

***Report of the
Primary Care Training
Task Force
to the
APA Board of Educational
Affairs

American Psychological
Association***

October 2011

Updated March 2012

Charge:

The Primary Care Training Task Force's charge is to develop a comprehensive strategic plan for education and training to prepare psychologists for integrated primary care in varied settings – including an assessment of psychology's current training in primary care and recommendations as to how the Board of Educational Affairs (BEA) and APA might further these efforts.

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Report of the Primary Care Training Task Force (PCTTF)

Executive Summary

The Primary Care Training Task Force (PCTTF) was charged in 2011 by the APA Board of Educational Affairs to develop a comprehensive strategic plan for education and training to prepare psychologists for integrated primary care in varied settings – including an assessment of psychology’s current training in primary care and recommendations as to how the Board of Educational Affairs (BEA) and APA might further these efforts.

The importance of developing this type of comprehensive strategic plan is underscored by many rapid transformations occurring in the fields of health care and education. Paradigm shifts to integrated care, patient centered health care and research, and interprofessionalism are the most central. Thus, the PCTTF focused on the main objectives of:

1. Addressing the key issues in creating a psychology workforce prepared to provide patient centered integrated care;
2. Discussing attitudinal, clinical, operational, administrative, and financial barriers to training in integrated care; and
3. Exploring the opportunities and challenges for psychology and primary care disciplines in creating meaningful integrated care training models.

This report examines and briefly summarizes psychological theory, research and clinical experience addressing the provision of psychological services in primary care settings. The report provides (a) an overview regarding the rationale for education and training in primary care; (b) a summary description of survey data collected by the PCTTF regarding current education and training efforts in primary care; and (c) recommendations regarding how to expand education and training in integrated primary care psychology. The report makes five main recommendations with several action steps. The recommendations are listed below with additional details appearing later in this report.

Recommendation 1: *It is recommended that APA support innovative ways to educate and train psychologists regarding (physical and mental) health promotion, disease prevention and*

management of acute and chronic disease across the lifespan to prepare psychologists for integrated primary care in varied settings.

Recommendation 2: *It is recommended that APA continue efforts to educate the public, other health professions, policy makers, and health care administrators about how psychology fits into integrated primary care.*

Recommendation 3: *It is recommended that APA encourage educational programs to further promote research and research training regarding the application of psychological knowledge and how it can be applied to enhance health-care settings, decrease health disparities, and lead to health and wellness (both physical and mental) in integrated primary care settings.*

Recommendation 4: *It is recommended that APA and the APAPO continue to focus on advocacy efforts that allow for the funding of education and training of psychologists, the inclusion of psychology in integrated care and other health-care reform policies (to include, but not be limited to, reimbursement issues).*

Recommendation 5: *APA should continue to evaluate ways to measure and improve education and training efforts in the area of integrated primary care psychology.*

Conclusion. Time is of the essence for psychology to formalize a strategic plan for training in primary care settings as rapid changes in the health care arena are occurring. Additionally, this is an optimal timeframe to further educate other professionals about the value of psychologists in health care reform endeavors, most notably the patient-centered initiatives. It is the viewpoint of the PCTTF that a psychology workforce that can address psychological and behavioral aspects of health care within primary care is vital to the advancement of the discipline. More opportunities for psychology trainees to receive education and training within practica, internships and postdoctoral fellowships in primary care settings need to be developed in order to address the reality that most patients seek their mental health treatment in primary care. These educational opportunities need to pay close attention to developing experiences that create the shared values and common goals between primary care providers and psychologists needed for trainee internalization of integrated care precepts.

Preface

Integrated care has been increasingly embraced in the health care system internationally as noted in the World Health Organization (WHO) 2008 World Report entitled *Primary Health Care - Now More Than Ever*, a call for collaborative primary care across the world (<http://www.who.int/whr/2008/en/>). Additionally, large scale organizations including the United States Military, Veterans Health Administration, Bureau of Primary Care and Private Health Care Organizations have heavily invested in innovative models of integrated care (Kessler & Cubic, 2009). To prepare a workforce capable of providing integrated care, health care professions are re-evaluating education and training models with increased focus on interprofessional collaborative practice competencies (IOM, 2003, WHO, 2010, Interprofessional Education Collaborative Expert Panel, 2011). This call to action is clearly overdue as seasoned clinicians have consistently known that the distinction between medical and psychological care

has always been arbitrary, having more to do with the focus and socialization of practitioner training than the reality of patient care (Twilling, Sockell, & Sommers, 2000).

To move the field forward, academic psychology has a great opportunity to participate in the development of interdisciplinary training and education related to patient-centered care (Cubic, Mance, Turgesen, & Lamanna, in press; Bluestein & Cubic, 2009), patient-centered research (Patient Centered Outcomes Research Institute, 2011) and program development for both the profession of psychology and for other health care disciplines (Cubic & Gatewood, 2008). However, to take advantage of this opportunity psychology as a discipline must prepare trainees with the requisite skills to effectively interface with all of the major stakeholders including primary care patients and their caregivers/advocates, primary care providers (at an individual and systems-based level), payers (both private and public), government regulators, and consumer advocacy organizations (Cubic, 2009).

Collaborations between psychologists and other health care providers can also help break down stigmatization associated with receiving mental health services; unify fractionalized care; identify creative solutions to systems-based barriers; and prevent frustration, burnout, and compassion fatigue amongst providers (Holleman, Bray, Davis, & Holleman, 2004). The positive impact of integrated care appears to be especially true for vulnerable populations such as the homeless (Kwan, Ho, Preston, & Le, 2008) and the elderly (Abeles & Victor, 2003; Molinari, 2003). Psychological and behavioral interventions can enhance prevention efforts by facilitating healthy lifestyles, patient coping, and patient involvement in their own care. It can also aid in the treatment of epidemic conditions such as diabetes, obesity, cancer and cardiac disease (Centers for Disease Control and Prevention, 2004). Lastly, because primary care is also the *de facto* mental health system (deGruy, 1996; Regier et al. 1993) where most patients receive treatment for depression, anxiety, substance abuse and other mental disorders, psychology can provide needed improvement in the availability and quality of these services. In other words, in essence, **integrated primary care psychology can improve physical health and often builds a bridge between the *de facto* mental health system in primary care and specialty mental health.** In doing so, integrated primary care psychology draws on over 20 years of evidence showing that integrated care improves patient access to mental health services in general (Alexopoulos et al., 2009; Watts et al., 2007; Bartels et al., 2004; Liu et al., 2003; Unützer et al., 2002) and may even overcome disparities in mental health access for certain minority groups, e.g. elderly black patients (Ayalon et al., 2007). Integrated care also has been shown to reduce wait times for mental health treatment (Pomerantz et al., 2008), enhance treatment engagement and adherence (Zanjani et al., 2008, Bartels et al., 2004, Hunkeler et al., 2006; Katon et al., 1999, 2002, Pomerantz et al., 2008; Zanjani et al., 2008; Guck et al., 2007), improve patient satisfaction (Pomerantz et al., 2008; Hunkeler et al., 2006; Unützer et al., 2002) and create better clinical and functional outcomes for commonly presenting problems like depression (Alexopoulos et al., 2009; Hunkeler et al., 2006; Katon et al., 2002; Unützer et al., 2002; Katon et al., 1999). Interventions in the primary care setting have similar remission rates and symptom reduction for depression compared to enhanced specialty referral (Krahn et al., 2006) and can result in decreases in at-risk alcohol use comparable to enhanced specialty referral (Oslin et al., 2006). But, to achieve these improved patient response and remission rates fidelity to the integrated care model is important (Oxman et al., 2006)

Psychologists trained to serve in integrated health care settings reflect the goal of preparing psychologists to serve as “health care providers” ready for the 21st Century (Belar 1989, 1995, 1997; DeLeon, Kenkel, & Belar, 2007). Simultaneously, as the demand for integrated care increases, so does the need to adequately prepare psychologists to have the requisite skill sets and competencies to work within these settings. However, faculty and trainees report difficulty determining what integrated care education training encompasses in a rapidly evolving field, where no specific model has yet received universal acceptance ((Cubic & Beacham, in press). Pomerantz, Corson, & Detzer, 2009). The lack of consensus regarding components of service delivery models has several consequences for education and training. Most notably, “just because an internship or fellowship identifies itself as offering training in primary care does not mean they offer an integrated primary care training experience” (Blount & Miller, 2009, p. 114).

In recognition of the paradigm shifts in health care and education, APA issued a report in 1998 that articulated education and training guidelines for interprofessional health care services in primary care settings. More specific recommendations regarding a curriculum for primary care were delineated (McDaniel, Hargrove, Belar, Schroeder, & Freeman, 2003) and it was underscored that programs needed to measure training outcomes (France et al., 2008; Levant, 2005). These recommendations consistently underscore the need for faculty and supervisors to possess specific expertise in clinical service delivery and supervision of trainees in health care settings (Spring et al., 2005; Collins, Leffingwell, & Belar, 2007), and preferably primary care settings as well. The full implementation of these recommendations is yet to be realized.

