Competencies for Psychology Practice in Primary Care[1]

Report of the Interorganizational Work Group on Competencies for Primary Care Psychology Practice[2]

Approved by APA Council of Representatives, 2015

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[1] This policy describes competencies that serve as aspirational goals for psychologists in primary care settings. It is meant to guide training programs' curriculum development and psychologists' self-monitoring. This policy is in no way intended to create a standard of practice, particularly for psychologists already trained and practicing in the field. Nor is it intended to limit the ability of psychologists to practice within their scope of licensure under state law, or to limit coverage, reimbursement or credentialing by third party payors for psychological services within that scope of licensure.

[2] The Interorganizational Work Group on Competencies for Primary Care Psychology was convened as initiative of APA President Suzanne Bennett Johnson, PhD. Members included Susan McDaniel, PhD (Chair); Barbara Cubic, PhD; Christopher Hunter, PhD; Michel Karel, PhD; Lisa Kearney, PhD; Rodger S. Kessler, PhD; Kevin Larkin, PhD; Stephen McCutcheon, PhD; Benjamin F. Miller, PsyD; Justin Nash, PhD; Sara Qualls, PhD; Kathryn Sanders, PhD; Catherine Schuman, PhD; Terry Stancin, PhD; Annette Stanton, PhD; Lynne Sturm, PhD and Education Directorate Staff Catherine Grus, PhD and Jan Sheri-Morris.

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Executive Summary

The majority of people in the United States seek and receive care for mental health, substance abuse and health behavior problems in primary care (PC). They present with problems as unique diagnoses and as part of other comorbid illnesses. As such, PC practices are addressing the biopsychosocial needs of their patients by including psychologists as interdisciplinary team members in their provision of integrated PC. Research shows that this type of integrated primary care (see Appendix A) is associated with improved outcomes for both health and mental health problems (Butler, Kane et al, 2008; Unutzer, Schoenbaum et al, 2006). Although PC psychology has been an area of focus over the past few decades, there is no generally accepted articulation of the competencies psychologists must have to effectively work in PC medial settings.

This report is the outcome of an initiative by the 2012 American Psychological Association (APA) president, Suzanne Bennett Johnson PhD to delineate competencies for PC practice. The work group consisted of representatives from nine national organizations with a central focus on education or practice in PC psychology. Six broad core competency domains and specific competencies for each area are described:

1. Science
    - Science Related to the Biopsychosocial Approach
    - Research/Evaluation
2. Systems
    - Leadership/Administration
    - Interdisciplinary Systems
    - Advocacy
3. Professionalism
    - Professional Values and Attitudes
    - Individual, Cultural and Disciplinary Diversity

Ethics in Primary Care
Reflective Practice/Self-assessment/Self-care

4. Relationships
Interprofessionalism
Building and Sustaining Relationships in Primary Care

5. Application
Practice Management
Assessment
Intervention
Clinical Consultation

6. Education
Teaching
Supervision

Within each competency, essential knowledge, skills, and attitudes as well as behavioral anchors (or examples) are provided. Delineation of these competencies is intended to inform education, practice and research in PC psychology and efforts to further develop essential team-based competencies in PC.

Definitions

The work group agreed to a set of definitions drawn from the current literature to guide the development of this document. Appendix A provides additional definitions employed by the work group.

Primary Care (PC) is the provision of integrated, accessible health care services by an interdisciplinary team of clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community (Institute of Medicine, *1994, p.1)*.

PC psychology is the application of psychological knowledge and principles to common physical and mental health problems experienced by patients and families throughout the lifespan and presented in PC (McDaniel, Hargrove, Belar, Schroeder & Freeman, 2004).

Competence in primary care psychology refers to the knowledge, skill, and attitudes – and their integration – that allow an individual to perform tasks and roles as a PC psychologist, regardless of service delivery model (Kaslow, Dunn, & Smith, 2008).

Competencies are distinctive elements necessary for competence, they correlate with performance and can be evaluated against agreed upon standards (Kaslow, 2004).

Essential Components are critical components that delineate the knowledge/skills/attitudes that make up each of the competencies consistent with the structure of the Benchmarks model (Hatcher et al., 2013).

Behavioral Anchors are observable, measurable examples of how the essential components **might** be demonstrated. Behavioral anchors are examples, so they vary by the model of service delivery being used, the population being seen, and the system of care.

