her and they are all fully licensed except for 1 so I don't know.

B: Do you mind sharing who that is?

Yeah, XXXXXXX counseling. It's XXXXXXXXX and she doesn't take any risk.

B: She doesn't take any risk? How does she do that?

I don't know, she doesn't take any risks, she has no associates under the Premera plan, she is very risk averse. She is 100% by the book.

B: But your plan with the lease thing is different than hers?

Yes, I'm not sure where she's at. I think she's in the process of franchising as well. I haven't talked to her as much these days, she's also working on finishing up her PhD.

B: Have you talked to her specifically about transitioning from the percentage to a lease model?

No but we consulted with each other, kind of, quite a bit, because she was the split fee as well, but as there was a couple of groups that were named, I think I called her and said hey there was a couple of groups that got into big trouble for this supposedly and she was also considering whether she needed to switch at that time to an employer/employee that day even, and I don't think she did.

B: She's still a split fee situation,

Yeah, I think so, there's a lot of groups that have switched. Dayspring has switched. Issaquah Highlands group switched, they're not actually in the Highlands. They're in the Meadow Creek complex. (bottom of Issaquah-Pine Lake Hill).

B: Do you have any like fellowship groups that you are a part of? Associations?

I just joined one on Facebook and that's been interesting to read. Like literally two weeks ago I didn't know existed. I saw this hey you've been invited to join this secret therapist group or something. But no, I feel like I need to be part of groups that are, I've got another person that I went to school, well we didn't go to school together, but we went to the same school and he worked at Northshore youth and family services while I was doing my internship there and he had a group down in Renton. And he also, I really respect him and the way he runs his group. His is also, it's like a family counseling, deals with recovery. His name is XXXXXX. It's like something renewal or something. He's great.

Clinic 2 Interview Transcription Part 2

B: Your business plan?

it's one thing for associates and another thing for fully licensed clinicians. For the fully licensed practitioners, it's a leased space fee, which includes office space for particular days/hours and marketing foundation, (website, phone calls and referrals) and psychology today internet directory.

B: Any other marketing or internet directory, their billing, their scheduling all of that stuff,

They are on their own.

B: You were talking about being frozen in this decision about what is next, particularly as it relates to bringing billing in house, and all of that kind of stuff as it relates to your business plan. Have you made a decision about billing?

I'm definitely not bringing billing in house anytime soon. And something else that I'm no longer frozen on, I had been thinking about a supervision track for myself, the AAMFT supervision track, I am not working on that now or probably anytime soon. I actually signed up for that and I read about it and it's a pretty extensive track. The course is pretty extensive, it's a like a regular college course, and then it takes a long time, you have to have a mentor that is already a supervisor and you have meetings with them and stuff. I'm not as interested in that and decided that. It was one of the associates that said, "I'd really like you to supervise me" and I thought, yeah this might be a good thing to supervise, but I am also not interested in bringing in anyone as an employee at this point. A friend out of mine that runs an agency out of Renton that we were going to use as a mentor, I say we because XXXXXX and I were going to go through the track together and XXXXXX is going to pursue it, but I went to them and told him my thoughts and I realized that for me to supervise an associate as part of our group, it would be an issue, not so much as the dual relationship but because it could be viewed as more on the level of looking like an employer/employee relationship, so I said absolutely not. I don't think anyone would come in and audit would understand how to separate that, Okay, who's your supervisor, well that would be me(owner), the business owner who might also be giving her directives on working with clients, which again looks like an employer/employee sort of this person, unless I was to bring on associates as employees, which I'm not interested for both myself and the associates as this point.

B: So, no supervision, no employees, and no billing. So, in a sense, it reinforces your commitment to the leasing space for a fee model?

Yes, although it's not like it's all done, I still struggle with if I should find a way, if I could find a way to find therapists that were fully licensed, that saw value, I mean quality therapists that see value in operating in a split fee structure, but I guess I'm going from my own experience and Shannon's experience and I know there are groups doing it but that would possibly warrant me making some shifts but at this point I don't see it, so this is just where I'm at for now but it could change in a month or two.

B: You were talking about that your mentor, XXXXXX, she has like 15 therapists and you think she might be franchising in some kind of way, you didn't know if she was doing split fee or employer/employee. What is it that XXXXXX is doing that you say, Yeah, I don't want to do that?

She has got a full billing and marketing department and everything. She has billers and several people working as employees, that are more of an office job not therapists that are employees, they answer the phone, she's got people billing, she's got people marketing.