Terminology

A variety of health care models have been proposed and implemented in primary care settings that result in some degree of physical and mental health integration. The terms *collaborative*, *coordinated*, *co-located*, *care management*, and *integrated* are often used interchangeably to refer to the combined behavioral health/primary care team. Additionally, various terms are used in various settings, for example, within the Veterans Health Administration services of this nature are referenced as *primary care-mental health integration (PC-MHI)* and PC-MHI programs are described as *blended* programs if they incorporate both care management and co-located, collaborative care services.

The key concept that ties these terms together is that they are used to describe a form of mental and behavioral health care services provided in collaboration between mental health professionals and primary care providers. While some of these terms reflect mental and behavioral health care services that are fully integrated into the primary care settings, others reflect services where approaches are used with a degree of collaboration.

Because there is no current consensus about nomenclature, the Primary Care Training Task Force utilized the following terms to reflect education and training of psychologists in the field of primary care until a nomenclature can be clearly, consistently articulated, operationalized, and implemented.

Definitions of Terms Used in this Report

Term	Source, context, connotation
Primary Care	Primary care is the “provision of <i>integrated, accessible</i> health care services by clinicians who are <i>accountable</i> for addressing a large <i>majority of health care needs</i> , developing a <i>sustained partnership with patients</i> , and practicing in the <i>context of family and community</i> (Institute of Medicine [IOM], 1994). Primary care includes, but is not limited to, health promotion and maintenance, disease prevention, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses. Primary care occurs in a variety of health care settings including outpatient clinics, hospitals, critical care settings, long-term facilities and within homes. http://www.aafp.org/online/en/home/policy/policies/p/primarycare.html#Parsys0002
Primary Care Psychology	Application of psychological knowledge and principles in primary care for common physical and mental health problems experienced by patients and families throughout the lifespan (McDaniel, Hargrove, Belar, Schroeder, & Freeman, 2003)
Co-located	Primary care and psychology providers and their trainees deliver care in the same practice setting (Miller, Mendenhall, & Malik, 2009).
Collaborative Care	Primary care and psychology providers and their trainees create ongoing relationships between clinicians to enhance patient care (Miller et al., 2009)
Coordinated Care	Primary care and psychology providers and their trainees practice separately within their respective systems and exchange information as needed (Miller et al., 2009).
Integrated Care	Primary care and mental health providers and their trainees work as a tightly integrated, on-site team with unified care plans (Miller et al., 2009).
Medical Home	A health care setting that facilitates partnership between individual patients and their personal physicians, and when appropriate, the patient’s family (National Committee for Quality Assurance, 2011, www.ncqa.org).
Patient-centered care	“Care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (IOM, 2001).
Integrated Primary Care Psychology*	Application of psychological knowledge and principles in primary care by primary care and psychology providers and their trainees for common physical and mental health problems experienced by patients and families throughout the lifespan utilizing a tightly integrated, on-site teamwork with unified care plans

*This represents a new term devised by the Primary Care Training Task Force.

Background

The Primary Care Training Task Force (PCTTF) was created in January of 2011 and convened its first meeting by teleconference on 3/1/11. Members of the task force were appointed by BEA; their biographical sketches can be found in Appendix A. The task force was funded by BEA to hold regular teleconferences every two weeks; it met face to face in September of 2011

supported by funds allocated for APA Strategic Plan initiatives. Appendix B includes the timetable followed by the PCTTF.

Guiding Principles

The main principles that guided the PCTTF were as follows:

- The field of health care has been and will continue to be in a state of rapid transformation catalyzed further by *Public Law 111-148* (Patient Protection and Affordable Care Act).
- Momentum behind constructs such as the Patient Centered Medical Home (PCMH), http://www.acponline.org/running_practice/pcmh/understanding/guidelines_pcmh.pdf, and Accountable Care Organizations (ACOs), that ensure that the rest of the health care delivery system works in concert with the PCMH, underscores the importance of psychology further developing education and training in integrated primary care psychology.
- APA advocacy should emphasize funding of education and training of psychologists, with special emphasis on (1) ways to achieve parity with funding for medical professionals; and (2) funding of education of psychologists in the newly developing Teaching Health Centers.
- Integrated primary care psychology has unique characteristics and is not simply services provided by psychologists relocated to primary care settings. Furthermore, a focus on primary care psychology does not eliminate the need for the specialty mental and behavioral health services provided by psychologists.
- A strategic plan for education and training in integrated primary care psychology needs to (1) include a workforce analysis so the proper number of psychologists needed in this area are trained; (2) be broad enough to retain the key education and training components that lead to a high quality, traditionally trained clinical/counseling/health psychologist while simultaneously training psychologists to operate within integrated care settings.
- Psychologists partner well with primary care providers because of their ability to provide a range of pragmatic, brief, empirically based assessments and interventions; however, integrated care is an inclusive model that involves many other mental health and behavioral providers. Therefore, as psychology develops education and training opportunities in integrated primary care psychology, close attention needs to be paid to capitalizing on disciplinary distinctiveness and developing experiences that create shared values and common goals between psychologists and all other health care providers in integrated care settings.
- Realistically, most psychology training programs cannot make a radical shift to training in integrated primary care psychology, especially since a number of trainees will still choose to enter specialty mental health care. However, recent trends in the health care field behoove all psychology training programs to introduce trainees to the concepts, culture, patient characteristics, provider characteristics and unique challenges of psychological service delivery

in integrated care and to provide advanced educational experiences for those individuals who have an interest in integrated care. This exposure needs to begin early in the training sequence.

➤ Training programs should use a logical progression model to add integrated care training into their curricula. In doing so, education and training should build on the clinical service delivery models of interdisciplinary medical and behavioral collaboration described in the literature and determine which, if any, of these models may be achievable given current or easily added resources. An exemplar model might be one under development by the Veterans Health Administration that utilizes a continuum approach, with descriptors of how to define and develop programs that meet basic, desirable, and optimal levels of integrated care program functioning. This stepped model provides guidelines for new primary care-mental health integrated settings in first accomplishing core programmatic features, while simultaneously providing benchmarks for more established programs to reach more advanced levels of interdisciplinary functioning.

PCTTF survey results, expertise of the task force members, and review of the literature will all be utilized to develop the final recommendations.

Brief Overview of PCTTF Preliminary Findings

The PCTTF developed and then conducted an electronic survey of 1180 education and training programs in professional psychology to assess psychology's current training in primary care. A total of 230 responses to the survey were received for a response rate of 19.5%. Of these, 111 (48%) provided training at the doctoral level, 126 (55%) at the internship level and 71 (31%) at the postdoctoral level. A description of the most significant findings follows, although the PCTTF expects that work will continue on collecting data and analyzing results. Appendix C provides more in-depth details about the survey findings.

- Albeit not necessarily easy to identify in a single comprehensive resource, education and training opportunities are becoming increasingly available. Fifty-two of the doctoral programs responding offered education and training in primary care, 51% of the internships and 55% of the postdoctoral programs offered education and training in primary care.
 - Unfortunately, while opportunities for education and training in primary care exist, it is not an experience that a majority of trainees receive at the doctoral level.
 - The number of faculty/supervisors at the doctoral and internship level that provide didactics or supervision in primary care is a small percentage of the total number of program faculty.
- Most opportunities across levels of training occur in family medicine, internal medicine and pediatric practices and within settings that identify themselves as PCMHs, Federally Qualified Health Centers and/or Veterans Health Administration programs.
- The most common models of care used are described as integrated or collaborative.
- There is a high degree of variability in the types of experiences trainees receive across sites. These results suggest it is possible that no two sites described as providing training in primary care actually provide similar types of education and training.

- A number of barriers to offering or expanding education and training in primary care exist in general and integrated primary care in particular.
 - Internship and postdoctoral programs appear to face the most barriers, with respondents at both levels of training identifying availability of settings for training as the greatest barrier.
 - Lack of faculty availability and expertise in primary care settings was identified across levels as a barrier and was identified by doctoral programs as the greatest barrier.
 - Financial support for trainees and supervisors was rated across levels as one of the most common barriers.
 - Institutional barriers were also identified by both internship and postdoctoral programs as a significant barrier.
 - Interestingly, training directors perceived that current definitions used by the Association of Psychology Postdoctoral and Internship Centers (APPIC) in the universal application for internship (AAPI) might pose problems for students who trained in primary care despite the fact that the APPI has been revised to include these types of training experiences.
- Supervision of psychology trainees in primary care settings is largely provided by psychologists who work at the primary care site or consult to the primary care site. Rarely is off-site supervision used.
- Adults were reported as the most common population that trainees work with across all levels, but primary care training offered exposure to a wide variety of patient populations.
- Trainees were described as providing a broad range of services in the primary care setting.
 - Intervention was endorsed as an activity that all trainees across all levels regularly provided.
 - Consultation was also rated as a common activity.
 - Training in program development, research in primary care, supervision and teaching were less common across all levels, although postdoctoral programs provided this experience more frequently than doctoral programs or internships.
- Respondents indicated that the primary care setting offered trainees experience with a variety of mental and behavioral health concerns, most commonly including management of chronic diseases, coping with illness, pain management, assessing health and behavior risk factors, and assessment and treatment of a full range of mental health problems (including depression, anxiety, ADHD, serious mental illness, substance abuse, marital and family issues, and parenting issues).
- At all three levels of education and training, training directors indicated that training to prepare for practice in primary care was moderately different than general training in professional psychology.
 - The next most common response was that training for primary care was radically different than general training of professional psychologists.
 - Responses clearly suggest that respondents did not feel that the training needed for primary care was synonymous with the training for health psychology.