The primary care psychology competencies:

- Assume that general competencies for professional psychology as articulated in the Benchmarks Model (Hatcher et al., 2013) and the competencies for psychologists as Health Service professionals (HSPEC, 2012) are attained and sustained.
- Draw from and add to the competencies that have been proposed for primary care psychology (see Key Documents in Appendix C).

Introduction

Background

The biomedical model – derived from the germ theory of disease--has characterized Western medicine for over a hundred years. The model was hugely successful at eliminating infectious diseases as the leading causes of death and is considered one of the primary reasons U.S. life expectancy increased from 49 years in 1901 (Glover, 1921) to 78 years in 2007 (Arias, 2011; ; Minino, Arias, Kochanek, Murphy, & Smith, 2002; National Office of Vital Statistics, 1947). However, this model has its limitations. It may be viewed as reductionistic, explaining all illness in biologic terms. It may be viewed as exclusionary, since symptoms that cannot be explained by a biologic pathogen or defect are excluded from consideration. This model reflected a mind-body dualism in which "mental" disorders are excluded from the primary concerns of Western medicine unless they could be explained by some underlying biologic defect (Engel, 1977). As a result of this perspective, mental health has been largely "carved" out of the larger health care enterprise and given limited resources (Belar, 1995). "Mental" health and "physical" health professionals have been trained separately, with little or no opportunity to train or work collaboratively.

Although George Engel proposed a new medical approach, the biopsychosocial model, in 1977, most of U.S. health care continued to embrace the biomedical model until very recently. As U.S. health care costs continue to rise (Centers for Medicare and Medicaid Services, 2011), it has become increasingly apparent that the biomedical model alone cannot successfully address today's health care challenges. Most Americans die of chronic diseases, the treatment

of which accounts for 75 percent of our health care costs (Centers for Disease Control and Prevention, 2009).

Further, the important role of behavior, both patient and health professional behavior, has become increasingly apparent in solving today's health care problems. For example, tobacco use and poor diet and sedentary behavior are the leading causes of death in the United States (Mokdad, Marks, Stroup, & Gerberding, 2004) and medical errors are ranked eighth (Institute of Medicine, [IOM]2000. In response, Engel's biopsychosocial approach is now more frequently espoused by many in medicine. In 1994, the Institute of Medicine proposed that primary care be defined as "the provision of integrated, accessible health care services by an interdisciplinary team of clinicians" (IOM, 1994). The Patient Protection and Affordable Care Act (ACA) [P.L. 111-148] (2010) should help make this a reality. ACA requires that essential health benefits include mental health, preventive and wellness services, and chronic disease management in addition to the biologic assays and interventions that have historically comprised U.S. healthcare. Healthcare in the United States is moving from provider-centered care focused on biologic aspects of disease, to patient-centered care (see Appendix A) characterized by interprofessional teams addressing all of the patient's needs, both physical and psychological (Johnson, in press).

Since most patients enter the health care system through PC, it is not surprising that patients bring their mental health concerns to their PC clinician; yet, PC providers focused on a biomedical model are poorly equipped to address mental health concerns appropriately (Kathol, Butler, McAlpine, & Kane, 2010). For this reason, there has been great interest in transitioning traditional PC service delivery to a patient-centered interdisciplinary team delivery

model, with teams that can provide a full range of patient care to include mental and behavioral health PC services.

From the perspective of psychology, patient-centered PC that offers integrated physical and behavioral health service provide opportunities for psychologists who wish to join integrated PC care teams. However, many psychologists lack the skills and expertise to function effectively in this context, and there is as yet little formal training related to service provision in PC provided in doctoral training programs. In fact, a task force of the American Psychological Association Board of Educational Affairs (2011) noted that there was not yet a generally accepted articulation of the competencies required for practice in PC settings and recommended that PC specific competencies for psychologists be developed.

The Inter-Organizational Work Group on Competencies for Primary Care Psychology Practice

In 2012, the Inter-Organizational Work Group on Competencies for Primary Care Psychology Practice was convened as an initiative of American Psychological Association (APA) President, Suzanne Bennett Johnson PhD, recognizing the need for the articulation of agreed-upon competencies for PC psychology. These competencies would be used in graduate psychology education and training programs; could provide guidance for those interested in developing or responding to opportunities in this area; would assist students and practitioners to make informed choices about available educational programs and certificates offered in this area; and would inform policymakers, other health professionals, and the public about the competencies of PC psychologists.