B: And you don't want to do the employee thing because of the commitment that's involved there?

Yeah, I think so.

B: and have you talked with XXXXXX about that?

No,

B: Do you anticipate that might change for you, after you are done being a mom and become an empty nester?

It might. It's really hard for me to see that far. I just don't know what that will look or feel like. Because within one year, I'm going to go from having 4 children at home to having zero. I don't know what that will look like. So, part of me says I just need to continue what I'm doing for right now because it's comfortable and there is not a lot of commitment. And I'm in a major life transition and I don't want to deal with the whole supervision thing. Besides that, whole realization, like supervising XXXXXXXX and that whole employer/employee relationship, it was not feeling right, starting this class. I was like, I do not have the bandwidth for this, I mean the class started last Tuesday, the Tuesday before Thanksgiving, for three hours a night for the next 5 weeks, Christmas, kids, everything else that is going on with the business, so it's like, uh-uh, I cannot do this. I don't see things easing up any until the end of next summer for me. So, I don't know where my brain is going to be then.

B: I think that's a lot of foresight and wisdom. I mean you are really young and you have plenty of time to jump into that full time if that's what you choose to do in the future. I think that's great.

B: Was it XXXXXX that you were meeting with in Renton, the supervisor guy?

Yeah, he owns an agency down there, a very well run, sound agency that is licensed with the state and he is going for a status that I hadn't heard of, I believe it's, he's also been involved with the chemical dependency side of things as well so he's now on team that

I've known since I was an intern, he was there at Antioch, not at the same time but really respect him, he's great.

B: Would it be okay if I contacted him, using your name as a reference?

Yeah, you can try.

B: What's his name?

XXXXXX, he's fabulous, I don't where he is at with that, he works like 6 days a week. He really has a nice operation.

B: What services do you use, on the internet, publications, forums, blogs, groups that you are a part of, what services do you use in order to stay in touch with the business aspect of running your practice?

I find that that is a challenge right now? Do you mean support, like therapists or do you mean also people like who do I use that powers my website or?

B: Everything, do you have a business coach, do you know small business people,

No I don't, if you have access to any of that, that would be fabulous.

B: A business coach or?

I'd love to get in touch with a group of people that are trying to do the same thing or something similar. What are the kind of questions they are having or maybe you have a clarity? I don't have a business coach, I don't know. Therapy is an isolating career as it is and then you add the business side, I mean like XXXXXX, I will occasionally I will talk with XXXXXX or in the past I would pay XXXXXX to consult with her. But she is very busy but I think something like that would be very beneficial.

B: Any forums, any magazines, any listservs that you are a part of where you gather that kind of information?

I get Family Therapy magazine but I don't read them regularly. There is a Facebook group. There are a couple that I have got involved with.

B: How did you get involved with those?

Friends invited me. So, that's been interesting but it's been interesting, it hasn't been that long but it's more like, "hey, I have a referral can anyone see this person? Any support groups for this? more like if you're a therapist working with your client and you, not really people that are leading groups.

B: In regards to the therapeutic aspects, are you involved in any groups, any colleagues that you interact with to help you stay up with 2 components, the therapy that you are delivering and also self-care.

Well we consult, not formally but informally here, I have a couple of friends that we consult informally, we never divulge any identifying information about clients, there's the online piece, one thing I do appreciate, the state requiring us to have continuing education. I guess I find that a great, I just took a class on risk management that was fabulous, I just really appreciate being able to choose what would be helpful and I just value new information.

B: Do you get that stuff as it comes in through the mail.

I just know which ones work for me now. It will come through the mail, it will come through email.

B: Which ones work for you?

I like the Wellspring, I like the trainings through Cascadia, some of the PESI, I heard PESI is even doing these cruises now for continuing education. You can go one cruises for 5 days and get like 36 hours of continuing education. Doesn't that sound great?

B: I don't know

I've never done it before.

B: When I'm on vacation, I want to vacate,

This is true, I was thinking that too. I don't want to sit in class from like 8-2 or 12 even. So really, I just start looking and all of these have websites so I talk to different therapists and they say you should take this, it was great and I'll go. And I prefer the in-person rather than the online because I prefer the interaction.

B: Yeah, I do too.

We don't get much of that.

B: I saw your DBT book, is that something that you have taken or are getting ready to take?

I just work with clients, I use the book with clients sometimes.

B: What do you think people are lacking in their preparation when they go into a private practice?