Recommendations

The recommendations of the PCTTF are intended to advance the field of psychology by creating a strategic plan for the education and training of psychologists to prepare a workforce for integrated primary care in varied settings. The recommendations are envisioned as integral to maintain the viability of psychologists in a rapidly transforming health care system, and each is linked directly to the strategic plan outlined by APA.

In this section, the task force provides the PCTTF's recommendations followed by a rationale for the recommendation. . Action steps and possible mechanisms for implementation are listed under each recommendation in order of deemed importance by the committee and with respect to their recommendations of priorities for BEA to take action. . Some action steps are easily accomplished and can be achieved relatively rapidly while others will require a philosophical shift and will likely take significantly longer.

Recommendation 1: *It is recommended that APA support innovative ways to educate and train psychologists regarding (physical and mental) health promotion, disease prevention and management of acute and chronic disease across the lifespan to prepare psychologists for integrated primary care in varied settings.*

Rationale: Given the current status of education and training in integrated primary care for psychologists, the task force recognizes that an evolutionary process is needed to move the field forward in regards to training in primary care. The task force views their recommendations as an important expansion of our educational model to shift psychology's identity more firmly towards that of a healthcare profession, and not solely that of a mental health profession. The task force also views this as necessary to prepare psychologists to engage in interprofessional education and practice which is imperative in the context of national trends in healthcare that are moving other health care professions to focus on interprofessional training and competencies.

Additionally, the task force recognizes that the competencies needed to provide integrated primary care services can be considerably different than those needed in general psychology and somewhat different than those needed in clinical health psychology.

To insure that training in integrated primary care complements rather than obstructs training in many other vital domains necessary to meet the foundational and functional competencies of psychologists, the Primary Care Training Task Force recommends that the field first consider short-term mechanisms for meeting the immediate demand to educate psychologists to provide behavioral services in primary care settings. Then, the field must position itself to move towards a more comprehensive, optimal model of training in integrated primary care.

Action Steps and Mechanisms for Implementation:

- 1.1 A work group should be convened to develop guidelines for education and training in integrated primary care psychology at the doctoral, internship and postdoctoral fellowship levels and across the CRSPPP taxonomy levels from exposure through major emphasis. These guidelines need to describe anticipated didactic components/coursework

content, expected service delivery activities and responsibilities, and amount and parameters of supervision and role modeling necessary. Concepts highly relevant to integrated primary care psychology such as interdisciplinary team care, interprofessionalism, health care delivery systems, population based approaches, models of consultation, and program development need to be addressed in the guidelines. These guidelines should insure that curricula provide training in conducting the types of research most relevant to integrated primary care settings to include, but not be limited to, investigations of evidence based assessments and interventions, effectiveness research, program development, quality assurance, and quality improvement. The proposed guidelines should also deal with distinctive issues related to resource requirements (e.g., space) so as to inform bodies such as the Commission on Accreditation (CoA) regarding standard practices in primary care settings.

- 1.2 A work group should be convened by APA to articulate the competencies for integrated primary care psychology through synthesizing existing formulations and developing a consensus report.
 - a. These competencies need to reflect the distinctiveness from as well as the overlap with existing competencies for other areas of professional psychology.
 - b. Essential features of what makes competence in primary care more than practice in a specific setting need to be articulated by delineating the principles and elements of integrated primary care.
- 1.3 Faculty development activities are needed to increase the availability of faculty with requisite competencies to teach and supervise trainees in integrated primary care.
 - a. A repository of resources related to integrated primary care for faculty members should be developed.
 - b. Opportunities for professional development and continuing education in the area of integrated primary care should be developed to include, but not be limited to:
 - i. Continuing education courses and programs that expand on available resources
 - ii. Identification of a resource pool of exemplar faculty consultants.
 - iii. Formalized programs to allow for shadowing of integrated primary care psychologists. When possible, these psychologists should be exemplars in the field.
 - iv. Mentoring networking across institutions.
 - v. Endorsement of utilization of technology (e.g. telesupervision) to allow supervision of supervision of trainees in integrated primary care settings.
- 1.4 APA should convene a work group for developing competency-based evaluation methods and tools that can be effectively and efficiently implemented to assess primary care competencies, to include but not be limited to, Toolboxes, i.e. resources to assist training directors in developing evaluation strategies.
- 1.5 Curricula should be developed to infuse primary care training into educational programs to create (at a minimum) exposure opportunities for trainees regarding integrated primary care.
 - a. Experts in the field should develop introductory and advanced training modules that can be delivered to doctoral, internship, and postdoctoral fellowship programs and easily integrated into current curriculum.

- b. Specific efforts should be made to promote awareness of integrated primary care learning opportunities, including provision of details regarding available resources.
 - c. Each training program should identify one or more faculty members accountable for insuring that trainees receive at a minimum exposure to integrated primary care.
 - d. There should be an articulation of ways programs can infuse content about integrated primary care into the existing curriculum, and the benefits in doing so, to mitigate concerns about the need to add separate courses (e.g. focus on efficiency of primary care training model; how it is population and relationship based; how this type of training impacts aspects of the Guidelines and Principles for Accreditation (G&P), e.g., consultation). This might be accomplished by creating a bulleted list of ways training in primary care could be beneficial to a training program.
 - e. A list of curricular resources, e.g., articles and textbooks that exist, should be compiled and placed on websites that are widely accessible similar to the MedEd Portal model (www.aamc.org). Consideration should be given to partnering with existing resources and those under development such as the initiative by the Patient Centered Primary Care Collaborative (PCPCC; www.pcpcc.org) and funded by the Robert Wood Johnson Foundation.
 - f. Trainees should be taught about credentialing and privileging processes at various settings where integrated primary care psychology occurs.
- 1.6 The areas where training in integrated primary care offers unique learning experiences should be highlighted, including how the model enhances consultation skills and opportunities for working with underserved, diverse populations.
- a. A request should be made to CoA to consider clarifying the competency in consultation required for doctoral programs via an Implementing Regulation to ensure some exposure to concepts of integrated care as an important setting for consultation.
 - b. A set of talking points should be created for all necessary constituents about the importance of integrated primary care regarding training in consultation and underserved populations.
- 1.7 All psychologists, particularly early career psychologists (ECPs), should be educated on the impact of health care reform on models of service delivery, and how they can develop skills and knowledge that will help them adapt to the changing healthcare landscape.
- 1.8 Opportunities for practicum training at the doctoral level should be developed in a manner that demonstrates how training in integrated primary care psychology is useful for the student. Areas to be highlighted include the training in efficient service delivery; achieving breadth as well as depth in service delivery; interdisciplinary opportunities; the

value of relational skills, clinical consultation, and research skills in primary care; and exposure to underserved, diverse populations.

- a. An immediate step should focus on the development of a matchmaking process, at local, regional and national levels, that pairs training programs interested in integrated primary care with available primary care training sites
 - b. APPIC should be asked to review the APPIC Application for Psychology Internships (AAPI) descriptors to insure that activities related to integrated primary care services are accurately reflected.
 - c. CoA should be asked to provide guidance for doctoral programs to ensure that programs feel empowered to offer training in integrated primary care without concerns about meeting accreditation guidelines.
 - d. A document should be created that details myths about integrated primary care and realities to dispel student concerns.
 - e. The use of social networking should be evaluated as a mechanism for informing students about integrated primary care.
 - f. APAGS should be contacted to determine the best mechanism for meeting the needs of the students who have an interest in integrated primary care psychology.
- 1.9 High school and college psychology courses should include information about the roles of psychologists in integrated primary care services.
- a. Career opportunities in integrated care could be included in presentations on the possible roles of psychologists as early as high school.
 - b. Content regarding integrated primary care psychology could be created to be included in lesson plans developed through the Teachers of Psychology in Secondary Schools (TOPSS).
- 1.10 APA should promulgate program development strategies that help programs evolve towards the delivery of exemplary education and training in integrated primary care psychology.
- a. Emphasis should be placed on the dissemination of strong education and training models and practices (i.e., ones that allow for bidirectional primary and behavioral health integrated practice, and ensures that trainees are well versed in concepts related to wellness and disease).
 - b. Grant writing workshops/mentoring that target accessing funds available for training in primary care (e.g. GPE grants, grants with emphasis on interprofessional training) should be developed for training directors.