Organizations with a central focus on education or practice in PC psychology were invited to identify 1-2 thought leaders in PC psychology to serve as members of the Work Group. The following organizations participated:

- APA Division 20, Adult Development and Aging
- APA Division 38, Health Psychology
- APA Division 54, Society of Pediatric Psychology
- Association of Psychologists in Academic Health Centers (APAHC)
- Collaborative Family Healthcare Association (CFHC)
- Council of Clinical Health Psychology Training Programs (CCHPTP)
- Society of Behavioral Medicine (SBM)
- Society of Teachers of Family Medicine (STFM)
- VA Psychology Training Council (VAPTC)

Susan McDaniel PhD served as Chair of the Work Group. The Work Group roster is attached as Appendix B.

Process. The Work Group conducted their initial work using conference calls and electronic mail. First, they reviewed the literature specific to PC psychology competencies. The Work Group used a technique known as "lightning talks," in which a brief summary of each document was provided by one member to the entire group, highlighting key points. A list of the key documents used by the Work Group is provided in Appendix C. The Work Group also discussed extant competency models in professional psychology and adapted the framework proposed by the Competency Benchmarks Work Group and used by others for their purpose

(Hatcher et al., 2013). The Work Group divided into four small groups, each of which began to articulate the essential components and behavioral anchors for one or more of the broad competency cluster areas. Once each group had a draft completed, the small groups were reconfigured, retaining one original member. These new small groups reviewed and provided input on the initial drafts. Then the whole group reviewed the entire document. The Work Group held one, two-day, face-to-face meeting during which the document was discussed and further revised, resulting in the current document. The document was reviewed by the organizations that sent representatives to the Work Group and this input was considered in the development of the final version completed in December 2012. This report will be available to be disseminated by participating groups, available on the APA web-site, and expanded upon in upcoming journal articles.

About the Competencies

The competencies for PC psychology practice are grouped into six clusters: Science, Systems, Professionalism, Relational, Application, and Education. The order of the clusters is consistent with that of the health service psychology competencies (HSPEC, 2012). Readers will want to review all the clusters but the order selected may differ depending on one's focus. Of note, the applied competencies are found in cluster 5 and will likely be of particular interest to practitioners, given the distinctive aspects of applied work in the PC setting.

The table below presents the six clusters and the competencies associated with each:

Cluster	**Competencies**
1. Science	Science Related to the Biopsychosocial Approach Research/Evaluation

2. Systems	Leadership/Administration Interdisciplinary Systems Advocacy
3. Professionalism	Professional Values and Attitudes Individual, Cultural and Disciplinary Diversity Ethics in PC Reflective Practice/Self-assessment/Self-care
4. Relationships	Interprofessionalsim Building and Sustaining Relationships in PC
5. Application	Practice Management Assessment Intervention Clinical Consultation
6. Education	Teaching Supervision

The key components of each competency are articulated as "essential components" to further describe the knowledge/skills/attitudes that make up the competency. A further category, behavioral anchors, is delineated to provide examples of how the essential components may be demonstrated. Although the essential components were considered "required" elements of each competency for practice in PC, behavioral anchors were considered examples. The extent to which a PC psychologist demonstrated acquisition of an essential component might vary somewhat based on the sites or organizations where the PC clinics were located and the models of PC practice evidenced during their training.

Competencies, Essential Components*, and Behavioral Anchors**

for Psychology Practice in Primary Care (PC)

Cluster 1. Science

Competencies	Essential Component(s)	Behavioral Anchors
1A. Science Related to the Biopsychosocial Approach	1A.1 Scientific Mindedness: values a scientific foundation the practice of PC psychology	Uses scientific literature in the daily PC practice Encourages evidence-based practice by all team members Emphasizes the importance of research while engaged in training in a PC setting
	1A.2 Knowledge of the biological components of health and illness	Describes accurately the relationship between commonly treated medical conditions in PC and psychological or behavioral concerns (e.g., recognizes depression is commonly co-morbid with diabetes and the implications of various blood sugar levels on cognition and mood Recognizes names and appropriate dosages of medications for commonly occurring medical and psychological/behavioral conditions (e.g., diabetes, hypertension, depression) seen in PC and their common side effects on cognition and mood Demonstrates knowledge of human anatomy, physiology, and/or pathophysiology Demonstrates knowledge of pharmacology