I actually co-authored an article that was published in the Family journal. It was a fun article, I co-authored with XXXXXX and my colleague XXXXXXXXX and it was kind

of about the process, I mean, really, they are just lacking so much. At least when I went to school there wasn't any classes that prepared you for the business side, you know how to market yourself, how to structure your business, how to get a license, all of this stuff, so this article talks about this stuff a little bit.

B: Could I get access to that? Is it on PsycInfo.

Um the magazine, I'm drawing a blank on the Family magazine they put out. Family, I'm drawing a blank.

B: It's for the AMFT that you co-authored

You know like Psychology Network that comes out?

B: I know the one the APA puts out called the Monitor.

Or Psychology Today or something like.

B: Tell me how I can get your article? Can you email it to me? So that's the license you have is MFT?

Yes. I'll find it. I will get that for you. The Family Therapy Magazine, that's what it is called. Anyhow.

B: So it talks about what grad school doesn't teach you in order to be a practitioner.

Yeah, I might even have a copy of the article on here. It was a long time ago, like 4 or 5 years ago.

B: A question, a little off the topic, but I'm asking this for dual relationships, do you attend church in this immediate area.

No

B: Is it because of the dual relationship or is it because you haven't found a church that you like or?

Probably both. I do not attend a church here. I am practically a member of a church here but I haven't been for years, but you asked if I, yeah

B: We left while I have been at XXXXXXXX, I have had clients from XXXXXXXX, and I've had clients from XXXXXXXX and I've had clients from XXXXXXXX, and I just wonder what that's like, I'm attending church and oh, there's my client.

You know what's different from me is that I go to the gym. And they just opened the YMCA and no no no I'm not going to go there. I mean I go to XXXXX in Redmond and I still see clients there. Or I go to yoga up here by Safeway. It seems like every other client is saying yeah, I go to the Y. It happens, I mean there are dual relationships when you live up here and you practice up here. Like even the last client, on the way out, I usually say at the beginning, and I forgot but I always tell people I look at their address and it's XXXXXXXXX, I know, I live up here and I work up here and I could see you at Safeway or Mod or the Alehouse and we look at each other and say, that's where we go all the time and you know, I say, I've now gotten to the point where I used to say I will not initiate contact but if you say hi to me, I'm going to wave back because that's my nature. I'm an extrovert. But now I say, would you like me to say hello? Just to establish that, that's been kind of new because I have, I have two clients in Yoga class. Thank goodness you don't talk or interact in Yoga. I always tell people, we could run into each other. Kind of a small-town type of mentality for us, the dual relationship, you know

because it is small. A lot of people appreciate staying up here not having to leave the Plateau to see a counselor, it will save them a lot of time.

B: Thanks, because I anticipate a fair amount of that. And not even church, but schools, youth groups and stuff like that. Are you satisfied with the amount of referrals and clients that are finding you out with the marketing strategy that you have going?

I actually am, I mean the associates that I have coming on, get full quickly enough and they are really only taking Premera. So as far as XXXXXX and I right now, we are completely full and XXXXXX is like, I have a waitlist right now. Because she'll see like teens and everything and I, the same thing but the associates take a little longer because they only take Premera. I have always said, I have no problem pounding the pavement and doing it the old-fashioned way, walking into Eastlake or Skyline, we are even getting referrals from the Eastlake Counseling Department. I know the counselors there because I had kids at Eastlake and all that but I never went in and said here's some cards and call us and all that because people know we are up here type thing. You get one person and they are telling someone else. I have seen it and I also have heard recently someone said they have these groups Ask Sammamish or Ask Issaquah, and they say "have you seen a counselor? Oh, go see XXXXXXX or XXXXXXXXX and so it's just not a need. If I were to market, I don't have the people for them. I've had people just see the sign and call.

Clinic 3 Interview Transcription

B: You have been practicing since 2007?

Yes, and I have been here since 2009.

B: So, when you starting out and you were opening your practice, what did you envision? What were you setting out to do? Who were you wanting to help?

What was my mission? To go immediately into private practice, I have two older sisters that are therapists, one who has since died but the other one has been in practice for over 40 something years.

B: Are you the baby?

No, I'm 4 out of 5, three therapists! What do you know? So, I knew I was going right into private practice because I couldn't afford to go to a PhD program. I had to start earning money and paying financial aid.

I knew it would probably individuals. I knew it would be adults not children.

B: Are all those financially driven or

No, the adults is totally personal driven. My passion certainly follows, oftentimes I think, as therapist we teach best what we need the most because it heals our own wounds, so my passion was around mid-life transitions.