Recommendation 2: *It is recommended that APA continue efforts to educate the public, other health professions, policy makers, and health care administrators about how psychology fits into integrated primary care.*

Rationale: Rapid changes in the health care arena mean that time is of the essence and that this is an optimal point at which to educate other professionals about the value of psychologists in health care reform endeavors, most notably the patient-centered initiatives. By describing the distinctive competencies of psychologists and how these competencies can benefit other

disciplines, we can insure that this effort does not become guild focused but instead promotes our unique role as part of the team.

The value of integrated care has been demonstrated in the management of chronic health problems that represent our nation's greatest health care costs and risks (e.g., diabetes, asthma, cardiac disease, insomnia, chronic pain; Buysse et al, 2011) and the management of common mental health issues (e.g. depression, anxiety; Katon et al., 2005; Roy-Byrne et al. 2010). In particular, when depression and anxiety are co-morbid with chronic diseases significant cost savings from integrated care have been documented (Katon et al., 2006; Lin et al., 2003). Systems that focus on a stepped care approach to behavioral issues, beginning with guided self-management, hold the greatest promise. Psychologists are ideally trained to design and implement these systems, as well as provide higher level care for patients who do not respond to less intensive steps of care. Unfortunately, creating models of integrated care that are practical, highly effective, and sustainable has been difficult. One source of these difficulties has been workforce readiness issues. Currently, training opportunities in primary care settings and with primary care providers are rarely available for psychology trainees. The creation of interdisciplinary team training models is critical to the success of efforts to create interdisciplinary team based healthcare for the future. Thus, educating other stakeholders is relevant to education and training as it becomes an avenue to increase opportunities and funding for psychology trainees.

Action Steps and Mechanisms for Implementation:

- 2.1 APA should formally endorse the core competencies listed in the *Core competencies for interprofessional collaborative practice: Report of an expert panel* by the Interprofessional Education Collaborative and seek ways to work with other disciplines to meet these core competencies. These competencies were finalized in May 2011 by a collaborative including American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, Association of Schools of Public Health, American Association of Colleges of Pharmacy, American Dental Education Association, and the Association of American Medical Colleges.
- 2.2 The Accreditation Council for Graduate Medical Education (ACGME) accreditation criteria for primary care disciplines should be reviewed to determine ways that psychology can help residency programs meet their criteria. In addition, as many primary care practice sites seek Medical Home status through NCQA, psychology should be educating primary care providers about the new Medical Home rubric that awards credit for integrated services. Marketing strategies should be developed geared toward health care organizations and health care education programs and institutions regarding how co-training with psychologists in integrated primary care benefits residency education (e.g., by improving residents' interprofessional competencies, interpersonal and communication skills, and behavioral sciences knowledge base).
 - a. Educational materials should be developed describing how cross-training opportunities benefit different disciplines – both in terms of meeting clinical care needs and in developing research projects – and are in line with the new interprofessional collaborative practice competency domains.

- 2.3 There should be a focus on developing alliances with academic health centers and federally qualified health centers (FQHCs) to increase the number of training sites for integrated primary care psychology.
- a. Identification of current psychologists in these settings is needed.
 - b. Psychologists in FQHCs and academic health centers should then be linked with the resources described in Recommendation #1 to encourage development of education and training in these settings.
 - c. Marketing materials should be developed for administrators that underscore how education and training of psychologists in integrated primary care psychology benefits primary care settings and the patients they serve.
 - i. Clear, specific talking points/modules should be developed that underscore how psychology's presence allows for a more developed patient-centered focus and reduces cost for the most challenging/costly patients.
 - ii. These materials should vary to address numerous issues of diversity, e.g. rural vs. urban differences, various types of primary care sites.
 - d. APA should increase efforts to work effectively with state and national associations as the health care landscape transforms to capitalize on funding at the national and state level that increases training opportunities in academic health centers, FQHCs, and teaching health centers.
- 2.4 A toolbox should be developed for Training Directors to develop training programs in settings such as academic health centers (AHCs), FQHCs, VAs, etc., to address issues around getting trainees on site, access to electronic health records (EHRs), overcoming space issues, etc.
- 2.5 Modules for staff training on common mental health presentations in primary care (e.g., ways for front desk staff to manage difficult situations); behavioral education tools (e.g., to tie with events such as diabetes awareness week); and tools outlining what a psychologist does in integrated primary care psychology should be developed.
- 2.6 The effectiveness data on integrated primary care psychology should be summarized for the public, with an emphasis on areas with the most support and including accountability data on outcomes.

Recommendation 3: *It is recommended that APA encourage educational programs to further promote research and research training regarding the application of psychological knowledge and how it can be applied to enhance health-care settings, decrease health disparities, and lead to health and wellness (both physical and mental) in integrated primary care settings.*

Rationale: While there is a need for more empirical research on the application of brief psychological assessments and interventions in primary care there is a misunderstanding regarding the amount of available empirical data that already exists to support integrated primary care services. Additionally, psychologists in general might benefit from opportunities to enhance their understanding of how primary care settings serve as optimal settings for the integration of

research and service delivery. Because health care reform provides numerous opportunities for psychology to shape the field through research looking at patient centered initiatives, psychologists need to better understand and further expand the research in integrated care psychology.

Action Steps and Mechanisms for Implementation:

- 3.1 A task force should be developed with members appointed who have expertise in primary care psychology and represent a breadth of perspectives including education, science, practice and public interest to synthesize available research in integrated primary care psychology.
 - a. Areas to highlight should be those where the research is the strongest.
 - b. Additionally, the task force should make recommendations regarding areas in need of the greatest amount of additional research. In this regard, resources for APA to pair with would be the Veterans Health Administration Center for Integrated Healthcare and the Veterans Health Administration PC-MHI Evaluation Office which have both already dedicated resources to evaluating the effectiveness of integrated care.
- 3.2 A recommendation should be made to BSA to offer an award on research in primary care psychology research (especially at the early career level).
- 3.3 Mechanisms should be developed to allow increased research on the application of evidence-based practices to integrated primary care psychology and their effectiveness. In particular, research is needed on whom to treat within the primary care setting versus referred for specialty mental health care.
- 3.4 Research curricula should provide training opportunities for trainees to conduct program development, quality assurance, and quality improvement projects and teach trainees to use treatment outcome measures.
- 3.5 Curriculum content in the area of integrated primary care should focus on those areas with the most empirical data regarding their effectiveness (e.g. insomnia, depression).
- 3.6 APA should encourage consideration of psychology trainees for awards offered by Collaborative Family Healthcare Association (CFHA), Society of Teachers of Family Medicine (STFM), American Academy of Family Physicians (AAFP) and other primary care organizations.
- 3.7 Linkages should be created between psychology departments and training programs with primary care settings and primary care psychologists to create research opportunities.
 - a. A clearinghouse of primary care settings that are seeking research trainees (to increase opportunities for dissertation and theses) and nearby psychological training programs/resources should be developed.
 - b. Documents/modules on how to overcome barriers in doing research in primary care settings should be created.
 - c. Mechanisms for easy identification for grant and funding opportunities for psychology to do patient-centered research in primary care settings should be identified.

- d. Recognition and awards dedicated to graduate, internship and postdoctoral programs that foster research in integrated primary care psychology should be prioritized.

Recommendation 4: *It is recommended that APA and the APA Practice Organization should continue to focus on advocacy efforts that allow for the funding of education and training of psychologists, the inclusion of psychology in integrated care and other health-care reform policies (to include, but not be limited to, reimbursement issues).*

Rationale: A number of administrative, operational, financial and institutional barriers inhibit the opportunities for education and training in integrated primary care psychology. Many of these barriers are related to reimbursement issues for the provision of psychological services in integrated care as well as limited funding existing to support training specifically for psychologists in integrated primary care psychology. This is most apparent for internships and postdoctoral fellows because of funding and licensure issues.

Action Steps and Mechanisms for Implementation:

- 4.1 From a workforce development perspective, barriers to expansion may be lowest at the doctoral level. It is essential that APA prioritize development of practica in integrated primary care settings through informal means as a mechanism for starting to establish a presence of interprofessional training and integrated care.
- 4.2 APA advocacy should place a strong emphasis on funding for education and training of psychologists, with special emphasis on (1) ways to achieve parity with funding for GME; and (2) funding of education of psychologists in teaching health centers.
- 4.3 APA and APAPO should continue advocacy for (1) alterations to the CPT codes so they are more applicable to how psychologists practice, (2) same day billing issues; (3) appropriate reimbursement of services; (4) psychologists' inclusion in the definition of physician; as well as (5) offering education regarding Health and Behavior Codes.
- 4.4 CoA should be encouraged to further evaluate costs and benefits of allowing provisional APA approval status for newly developing internship and postdoctoral fellowships sites in integrated primary care.
- 4.5 APA should be encouraged to advocate for the inclusion of psychology in future interprofessional activities such as those that lead to the development of the *Core competencies for interprofessional collaborative practice: Report of an expert panel*.