		Able to search the literature for information on the usual course of medical treatment and primary variations in treatment for the medical condition
	1A.3 Knowledge of the cognitive components of health and illness	Articulates an understanding of health belief models and attitudes regarding help seeking that influence health and illness Demonstrates knowledge of cognitive factors that influence reactions to medical diagnoses and processing of health information Demonstrates knowledge of the impact of biological factors on cognitive functioning
	1A.4 Knowledge of the affective components of health and illness	Demonstrates knowledge of affective factors that influence reactions to diagnoses, injury, disability and processing of health information Recognizes that medical problems can present as affective disorders
	1A.5 Knowledge of behavioral and developmental aspects of health and illness	Describes effect of age and developmental context on health across the lifespan Recognizes impact of learning and conditioning on health behavior Demonstrates knowledge of behavioral risk factors, including the effect of coping on health
	1A.6 Knowledge of the role and effect of families on health	Recognizes the effect of acute and chronic illness on physical and mental health of caregivers, siblings, and other family members Utilizes knowledge about the effect of the family and other members of the

		support system on medical regimen adherence
	1A.7 Knowledge of the effect of sociocultural and socio-economic factors and historical context on health and illness	Describes association between socioeconomic status and health outcomes and access to care Recognizes the relationships between ethnicity, race, gender, age/cohort, religion, sexual orientation, culture, and disability on health behavior and disease management in PC
	1A.8 Knowledge of epidemiology, public services, and health policy research	Articulates epidemiological research methods relevant to PC Employs knowledge of population-based approaches to health promotion Demonstrates knowledge of health policy and health services research
	1A.9 Knowledge and understanding of evidence-based practice and its application to the practice of PC psychology	Demonstrates knowledge of research methods for quality improvement initiatives to enhance patient safety, patient satisfaction, and health outcomes Understands, reads, and implements clinical algorithms in PC Understands, values, and applies evidence-based approaches to patient care and encourages their use in the PC setting Appreciates, understands, and demonstrates a population-based approach to care in the PC setting, including screening to inform further assessment, use of stepped care approaches to match treatment effort with patient complexity, proactive follow-up to support self-management, and targeted interventions to help prevent and manage costly chronic

		diseases Understands and values scientific approaches and research methods and their application for improving patient care in PC settings to contribute to the growing evidence base Uses informatics – communicates, manages knowledge, mitigates errors, and supports decision making using information technology
1B **<u>Research/Evaluation</u>**	1B.1 Ability to conduct research in PC settings	Engages in practice-based research associated with practice-based networks where collective results can be used to demonstrate the effectiveness of PC efforts on health outcomes Conducts effectiveness, comparative effectiveness, and/or dissemination and implementation research within the PC setting Demonstrates the ability to generate retrievable information from the electronic health record (EHR) used for conducting effectiveness and comparative effectiveness trials Demonstrates an understanding of quantitative and qualitative analytic procedures and mixing these methods for evaluating outcomes in PC settings (e.g., biostatistics) Demonstrates the ability to generate and execute research designs that maintain internal validity but enhance external validity (e.g., effectiveness trials and other alternatives to RCTs) Demonstrates awareness of challenges

		(such as power differentials) faced while doing research in PC settings, including conducting randomized controlled trials across sites
	1B.2 Ability to select valid, brief and actionable measures for conducting research in PC settings	Demonstrates knowledge of brief patient outcome measures appropriate for research in PC settings Employs outcome measures used across disciplines (e.g., lab levels, financial outcomes, cost effectiveness) in addition to psychological outcomes
	1.B.3 Ability to conduct research in an ethically responsible manner in the PC setting	Demonstrates an understanding of the IRB/Human Research requirements as they apply to research conducted in PC Demonstrates an awareness of technical/ethical/legal issues that arise when conducting research using electronic health records
	1B.4 Ability to conduct research within the context of an interdisciplinary team	Collaborates on interdisciplinary research teams Consults on research conducted by interdisciplinary team members
	1B.5 Application of research skills for evaluating practice, interventions, and programs	Evaluates the effectiveness of screening programs used in PC settings Creates or implements baseline needs assessment within PC settings for both patients and health providers Evaluates effectiveness of biopsychosocial intervention and prevention programs used in PC settings Develops new programs for PC settings using program development standards of excellence Develops or implements a research protocol in program evaluation