B. And that was what was going on in your life when you were making,

Not when I was

B: Oh, you were already past that.

Yeah, I went through that stuff in my forties and I continued to work and I didn't go back to grad school until my fifties but that was a powerful influence.

B: Did you have any sense of, I want to do it in XXXXXXXX, any geographical thing,

I live in XXXXXXXX, I didn't want to travel far, so I stayed in XXXXXXXX, I've lived in and around XXXXXXXX in one form or another. So, close to home, not a big commute, make life easy, plus, Okay, I'll tell you the story, when I started practice, I was gifted, I walked into an opportunity where I had a free office. You can't turn down that. Not only was it free but it was really an office of a friend, I would get paid a stipend that it worked out that I got $1200 a month to just hang around the office and change the toner in the printer once every 6 months when it ran out. So, it was, the universe truly rolling out the red carpet, saying let me make this easy for you. And so that is why I started out in the XXXXXXXX office that I did. And then when it came time that he was no longer going to have that office, I had visited a gal here and I liked the nice little space and so I talked to the property managers and her little tiny one, that size wasn't, and this was what was available so I took it.

B: Did you have narrowing it down a little bit more, as far as population, did you have like professionals, healthcare people, housewives, anything along those lines or just whoever shows up.

Because I didn't take insurance, I took whoever showed. But they tended to come initially because of my website. And my website spoke about being at the crossroads.

B: I loved your website by the way.

I just updated it today for the first time in 4 years. Do I know how to do this?

B: Did you have a formal business plan together when you started?

I did not have a business plan, I did have a business background, so I modeled my first year a lot off of my best friend, her name is XXXXXX, XXXXXXXXX she was a Pacifica grad as well, a year or two ahead of me but in the PhD program and she had a business background prior to doing all of this. So, I simply said, how do you keep your records? Your financial records? She had an old-fashioned ledger book and showed me how she listed her clients and the session number and the date and I said, this is easy and I put it on an Excel spreadsheet. So, I had that to start and I still to this day use it. With that expensive accountant, I tried to do QuickBooks for a year, and I hated it. So, this is plan enough, open my office, have enough clients that I can pay the rent, pay the insurance, and grow.

B: Did you have an idea of how long that was going to take?

No, when I moved here, I probably had 10 or 12 clients. I wasn't accepting insurance. I could at how much I was bringing in and if it could sustain me. I actually told a client of mine who is a therapist, we were talking about when to get her own office and when you have about 10-12 or 13 clients, you are probably there.

B: Did you have any thoughts or ideas about the ACA, AppleCare, Medicare, or Medicaid and all of that type of clientele?

LMHC's are not allowed to bill Medicare only social workers so that was not an option. I don't know about Medicaid. And AppleCare wasn't around back then. No! I didn't even think about that. I have and had a sliding scale option which I utilized but I decided I would only do 2 of my clients on a sliding scale so I could afford to exist.

B: Did you have a formula for that all worked out?

You know that's a good question, I think I started out my first fees were $85 and sliding scale might have been $60, I ballparked something like 20%. And when it got to a $100, it was maybe $80. But you know, because I wasn't involved in insurance, I could make up anything that I wanted. I know I had one client for years that I charged $65.

B: Did you do that based on their financials?

Absolutely, yes, it was definitely based on need, I never made anybody bring in tax returns, it was just people that I knew who they were and where they were at, countless dumping

B: From the get, did you ever have any, how frequently did you have to say, I'm sorry I can't help you, that's what my fees are. They couldn't afford you.

Financially, yeah, did I ever have to say I couldn't, yeah, I would get calls all the time and people would say, I can't afford private pay, I don't have insurance and I would refer them out to agencies. And I went out of my way to find the agencies, give them the names and numbers, so even though I'd never hear from them again, it's so easy to get lost in that world, so I had a little Word sheet of different agencies that I could say, here let me send you some info, and I'd have the contact number and a little information about the population they take.

Do you still get a lot of those calls?

Yeah, as a matter of, not quite a few, I get them once in a blue moon, I had a gal call me this week, she was referred by other friends from her company who all seemed to, they

have a little fan club going, but her boyfriend who has, she wanted a therapist for her boyfriend who has, I don't know, no job, no insurance, or something so I referred her to APS, the Alliance for Psychoanalytic Study has a clinic, I and recently got a notice from them, of which I am a member of them, their clinic will offer, therapists can work for their clinic and get free supervision and so, or yeah they get free supervision but they also are a lot of people who are just starting out. So, it's very low fee to know fee, whatever. I just referred the young man to the clinic.