Recommendation 5: *APA should continue to evaluate ways to measure and improve education and training efforts in the area of integrated primary care psychology.*

Rationale: The Primary Care Training Task Force utilized survey results and expert consensus to make recommendations to APA regarding training in integrated primary care psychology. The task force acknowledges there were limitations to the survey data, including the low response rate and survey length. Given the critical importance of clear information about current psychology training in integrated primary care psychology, the task force recommends that BEA continue to ascertain the status of education and training in the field.

Action Steps and Mechanisms for Implementation:

- 5.1 In the Fall of 2011, additional efforts should be made to circulate the survey utilized by the Primary Care Training Task Force to increase the sample size. It is noted that the survey was originally launched during the summer, which was probably not optimal for reaching programs organized around the academic calendar.
- 5.2 Efforts should be made to contact doctoral programs directly and to review websites to determine the degree of training in integrated primary care psychology, as it seems the least is known about education and training efforts at the doctoral level.
- 5.3 The current survey focused on faculty, but it may be worthwhile to survey members of other populations that participate in integrated care such as students, early career psychologists (both those who do and do not practice in integrated care), administrators, and trainees and educators from other primary care professions.

Conclusion

Time is of the essence for psychology to formalize a strategic plan for training in primary care settings as rapid changes in the health care arena are occurring. Additionally, this is an optimal timeframe to further educate other professionals about the value of psychologists in health care reform endeavors, most notably the patient centered initiatives. It is the viewpoint of the PCTTF that a psychology workforce that can address psychological and behavioral aspects of health care within primary care is vital to the advancement of the discipline. More opportunities for psychology trainees to receive education and training within practica, internships and postdoctoral fellowships in primary care settings need to be developed in order to address the reality that most patients seek their mental health treatment in primary care. These educational settings need to pay close attention to developing experiences that create the shared values and common goals between primary care providers and psychologists needed for trainee internalization of integrated care precepts.

References

- Abeles, N., & Victor, T. (2003). Unique opportunities for psychology in mental health care for older adults. *Clinical Psychology: Science and Practice, 10*, 120-124.
- Alexopoulos, G. S., Reynolds, C. F., Bruce, M. L., Katz, I. R., Raue, P. J., Mulsant, B. H., et al. (2009). Reducing suicidal ideation and depression in older primary care patients: 24-month outcomes of the PROSPECT study. *American Journal of Psychiatry, 166*, 882–890.
- Ayalon, L., Arean, P., Linkins, K., McCulloch, C. E., Linkins, K., Hongtu, C., et al. (2007). Integration of mental health services into primary care overcomes ethnic disparities in access to mental health services between black and white elderly. *American Journal of Geriatric Psychiatry, 15*, 906-912.
- Bartels, S. J., Coakley, E. H., Zubritsky, C., Ware, J. H., Miles, K. M., Arean, P. A., et al. (2004). Improving access to geriatric mental health services: A randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry, 161*, 1455–1462.
- Belar, C.D. (1989). Opportunities for psychologists in health maintenance organizations: Implications for graduate education and training. *Professional Psychology: Research and Practice, 20*, 390-394.
- Belar, C.D. (1995). Collaboration in capitated care: Challenges for psychology. *Professional Psychology: Research and Practice, 26*, 139-146.
- Belar, C. D. (1997). Clinical health psychology: A specialty for the 21st Century. *Health Psychology, 16*, 411-416.
- Blount, F.A., & Miller, B.F. (2009). Addressing the workforce crisis in integrated primary care. *Journal of Clinical Psychology in Medical Settings, 16*, 113-119.
- Bluestein, D., & Cubic B. A. (2009). Psychologists and primary care physicians: A training model for creating collaborative relationships. *Journal of Clinical Psychology in Medical Settings, 16*, 101-112.
- Buysse, D. J., Germain, A., Moul, D. E., Franzen, P. L., Brar, L. K., Fletcher, M. E., et al. (2011). Efficacy of brief behavioral treatment for chronic insomnia in older adults. *Archives of Internal Medicine, 171*, 887-895.
- Centers for Disease Control and Prevention. (2004). Mortality data from the national vital statistics system. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics. Available at <http://www.cdc.gov/nchs/about/major/dvs/desc.htm>.

- Collins, F. L., Leffingwell, T. R., & Belar, C. D. (2007). Teaching evidence-based practice: Implications for psychology. *Journal of Clinical Psychology, 63*, 657-670.
- Cubic, B.A. (Fall, 2009). The importance of interprofessional training opportunities to create an integrated care workforce for integrated care. *Register Report, 35*, 19-25.
- Cubic, B.A., & Gatewood, E. (2008). Roles for AHC psychologists in assisting physicians in meeting ACGME core competencies. *Journal of Clinical Psychology in Medical Settings, 15*, 28-39.
- Cubic, B. A., Mance, J., Turgesen, J., & Lamanna, J. (In press). Training psychologists to provide integrated care: Current educational models and future directions. *Journal of Clinical Psychology in Medical Settings, 18*.
- Cubic, B. A., & Beacham, A. O. (in press). Creating educational and training opportunities for psychology trainees in integrated care. In Hunter, C., Hunter, C. & Kessler, R. S. (Eds.) *Handbook of clinical psychology in medical settings: Evidence based assessment and intervention*. New York, Springer.
- deGruy, F. (1996). Mental health care in the primary care setting. In M. S. Donaldson, K. D. Yordy, K. N. Lohr & N. A. Vanselow (Eds.), *Primary care: America's health in a new eEra*. Washington, D.C.: Institute of Medicine.
- DeLeon, P., Kenkel, M., & Belar, C. (2007). Community health centers can reduce health disparities and train the next generation of psychologists. *Monitor on Psychology, 38*.
- Guck, T., Guck, A., Brack, A., & Frey, D. (2007). No-show rates in partially integrated models of behavioral health care in a primary care setting. *Families, Systems, and Health, 25*, 137-146.
- Hunkeler, E. M., Katon, W., Tang, L., Williams, J. W., Jr., Kroenke, K., Lin, E. H. et al. (2006). Long term outcomes from the IMPACT randomized trial for depressed elderly patients in primary care. *British Medical Journal, 332*, 259-263.
- Holleman, W. I., Bray, J. H., Davis, L., & Holleman, M. C. (2004). Innovative ways to address the mental health and medical needs of marginalized patients: Collaborations between family physicians, family therapists, and family psychologists. *American Journal of Orthopsychiatry, 74*, 242-252.
- Interprofessional Education Collaborative Expert Panel. (May, 2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, D.C.: Interprofessional Education Collaborative.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

- Institute of Medicine (2003). *Health professions education: A bridge to quality*. Washington, DC: National Academy Press.
- Katon W.J., Schoenbaum, M., Fan, M.Y., Callahan, C.M., Williams, J.W., Jr, Hunkeler, E., et al. (2005) Cost-effectiveness of improving primary care treatment of late-life depression. *Archives of General Psychiatry*, 62, 1313-1320.
- Katon, W., Russo, J., Von Korff, M., Lin, E., Simon, G., Bush, T., Ludman, E., & Walker, E. (2002). Long-term effects of a collaborative care intervention in persistently depressed primary care patients. *Journal of General Internal Medicine*, 17, 741–748.
- Katon, W.J., Unützer, J., Fan, M.Y., Williams, J., Schoenbaum, M., Lin, E. et al. (2006) Cost effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression. *Diabetes Care*. 29, 265-270.
- Katon, W., Von Korff, M., Lin, E., Simon, G., Walker, E., Untzer, J. et al. (1999) Stepped collaborative care for primary care patients with resistant symptoms of depression. *Archives of General Psychiatry*, 56, 1109 -1115.
- Kessler, R. S., & Cubic B. A. (2009). The train is leaving the station: Is psychology on board? *Journal of Clinical Psychology in Medical Settings*. 16, 1-3.
- Krahn, D.D., Bartels, S. J., Coakley, E., Oslin, D. W., Chen, H., McIntyre, J., et al., 2006. PRISM-E: comparison of integrated care and enhanced specialty referral models in depression outcomes. *Psychiatric Services*, 57, 946–953.
- Kwan, L., Ho, C. J., Preston, C. & Le, V. (2008). Puentes clinic: An integrated model for the primary care of vulnerable populations. *Permante Journal*, 12, 10-15.
- Lin, E.H.B., Katon, W.J., Von Korff, M., Tang, L., Williams, J.W. Jr., Kroenke, K., et al. (2003). Effect of improving depression care on pain and function among older adults with arthritis. *JAMA*, 290, 2428-2803.
- Liu, C. F., Hedrick, S. C., Chaney, E. F., Heagerty, P., Felker, B., Hasenberg, N., et al. (2003). Cost-effectiveness of collaborative care for depression in a primary care Veteran population. *Psychiatric Services*, 54, 698–704.
- McDaniel, S., Belar, C., Schroeder, C., Hargrove, D., & Freeman, E. (2002). A training curriculum for professional psychologists in primary care. *Professional Psychology: Research and Practice*, 33, 65-72.
- Miller, B.F., Mendenhall T.J., & Malik, A.D. (2009). Integrated primary care: An inclusive three-world view through process metrics and empirical discrimination. *Journal of Clinical Psychology in Medical Settings*, 16, 21-30.