		research in PC settings that is sensitive to cultural factors
	1B.6 Ability to select valid, brief and actionable measures for evaluating applied clinical activity in PC	Creates reliable and valid screening, diagnostic, and monitoring instruments using health information systems Considers clinical, operational, and financial outcomes when evaluating programs occurring in PC settings Develops new reliable and valid outcome measures for measurement of patient outcomes when no such instruments exist
	1B.7 Effectively uses information technology to track patient outcomes and provide a means for program evaluation	Uses health information technology to improve patient safety, satisfaction, and quality of care, particularly as it relates to behavioral health Evaluates use of technology to deliver care (e.g., telemedicine programs; HER reminders and tracking of outcomes)
	1B.8 Awareness of and participation in developing and measuring Quality Improvement standards in PC	Demonstrates the ability to participate in the formal evaluation and assessment of standards for being a National Committee for Quality Assurance (NCQA) -certified Patient Centered Medical Home (PCMH) Works with clinical leadership and the team to design, implement, and evaluate quality improvement initiatives that impact how care is routinely delivered Applies quality improvement processes: identifying errors and hazards in care, implementing basic safety design principles and measures to assess quality of care, and designing and testing interventions to change processes and systems of care

Cluster 2. Systems

Competencies	Essential Component(s)	Behavioral Anchors
2A <u>Leadership/ Administration</u>	2A.1 Understands the mission and organizational structure, relevant historical factors, and position of psychology in the organization	Recognizes appropriate chains of communication to initiate a change in local systems of care Understands current reporting lines for psychologists within the organization
	2A.2 Along with other practice leaders, facilities integration across multiple domains (clinical, operational, and financial)	Works effectively with organizational leaders to ensure that the necessary resources are available for an effective behavioral health practice Creates business plans that track costs and quality associated with integrated care Develops standards of care for psychology services within the PC setting
	2A.3 Contributes to planning and implementing organizational change to optimize service delivery	Understands systems redesign and approaches to productivity enhancement (e.g., Plan-Do-Sudy-Act [PDSA], Institute for Healthcare Improvement, 2011; Lean, Levinson & Rerick, 2002). Examines space utilization and makes recommendations accordingly, with particular attention to impact upon interprofessional team functioning Notices an inefficient work process and collaborates with team to identify and try a new strategy

Cluster 2. Systems

Competencies	Essential Component(s)	Behavioral Anchors
		Leads quality improvement initiatives in the clinical and operational domains (e.g., increases use of Patient Health Questionnaire 2 (PHQ2) to screen for depression, or modifies the EHR to track high risk patients and optimize care for chronic disease management) Consults with colleagues with expertise in industrial-organizational psychology to address systems issues
	2A.4 Demonstrates and promotes effective communication in a range of leadership roles	Promotes effective communication and collaborative decision-making in healthcare teams, including facilitating each team member communicating his/her perspective Leads or participates in staff meetings, clinical meetings, and organizational meetings Provides effective and constructive feedback that combines praise for effective performance along with constructive criticism to team members and employees Works with providers on better communicating sensitive issues with staff and patients
	2A. 5 Understands and applies organizational policies regarding health care professional employment, particularly for psychologists and other behavioral health clinicians	Participates in developing and implementing standards for psychologists and other behavioral health professionals as part of employment in PC

Cluster 2. Systems

Competencies	Essential Component(s)	Behavioral Anchors
		Collaborates with practice leadership to implement a comprehensive 360-degree evaluation process for annual performance evaluations (Panagar, 2009) Demonstrates familiarity with hospital/medical setting bylaws, credentialing, privileging, and staffing responsibilities Participates in developing standards for psychologists as part of the peer review process
	2A.6 Supports training programs in PC psychology and interprofessional education at local, regional, and national levels	Advocates for institutional investment in an accredited psychology PC program supported by formal business plans Oversees efforts to develop PC psychology continuing education programs for psychologists and other healthcare professionals
2B. <u>Interdisciplinary Systems</u> (appreciation of systems of care)	2B.1 Appreciates that PC takes place in the larger "healthcare neighborhood," within the community and social context	Engages schools, community agencies, and healthcare systems to support optimal patient care and functioning Demonstrates understanding of long-term care needs and options including in-home care, assisted living, and nursing home care Shares literature about, and elicits from PC team members, the various social and environmental factors associated with health and illness