Yeah, it's a great organization.

B: Have you kind of developed a plan of where you want to go going forward or are you just kind of just existentially doing your thing?

I'm doing exactly what I want to do. There is sort of this magic and I notice life is low and there is space in my calendar, I tell the universe, okay I'm ready to take one more, and calls come in and right now I'm sort of in this in-between where some people are cancelling, I have this one person, I have two people who are like at 6 or a 5 o'clock and have cancelled within time, I have a 24 hour thing but consistently, you know my office is shutting down, I'm not coming in, just stupid reasons, and so I'm like, Okay, I can't hold this space for you anymore, you might have to call me when it's available. One of the gals I've seen for a long time so I offered her another spot at lunch, but we will see, she just has to be on notice that I'm a "oh I don't feel like it because the office is closed and I don't want to drive up to XXXXXXXX." That's not the point of, I have people that want to come in and they come in consistently and that's the only time they can do it, after work, so you have a primo spot and you cancelled 2 or 3 times in a row, bye-bye.

We talk about another time, her coming as needed. That's part of what tells me they are committed to the work. And I do it in a really nice way but uh uh, that's not okay.

B: Yes, you need to hold people accountable?! Part of it is finances and showing up on time. Did you have, beyond paying your bills and paying your student loans, did you have financial goals that you were expecting or anticipating or in the back of your mind somewhere?

I did have expectation of higher income when I raised my rates when I got licensed from $85 to $ 100. So, there was a distinct impact there, then I raised my rates from 100 to 120 and went on Premera. I think that might have happened around the same time. I saw a distinctive jump there. It's probably held at that point, I can give you, you know the numbers that went up and even in the first years, I logged how many hours I had.

B: How long does it take you to do your billing?

It probably takes me about 20 minutes to do my Premera billing. I have 15 people, 12 people, easy half hour. It's just boom, boom boom boom. It takes longer to do Regence but soon I'll be off that. I keep all my insurance stuff in the back, you know with everybody's names and birthdays and pertinent information that I have to have, that' s how I googily google them. How long does it take me? Here I am going into November, I sat around one week, last weekend or one weekend and I kind of enter all of these things here in the dates for my calendar and then I start adding this part, and to be honest because I live off of it, it gives me a general idea of what I can expect will go in the bank on Monday Tuesday, and then I go "okay, I can live" and then I plug that into my lovely

little budget and go "okay, I put that in, put that in and now have I gone down to zero yet? So that's the way I been living my life and you know it's not…

B: Do you have any restrictions or focus on particular services that you offer? Is it just one on one therapy with individuals, do you do couples therapy, do you do family therapy?

I do couples therapy and in family situations where I have an individual I will have them bring in the family member sometimes periodically whatever,

B: And do you do group therapy at all?

No, content wise, I refer out for a number of issues. I don't even take on chemical dependency, sexual addiction, I have a whole string of, I call it the back 40 here, a whole string of CDP, sexual, anyways, they've got a whatever the certification is for that. So, there are a lot of things I refer out.

B: Sex, chemical dependency, what else?

To be honest, I will be very careful if a borderline shows up for a consult. I may refer them out. I do not have a problem with Bipolar and I work with providers for medication stuff. But borderlines I became wary of because I had chewed up and spit out by a couple. The good news is that I have found people that are very good at and like working with them, so I'm familiar with the DBT side group. there is a gal who is moving here who is very good with Axis 2 so I make sure that I don't leave them stranded, "you know there is somebody who really specializes in people working with your issues" I never tell them you're a Borderline, or I'm killed. So, I'm watchful for that.

B: can you at any point times where you had to modify your business plan, "if I'm going to make it to this level financially, or if I'm going to make it to this level of fulfillment, as far as meeting the needs of the people, did you ever have to, "I'm going to have to quit doing this or start doing this?

I think that would be appropriate for when I raised my rates. It also probably pertains to how I run my schedule. In terms of my own personal performance. I don't start seeing clients until 12 noon. I'm not a pleasant person before noon. I would not be personally fulfilled, (laughing). Nor would I be in any shape to cope with somebody else's stuff.

B: Your census is typically 80%? 90? 100%? Filled?

Oh, my caseload is typically 90-100% filled. Except during the summer when suddenly everybody goes on vacation. Then I can have a lot of holes.

B: how transient your population is as far as you'll see, an average amount of months you see them?