- Molinari, V. (2003). Nursing homes as primary care sites for psychological practice. *Clinical Psychology: Science and Practice, 10*, 112-114.
- National Committee for Quality Assurance. (2011). Patient centered medical home defined. Available from www.ncqa.org.
- Oslin, D.W. (2006). Substance Abuse. In Calhoun, K. and Eibling, D.E. (eds). *Geriatric Otolaryngology*, Marcel Dekker.
- Oxman, A.D., Fretheim, A., & Schünemann, H. J. for the Subcommittee on the Use of Research Evidence of the WHO Advisory Committee on Health Research. 2006. "Improving the Use of Research Evidence in Guideline Development: Introduction." *Health Research Policy and Systems, 4*: 12.
- Patient Centered Outcomes Research Institute (2011). Patient centered outcomes research defined. Available from <http://www.pcori.org/pcorinput.html>
- Pomerantz, A. S., Corson, J. A., & Detzer, M. J. (2009). The challenge of integrated care for mental health: Leaving the 50 minute hour and other sacred things. *Journal of Clinical Psychology in Medical Settings, 16*, 40-46.
- Pomerantz, A., Cole, B. H., Watts, B. V., & Weeks, W. B. (2008). Improving efficiency and access to mental health care: combining integrated care and advanced access. *General Hospital Psychiatry, 30*, 546-51.
- Regier, D., Narrow, W., Rae, D., Manderscheid, R., Locke, B., & Goodwin, F. (1993). The de facto mental health and addictive disorders service system. *Archives of General Psychiatry, 50*, 85-94.
- Roy-Byrne, P., Craske, M. G., Sullivan, G., Rose, R.D., Edlund, M. J., Lang, A. J., et al. (2010). Delivery of evidenced based treatment for multiple anxiety disorder in primary care: A randomized controlled trial. *JAMA, 303*, 1921-1928.
- Twilling, L. L., Sockell, M. E., & Sommers, L. S. (2000). Collaborative practice in primary care: Integrated training for psychologists and physicians. *Professional Psychology: Research and Practice, 31*, 685-691.
- Unutzer, J. W. Katon, C. M. Callahan et al. 2002. Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA, 288*, 2836-2845.
- Veterans Health Administration (2011). Blended Program Functional Tool for Primary Care Mental Health Integration. Internal Document Draft, Washington, DC: U.S. Department of Veterans Affairs.

Watts, B.V., Shiner, B., Pomerantz, A., Stender, P., & Weeks, W.B. (2007). Outcomes of a quality improvement project of integrated mental health into primary care. *Quality and Safety in Healthcare, 16*, 378-381.

World Health Organization. (2008). 2008 World Report: Primary health care -Now more than ever. Available from <http://www.who.int/whr/2008/en/>

World Health Organization. (2010). Framework for action on interprofessional education and collaborative practice. Available from http://www.who.int/hrh/resources/framework_action/en/

Zanjani, F., Miller, B., Turiano, N., Ross, J., & Oslin, D. (2008). Effectiveness of telephone-based referral care management, a brief intervention to improve psychiatric treatment engagement. *Psychiatric Services, 59*, 776-781

Appendix A

Biosketches of the Task Force Members

Barbara Ann Cubic, Ph.D. (Chair, PCTTF) is an Associate Professor at Eastern Virginia Medical School (EVMS) with joint appointments in the Department of Psychiatry and Behavioral Sciences and the Department of Family and Community Medicine. She serves as the Co-Director of the EVMS Clinical Psychology Internship Program and Director of the EVMS Center for Cognitive Therapy. She is a Certified Cognitive Therapist and Founding Fellow of the Academy of Cognitive Therapy and her clinical and research interests are in cognitive behavioral therapy, eating disorders, psychological aspects of bariatric surgery, and primary care psychology. She has been awarded multiple state and national funding grants focused on preparing psychologists to work in integrated care settings. In 2002, she wrote one of the first funded HRSA Graduate Psychology Education grants and has secured a total of three HRSA Graduate Psychology Education grants focused on training psychologists and primary care physicians to provide integrated care. She has also received two substantial grants from the State of Virginia for Workforce Development. She serves as the editor of the *Journal of Clinical Psychology in Medical Settings* and President-Elect for the Association of Psychologists in Academic Health Centers. In 2010 she was awarded the Cummings PSYCHE Prize by the American Psychological Foundations for her work in Integrated Care.

Chris Neumann, Ph.D. earned his Ph.D. in clinical psychology from Oklahoma State University, with an emphasis in health psychology. He completed his pre-doctoral internship at the University of Alabama Birmingham Training Consortium and postdoctoral residency at Florida International University, where he worked primarily with Hispanic/Latino adolescents who were at risk for alcohol and substance use disorders. Dr. Neumann has received extensive training in Motivational Interviewing and has been a member of the Motivational Interviewing Network of Trainers since 2007. Currently, Dr. Neumann is an Associate Professor at Forest Institute, Chair of the Diversity Committee and the Director of the Primary Care Psychology program. In addition to serving as the Director of the program, he also teaches several courses in integrated primary care psychology and provides clinical supervision in a community health center which serves and uninsured population. His primary clinical and research interests include primary care psychology, motivational interviewing, and addressing inequalities in health care.

Lisa Kearney, Ph.D. is the National Integrated Care Coordinator for VA Central Office, Office of Mental Health Operations. Previously she served as the Chief, Director of Training, Assistant Chief, and Primary Care-Mental Health Integration Psychologist at the South Texas Veterans Health Care System. In addition to serving on the AVAPL Executive committee, she has also have been dedicated to service in other psychology communities locally and at the national level, including President of the Bexar County Psychological Association, Conference Chair for the VA Psychology Leadership Conference, and Secretary of the APPIC Board. She previously served as the VA VISN 17 Primary Care-Mental Health Integration Lead, assisting VA facilities in initiating primary care-mental health integration programs locally. Dr. Kearney is appointed as Clinical Assistant Professor of Psychiatry at the University of Texas Health Science Center,

where she is involved in the training of medical students, psychiatry residents, and pharmacy residents. Her primary professional interests include establishing interdisciplinary programs to address chronic medical conditions, such as diabetes, chronic pain, and hypertension, and integrated primary care clinics; training of future psychologists; and research in gender/cultural dynamics in therapy and program outcomes related to brief psychological interventions in primary care settings.

Robert E. McGrath, Ph.D. is a Professor in the School of Psychology at Fairleigh Dickinson University, Teaneck NJ. Currently he serves as the Director of Training for the Ph.D. Program in Clinical Psychology, the Postdoctoral M.S. Program in Clinical Psychopharmacology, and the new Certificate Program in Integrated Primary Care. He is a former President and current Council Representative for APA Division 55 (American Society for the Advancement of Pharmacotherapy). He is also Co-Chair of Division 38's (Health Psychology) Integrated Primary Care Committee. He maintains an active research program in assessment, measurement, methodology, and professional issues in psychology. He has received the Martin Mayman Award from the Society for Personality Assessment for his theoretical contributions to the study of personality assessment. In 2010 he was the lead psychologist for the team that revised the disability rating schedule for mental disorders used by the Veterans Benefits Administration. In 2011 he was awarded Fairleigh Dickinson's Distinguished Faculty Award for Research and Scholarship in recognition of his over 150 publications and presentations.

Nancy Ruddy, Ph.D. is the Director of the Behavioral Science Program at Mountainside Family Practice Residency in Verona, NJ. She was on faculty in the Departments of Family Medicine and Psychiatry at the University of Rochester School of Medicine and Dentistry from 1991-2000. From 2001-2008 she served on the faculty of the Hunterdown Family Practice Residency in Flemington, New Jersey. In each of these settings her focus has been on training medical students, family medicine residents, family therapists and psychologists to work together effectively. To expand the mission of increasing collaboration and communication between mental health and medical professionals she published *The Collaborative Psychotherapist: Creating Reciprocal Relationships with Medical Professionals* with APA Books in 2008. She currently serves on the Division 38 (Health Psychology) Integrated Primary Care Committee, the Commission on Accreditation, and Patient Centered Primary Care Collaborative Workforce Readiness and Behavioral Health Task Forces. In addition, she maintains an independent practice in Mountain Lakes, New Jersey.