Cluster 2. Systems

Competencies	Essential Component(s)	Behavioral Anchors
		and their implications in healthcare Collaborates with other team members on the development of protocols for behavioral health issues Demonstrates understanding of the system of care involved in a patient visit, including the role of each professional who interacts with the patient Demonstrates understanding of diverse PC systems (e.g., out-patient, in-patient, nursing homes, group homes) and works to facilitate smooth transitions between them for effective patient care
2C <u>Advocacy</u> (actions targeting the impact of social, political, economic or cultural factors to promote change at the systems level	2C.1 Demonstrates knowledge of health care policy and its influence on health and illness and PC services	Describes how Centers for Medicare and Medicaid Services (CMS) policies impact health insurance reimbursement for screening and integrated behavioral health services Identifies opportunities to advocate for better integration of mental health services in PC at the local, state, and federal levels Demonstrates understanding of the differences between the mental health system and PC, and where there are opportunities for better integration at proximal (community) and distal (state/federal level) levels

Cluster 2. Systems

Competencies	Essential Component(s)	Behavioral Anchors
		Demonstrates an understanding of system-related barriers to care, such as lack of access due to insurance or other resource limitations
	2C.2 Recognizes and addresses the healthcare needs of the community, and works to address how they are prioritized in care delivery, state funding, and resource allocation	Establishes collaborative relationships with key community resources to decrease population rates of sexually transmitted diseases Works with school and early intervention systems to address the population's rates of childhood obesity Advocates at various government levels for resources to address the needs of the community's PC patients
	2C.3 Recognizes that advocacy to improve population health may involve interacting with a number of systems	Demonstrates understanding that transitions of care (e.g., inpatient to home) are influenced by funding, caregiver availability, and patient capacity Recognizes the unique and sometimes competing interests of different stakeholders in the health care system (e.g., patients, providers, payers, employers, and government) Demonstrates understands that policy has a significant impact on individual health behaviors that contribute to chronic disease (e.g. cigarette tax on tobacco cessation).

Cluster 2. Systems

Competencies	Essential Component(s)	Behavioral Anchors
		Understands which clinicians can see patients with which insurances for what conditions, and advocates or supports advocacy (i.e., with claims representatives, state or federal legislators) when change is needed
	2C.4 Informs policy relevant to PC psychology care at local, state, and federal levels	Serves on advisory boards of community agencies Engages in active outreach efforts and to policy makers Uses data to show impact of PC psychology on chronic disease prevention in order to advocate for funding to improve patient access to these services
	2C.5 Ability to advocate within the psychology profession for increased research, training, and practice in PC	Work with the appropriate psychology training councils to increase graduate level education and practicum opportunities in PC Work with the state psychological association on a coordinated effort to train psychologists and integrate psychology into PC practices

Cluster 3. Professionalism

Competencies	Essential Component(s)	Behavioral Anchors
3A <u>Professional Values and Attitudes</u>	3A.1 Consolidates professional identity as a PC psychologist	Conveys to others the roles/skill sets that the PC psychologist brings to the setting Participates in professional groups regarding the development and advancement of PC psychology Identifies self as a doctoral-level professional and conveys role to patients Raises psychological, relational, and systemic issues related to patient care to team
	3A.2 Values the culture of the PC setting and conveys an attitude of flexibility	Willing to adapt role and activities in the best interest of patient care (e.g., service as consultant, team leader, advocate, case manager, health educator, or community liaison) Adapts to PC environment, including frequent interruptions, fast pace of clinic, and unpredictable access to space Able and willing to participate in the care of the full range of patients seen by the PC team Uses language consistent with a PC setting
3B <u>Individual, Cultural and Disciplinary Diversity</u>	3B.1 Monitors and applies knowledge of self and others as cultural beings in PC settings	Asks about cultural identities, health beliefs, and illness history that impact health behaviors and integrates and tailors diversity