That's a good question. So, average? Makes me immediately go to my spreadsheet. Looking at the average number of sessions. 90, 65, 130, 63, 61 72 24,113, So an average, I suppose I could up with an average with all these numbers, 101,

B: So, the majority of your clients you see for a fair amount of time.

Yes, And, some of these numbers that I am looking at that are high, one person, like stopped coming for a year and then come back.

B: So, you don't have very many clients that you will see only 5 or 6 times?

5 or 6 times, Never. That would be rare.

B: So maybe a few that would come once or twice

Right usually something happens where it's not a fit, I have had that, I've only had one where I made a therapeutic mistake. Cause she told me, and I felt really awful about. It was unconscious but she was going to another therapist and another gal that I was seeing for a long long time and she's now going to see another therapist for skills I don't have. I don't do EMDR. So, she's off with them.

B; And with you running at a 90-100% caseload, how often do you do those 30 minute consults?

Whenever they crop up, every now and then. Not very often lately, more like once every 4-6 months. It's pretty rare.

B: Really? So, you are not getting very many new clients because you don't have the space for any new clients.

Yeah, and if I get any new clients.

B: What other types besides the internet directories of marketing did you do?

When I first started out, I pretty much did everything. I went to as many of those WAMFT meetings, early on they had breakfasts or coffees they called them. And I went to those in particular I think XXXXXX, I knew XXXX was leading them, so I made it a point to go there, once a month so you would meet other therapists, right, so XXXXXXXXX, is both a therapist and a mediator, an attorney, and she and I have since become very good friends but I don't know if it was XXXXX and I talked, instead of just meeting and introducing ourselves talking about the practices, it would be really nice to

have some education and have someone speak. So, it either started with her or with XXXXXXXX in this building took it over and I talked with XXXXXX about that, let's have speakers, wouldn't that be nice, if one or two came in. and then I took over after XXXXXX and I had an entire year of speakers laid, we didn't get any CEU's for it but the attendance at the meeting doubled. So, this business of my name is Bob, bla bla bla, nice but we would do that and then we would have an hour and they were really good talks and valuable. And so, the word got out, go to XXXXXXXX. So, we would like burst out of the conference rooms. So, we have two conference rooms and anyone who is a tenant can use them for free. I did it for I think two years and then I passed it off to someone else, who I think has passed it off to someone else. And I think they have continued now, they always have a speaker, and I think they even got WAMFT to provide like an hour of CEUs for those people who can submit, process all the paperwork.

B: So, besides the education provides?

Networking, people will know who you are and refer to you or if I had to many clients, I would refer to them. So, there was value in that. Through WAMFT, I even went to their holiday party. This one gal who teaches at Antioch, I think it is, she has this big giant house overlooking Lake Union and their annual holiday party. And so, you go a couple of times, you meet a few people, you just become a familiar face, you talk about what you do, where you are, someone like was lost, I think I was at the Jung society, I may have people that I need to refer on the Eastside that I may need to refer can you give me your card? So, I gave her my card, I have no idea what her name is and who knows and then suddenly somebody calls. So, you don't know, it's like planting seed, you have to do a lot

of it. I don't do as much anymore, I used to always go to the Jung society Friday night meeting. Most of the time there was a topic I really liked but the first couple of years I went a lot. What other things did I do?

B: have you developed or felt the need to develop a policies and procedures manual for risk management.

Yes, yes, yes and no. My disclosures are my policies and procedures.

B: On your website?

Yes, I stole it from someone else who gave it away, it's actually on my list this weekend to go back in and I just have this feeling that there are some things in there that I need to be more specific about and I tell people when they do their paperwork with me that Okay, you're signing on the line, saying that you've read this and now you are signing on that line saying I've got a copy. They hate it when they call 12 hours ahead of time and I say I have to charge you and they say, What? Why? I'm sick. It was in all of this paperwork you signed when you first started. So, I really try and go over that verbally with them. I go over the consent to treat, verbally even though they signed that they have seen it and read it.

B: On the phone or at their first appointments?

First appointment.

B: So, are your intakes longer than the 50 minutes?

90, I use a whole different cpt code, 90791

B: What are the resources for hospitalization:

Northwest alliance listserv and my WAMFT listserv Every day: about a minute. You have to be a member to get on the listserv

B: any reason why you have chosen to be in private practice rather than be in a group practice:

Freedom: I don't have to explain anything to anybody about anything that I do.

B: But you'll find enough fellowship, if you will, camaraderie.

There's enough in the building. We meet in the hallway we meet in the mailroom. You find a building with people that are nice. Here's a new therapist moving into our building