Bruce Rybarczyk, Ph.D. is an Associate Professor and the Director of Training at the Clinical Psychology at Virginia Commonwealth University (VCU). Prior to that he was an Associate Professor and Director of Training for the internship at Rush University Medical Center in Chicago for 18 years, While at Rush he earned his ABPP diplomate in rehabilitation psychology and was the principal investigator for a 6-year NIH study testing the efficacy of CBT for insomnia that is co-morbid chronic medical illness. His research has covered several areas related to adaptation to chronic medical conditions including psychological adjustment to amputation, heart transplant and stroke, designing and testing coping enhancement and wellness interventions for older medical patients and testing self-help and classroom cognitive-behavioral treatments for insomnia. Current grant funding and research is focused on training doctoral students in primary care psychology and testing brief interventions for this setting. He has a 3-

year HRSA Graduate Psychology Education grant and Virginia Health Care Foundation grant to facilitate the integrated care training program at VCU. He is also an Associate Editor of the *Journal of Clinical Psychology*.

Anthony Zamudio, Ph.D. is an Associate Professor of Clinical Family Medicine at the Keck School of Medicine of USC and the Behavioral Science Director at the USC Family Medicine Residency Program at California Hospital. He has over twenty years of clinical and teaching experience with medical students, family medicine residents, psychology graduate and post doctoral students on the psychosocial aspects of primary care. He's a generalist with experience in various theoretical models of treatment with children, teens, adults and geriatric populations from working in community mental health, university counseling, child guidance, and medical HMO inpatient and outpatient settings. His publications focus on the clinical encounters in primary care and residency education. His conference presentations and guest lectures address the psychology of medical education for mental health providers working in primary care. He currently serves on the Los Angeles County Psychological Association Ethic's Committee and a former ethic's member of the California Psychological Association. His research interests focus on the utilization and mental health service delivery for underserved ethnic minorities and gay and lesbian populations. He received intensive clinical training in Integrative Couple Behavioral Therapy through an NIMH research grant under the supervision of Andrew Christensen, Ph.D. at UCLA and Neil Jacobson, Ph.D. at University of Washington.

Appendix B

PRIMARY CARE TRAINING TASK FORCE TIMETABLE

<u>Steps</u>	<u>Goal and Activities</u>	<u>Target Date</u>	<u>Goal</u>
One	<p>Develop clear definitions of activities related to education and training and various models of psychologists providing services within primary care (e.g. collaborative care, co-located practice, integrated care)</p> <ol style="list-style-type: none"> 1. PCTTF members to share key articles related to definitions of models 2. APA to develop a team site as a repository for seminal articles related to definitions of models as well as other materials that the PCTTF may need to share 	March 2011	
Two	<p>Develop a survey to determine the current state of education and training of psychologists in primary care settings to include what training is occurring in primary care, if training in primary care is not occurring why not, funding streams for training, other resources needed for training, assessment and intervention techniques taught to trainees, skills and competencies measured and assessment tools to evaluate those competencies.</p> <ol style="list-style-type: none"> 1. Robert McGrath to contact members within Division 38's Integrated Primary Care Committee (IPCC to determine whether PCTFF and IPCC can work collaboratively on a survey 2. Develop a comprehensive list of graduate programs, internships and postdoctoral fellowships to survey 	April 2011	
Three	<p>Disseminate a survey to determine the current state of training of psychologists in primary care settings</p>	July 2011	

Four	Tabulate survey results to determine the current state of training of psychologists in primary care settings	August 2011
Five	<p>Identify some of the key barriers to education and training of psychologists in primary care</p> <ol style="list-style-type: none"> 1. Synthesize the results of the survey 2. Attempt to define programs that did provide training in primary care and no longer do so and request information about reasons the program was discontinued 	August 2011
Six	Finalize report from PCTTF to BEA	October 2011

Appendix C

Primary Care Training Task Force Preliminary Findings

The Primary Care Training Task Force developed and then conducted an electronic survey of education and training programs in professional psychology to assess psychology's current training in primary care. A description of the preliminary findings follows, although the Task Force expects that work will continue in collecting data and analyzing results.

An email invitation requesting participation in the survey was sent to 1180 directors of training from APA accredited doctoral programs, and APA accredited and APPIC member internship and postdoctoral programs, as well as CAPIC (California Psychology Internship Counsel) postdoctoral programs. Two email reminders were sent to individuals who did not complete the survey at approximately one week intervals. In addition, general requests to complete the survey were forwarded to relevant psychology listservs. This resulted in 194 responses, given this low response rate (16%) in November 2011 the survey request was sent again to those programs who had not responded to the initial requests for participation. It was hoped that the fall might be a better time to recruit participants than the initial launch of the survey which took place during the summer of 2011. An additional 36 completed surveys were obtained. Results reported below reflect all responses received or 230 responses (approximate response rate of 19.5%). Of these, 111 (48%) provided training at the doctoral level, 126 (55%) at the internship level and 71 (31%) at the postdoctoral level. In that programs provide training at multiple levels, respondents were asked to identify at what levels they provided training, as seen below, a majority (72%) of respondents were responsible for training at one level.

Table 1: Percentage of Training Directors Responding by Type of Training Program

Type of Training Program	Percent of Respondents
Doctoral program	34.5
Internship program	28.8
Postdoctoral program	8.8
Doctoral and internship program	5.2
Internship and postdoctoral program	13.1
Doctoral and postdoctoral program	1.3
Doctoral, internship and postdoctoral program	8.3

The survey methodology utilized logic mechanisms such that individuals responded to questions specific to the level(s) of education and training for which they were responsible. In some cases, survey questions were nested such that additional questions would appear contingent on the response to a previous question. In addition, in recognition of the considerable length of the survey (see limitations section below) the survey was divided such that approximately one-third of the way through the survey respondents were asked whether they wished to continue answering questions or conclude the survey. Seventy-five respondents elected to continue. As a result, the number of responses varies by item.

Early in the survey respondents were asked if their education and training program offered opportunity for training in primary care. Programs that indicated they did not offer training in primary care were asked to identify from a list of reasons why training was not offered:

Table 2: Reasons Programs do Not Offer Training in Primary Care by Level of Training

	Doctoral (n=54)	Internship (n=63)	Postdoctoral (n=33)
Does not fit with the program's training model	18.5%	19.1%	21.2%
Settings for training not available	42.6%	63.5%	60.6%
Faculty to provide the training not available	51.9%	41.3%	33.3%
Trainees do not show interest in the area	11.1%	4.8%	6.1%
Training in primary care not deemed relevant to needed competencies	9.3%	17.5%	21.2%
Other	42.5%	22.2%	15.2%

Internship and postdoctoral programs both identified availability of settings for training as the most common reason for not providing education and training in primary care, this was the second highest rated (42.6%) reason endorsed by doctoral programs. Faculty availability was also identified across levels as a reason for not offering training in primary care and was the most common reason identified by doctoral programs .

Training opportunities in primary care: Fifty-nine (52%) of the doctoral programs responding indicated that they offered education and training in primary care compared to 65 (51%) of the internships and 40 (55%) of the postdoctoral programs.

Programs who indicated that they offered training in primary care were then asked to respond to a series of questions in order to obtain a description of program characteristics, opportunities available and perceptions about education and training in primary care. The most relevant results are described below.

Types of training settings: The top three primary care practice sites identified did not vary greatly across levels of training. Doctoral and internship programs both reported outpatient family medicine, outpatient internal medicine, and outpatient pediatrics as most common. Postdoctoral programs reported outpatient family medicine, outpatient internal medicine, and inpatient internal medicine as the most common practice sites. Respondents were also asked to identify the setting in which primary care education and training was occurring.

Table 3: Primary Care Practice Sites by Level of Training

	Doctoral (n = 31)	Internship (n = 34)	Postdoctoral (n = 31)
Patient-centered medical home	38.7%	44.1%	58.1%
Community health center	35.5%	11.8%	16.1%

Community mental health center	6.5%	5.9%	0.0%
Academic health center	41.9%	23.3%	32.3%
Federally Qualified Health Center	48.4%	14.7%	25.8%
Military setting	6.5%	2.9%	0.0%
Veterans Administration	22.6%	47.1%	32.3%
Rural Health Center	16.1%	8.8%	16.1%
Other	19.4%	20.6%	12.9%

Results indicate that education and training in primary care is occurring in a wide variety of settings with the patient centered medical home reported as common across all three levels; it was the most common setting for postdoctoral programs. For doctoral programs, Federally Qualified Health Centers were the most common, while for internship programs training was most frequently occurring in Veterans Health Administration programs.

The model trainees receive the most exposure to when providing primary care psychology services was self-described by respondents as the following:

Table 4: Primary Care Model by Level of Training

	Doctoral (n = 30)	Internship (n = 34)	Postdoctoral (n = 29)
Care management	0.0%	5.9%	6.9%
Collaborative care	33.3%	32.3%	20.7%
Co-located practice	10.0%	5.9%	6.9%
Integrated practice	46.7%	47.1%	51.7%
Unsure	3.3%	2.9%	0.0%
Other	6.7%	5.9%	13.8%

While a caution must be raised that programs may have differing definitions for the models, integrated practice was rated at all levels as the most common model followed by collaborative care.

Table 5: Program and Faculty Size by Level of Training

	Doctoral	Internship	Postdoctoral
Median number of trainees in program	31	5	3
Median number of trainees receiving primary care training	5	3	2
Median number of faculty	10	18	9
Median number of faculty who provide didactics in primary care psychology	2	2	3
Median number of faculty who provide supervision in primary care psychology	2	3	3

Program faculty/supervisors and trainees:

A higher percentage of trainees in internship (60%) and postdoctoral (66%) settings were receiving training in primary care as compared to doctoral programs (16%). In addition, the number of faculty who provided either didactics or supervision was a minority of the overall program faculty for doctoral (40%) and internship programs (28%). For postdoctoral programs, respondents indicated that 66% of program faculty members were providing either didactics or supervision. These results indicate that education and training in primary care is not an experience that a majority of trainees receive at the doctoral level, and that the number of faculty/supervisors at the doctoral and internship level providing didactics or supervision in primary care are a small percentage of the total number of program faculty.

Supervision of psychology trainees in primary care settings is largely provided by psychologists who work at the primary care site (77, 88, and 86% respectively by level of education and training) or who consult to the primary care site (45, 26, and 31% respectively). Supervision by a psychologist off-site is used less frequently (35, 12, and 17%) although this occurs somewhat more frequently at the doctoral level. Finally, supervision by other health professionals does occur, but was reported as the least frequent category of supervision provider with 19, 15, and 3% by level respectively.

Breadth and depth of education and training opportunities available: Respondents reported on the variety of patient populations trainees are exposed to in the primary care setting as seen below.

Table 6: Patient Populations Served by Level of Training

	Doctoral (n=31)	Internship (n=34)	Postdoctoral (n=30)
Adult	87.1%	88.2%	90.0%
Pediatrics	61.3%	41.2%	46.7%
Adolescents	61.3%	47.1%	46.7%
Geriatrics	61.3%	70.6%	73.3%
Families	45.2%	58.8%	53.3%
Couples	38.7%	44.1%	46.7%

While adults were reported as the most common population that trainees work with across all levels, replies to this question suggest that primary care offers opportunity for exposure to a wide variety of patient populations.

Trainees were further described as providing a broad range of services in the primary care setting:

Table 7: Services Provided by Level of Training

	Doctoral (n=31)	Internship (n=34)	Postdoctoral (n=30)
Assessment	96.8%	91.2%	83.3%
Intervention	100.0%	100.0%	100.0%
Consultation	90.3%	94.1%	93.3%
Program development	35.5%	35.3%	73.3%

Research in primary care psychology	32.3%	35.3%	60.0%
Teaching to others in areas or settings specific to primary care	16.1%	35.3%	70.0%
Supervision	29.0%	23.5%	50.0%

Intervention was endorsed as an activity in which all trainees participate across all levels. Consultation was also rated quite common. Training in program development, research in primary care, supervision and teaching were reported to occur less frequently across levels. However, consistent with a developmental approach to education and training, postdoctoral programs provided this experience more frequently than doctoral programs or internships.

Further, respondents indicated that the primary care setting offered trainees experience with a variety of mental and behavioral health concerns. For students at the doctoral level, management of chronic diseases (90%), coping with illness (90%), pain management (87%), and health and behavior risk factors (84%) were reported as the most common concerns addressed, followed by other mental health problems (77%; e.g., depression, anxiety, ADHD), serious mental illness (61%), substance abuse (55%), and marital and family issues, learning or cognitive difficulties, and parenting (each 52%). Internship programs reported that other mental health problems were the most common issue (94%) trainees addressed in the primary care setting, followed by coping with illness and pain management and health behavior risk factors (82% each), substance abuse (76%) and serious mental illness (71%).

Not surprisingly, postdoctoral education and training programs reported trainees were exposed more frequently to a wide variety of behavioral and mental health issues. The most common issues encountered by trainees were health behavior risk factors (96%), other mental health problems, coping with illness, and pain management (each at least 90%). Chronic disease management and substance abuse were each rated as issues to which at least 80% of trainees were exposed. While rated as somewhat less frequent in occurrence, trainees at the postdoctoral level also frequently obtained experience with marital and family issues (67%), death and dying (56%), serious mental illness (53%), and parenting (53%). More advanced professional activities such as staff development and quality improvement were reported for 53% and 50% of postdoctoral training sites. These were not as common for doctoral (26% and 19% respectively) or internship (32% and 26%) programs.

Respondents also answered a series of questions to describe the depth of education and training opportunities in primary care that are available to trainees. When asked if the training experience was an elective or required component of the program, a clear difference emerged across levels. Postdoctoral programs were more likely to report this experience was required for all students in the program (65%). In contrast, doctoral programs and internship programs were more likely to describe it as being an elective experience (68% and 45% respectively). Consistent with these results, when asked about the minimum level of education and training in primary care expected by the program of all trainees ranging from exposure at the low end to experience to emphasis to major area of emphasis at the high end, doctoral and internship

programs reported no minimum expectation (47% and 46% respectively). Postdoctoral programs were split between expecting experience for all trainees (31%). Respondents were also asked the maximum level of education and training in primary care that was available to trainees. Again, differences were noted across levels, with doctoral programs reporting experience and emphasis as the most frequent (35% each), internships reporting emphasis (34%) and postdoctoral programs reporting major area of study (62%).

Perception of primary care psychology training: Respondents were asked their perceptions regarding how unique or distinctive education and training in primary care is from general training in professional psychology.

Table 8: Perceived Differences of Primary Care Psychology from Professional Psychology by Level of Training

	Doctoral (n=59)	Internship (n=63)	Postdoctoral (n=39)
Radically different	23.7%	17.5%	35.9%
Moderately different	59.3%	57.1%	51.3%
More similar than different	15.3%	22.2%	12.8%
Synonymous	1.7%	3.2%	0.0%

Respondents were then asked to compare training for primary care with training in clinical health psychology.

Table 9: Perceived Differences from Clinical Health Psychology by Level of Training

	Doctoral (n = 55)	Internship (n = 52)	Postdoctoral (n = 39)
Radically different	5.5%	5.7%	12.8%
Moderately different	14.5%	25.0%	33.3%
More similar than different	29.1%	28.9%	20.5%
Synonymous	7.3%	1.9%	10.3%
Do not have a clinical health track or rotation	43.6%	38.5%	23.1%

Survey questions also asked respondents to rate the perceived interest in primary care training by both trainees and faculty/supervisors in their program. At the doctoral level, the most frequent response was that both faculty/supervisors and trainees would see training in primary care as valuable to add to the curriculum if the training schedule permits, although faculty were rated as somewhat more likely (72%) than trainees (56%) to consider it valuable. While still rated as the most frequent response at the internship level, overall percentages rating primary care training as valuable dropped to 46 and 49. Interestingly, results were very different for postdoctoral programs who indicated perception that faculty/supervisors and trainees would see such experience as crucial (54% each).

Barriers to education and training in primary care:

Survey questions were also designed to elicit information about barriers programs face in providing education and training in primary care.

Table 10: Barriers to Primary Care Education and Training by Level of Training

	Doctoral (n=28)	Internship (n=31)	Postdoctoral (n=25)
Lack of access to primary care setting	35.7%	19.4%	20.0%
Lack of trainee interest	25.0%	12.9%	4.0%
Lack of trainee readiness	17.9%	9.7%	8.0%
Financial support for trainees	57.1%	41.9%	56.0%
Financial support for supervisors	60.7%	41.9%	44.0%
Faculty expertise	50.0%	22.6%	12.0%
Faculty attitudes	14.3%	12.9%	12.0%
Institutional barriers	25.0%	45.2%	52.0%
Insufficient time for adding new competencies	n/a	n/a	20.0%
Other	14.3%	25.8%	12.0%

Respondents also provided information about reimbursement sources for primary care psychology services.

Table 11: Funding Sources for Primary Care Psychology Services by Level of Training

	Doctoral (n=29)	Internship (n=34)	Postdoctoral (n=29)
Fee for service (private insurance)	51.7%	35.3%	44.8%
Medicare	34.5%	29.4%	27.6%
Medicaid	41.4%	29.4%	34.5%
Service contracts	41.4%	23.5%	31.0%
Grants	37.9%	32.3%	37.9%
Unfunded	51.7%	17.7%	17.2%
Other	17.3%	50.0%	41.4%

Of note, the most frequent response in the other category for internship and postdoctoral programs was funding from the Department of Veterans Affairs.