Cluster 3. Professionalism

Competencies	Essential Component(s)	Behavioral Anchors
		factors into treatment planning Demonstrates sensitivity to a variety of factors that influence health care (e.g., developmental, cultural, socioeconomic, gender, race, religious, sexual orientation and expression, gender identity and expression, disability, veteran status) as well as the intersections of these variables Reflects on own cultural identity and its impact on treatment of patients
	3B.2 Identifies the relationship of social and cultural factors in the development of health problems	Modifies interventions for behavioral health change in response to a variety of social and cultural factors Uses culturally sensitive measures and procedures when conducting research, evaluation, or quality improvement projects
3C <u>Ethics in PC setting</u> (application of ethical concepts and awareness of legal issues regarding professional activities)	3C.1 Identifies and addresses the distinctive ethical issues encountered in PC practice	Demonstrates a commitment to ethical principles with particular attention to multiple relationship matters, confidentiality, informed consent, boundary issues, team functioning, and business practices (APA, 2010). Demonstrates understanding of the major ethical dilemmas in PC Identifies the multiple consumers of PC services and potential role conflicts

Cluster 3. Professionalism

Competencies	Essential Component(s)	Behavioral Anchors
		Demonstrates understanding of the distinctive issues related to informed consent and confidentiality (e.g., documentation) related to team-based care, and patients will be informed of the limits of confidentiality Demonstrates sensitivity and knowledge of ethical codes of other disciplines present in PC
	3C.2 Demonstrates knowledge about the legal issues associated with health care practice	Practices appropriate documentation, billing, and reimbursement procedures for services Follows state laws related to abuse reporting, adolescent reproductive health, and determination of decision making capacity Addresses effectively scope of practice concerns for psychologists in PC Demonstrates understanding of liability issues in PC (e.g., with shared care) Identifies problems encountered in team functioning (e.g., diffusion of responsibilities) Can articulate state and federal laws and regulations related to billing (especially regarding Medicare and Medicaid services)

Cluster 3. Professionalism

Competencies	Essential Component(s)	Behavioral Anchors
	3C.3 Articulates aspects of policies that regulate the delivery of services in health care systems	Demonstrates familiarity with hospital/medical setting bylaws, credentialing, privileges, and staffing responsibilities Demonstrates knowledge about standards set forth by national accrediting bodies
3D. Reflective Practice/Self–Assessment/Self-care	3D.1 Supports importance of reflective practice in PC settings	Develops skills of self-awareness and mindfulness (defined as "bringing one's complete attention to the present experience on a moment-to-moment basis," Marlatt & Kristeller, 1999, p. 68) Manages stress associated with PC practice by actively creating a consultation network with other PC psychologists Identifies clinical situations in which intra- and inter-disciplinary supervision and consultation are indicated Seeks and is receptive to feedback on performance
	3D.2 Understands importance of self-assessment in PC settings	Evaluates one's own competencies and determines need for continuing education Acts in best interest of patient by seeking consultation and professional support when needs for services exceed level of professional competence

Cluster 3. Professionalism

Competencies	Essential Component(s)	Behavioral Anchors
		Responds to common interpersonal challenges experienced by health care providers in a reflective manner Engages in self-assessment to ensure service delivery is balanced with self-care activities Appropriately seeks support from team members
	3D.3 Understands importance of health professional self-care in PC	Actively promotes self-care consultation opportunities for other PC health professionals (e.g., psychotherapy, exercise, psychiatric consultation, marriage and family therapy)

Cluster 4. Relationships

Competencies	Essential Component(s)	Behavioral Anchors
4A <u>Interprofessionalism</u>	4A.1 Values interprofessional team approach to care	Demonstrates understanding that care of patient is the responsibility of a team of professionals, not a single clinician Recognizes, respects, and supports activities of other members of the PC team in the provision of behavioral health services Views self as essential team member in care of patient
	4A.2 Appreciates the unique contributions that different health care professionals bring to the PC team	Communicates the various roles of the psychologist to team members Recognizes when and how to use other team members' specific disciplinary expertise
	4A.3 Develops collaborative relationships to promote healthy interprofessional team functioning characterized by mutual respect and shared values	Promotes collegial and mutually respectful relationships with colleagues from different disciplines Promotes and participates in team huddles prior to clinical work Contributes to an environment that facilitates the integration of the expertise from the professionals from different disciplines Facilitates team meetings with rotating roles to help all members actively participate

Cluster 4. Relationships

Competencies	Essential Component(s)	Behavioral Anchors
		Recognizes and manages power differentials amongst professionals Fosters informal team building interactions (e.g., lunch) Works with team when stressful events occur (e.g., death of a patient) Encourages constructive feedback about self and others on the team, for example, through 360 degree evaluations
	4A.4 Able to assess team dynamics and coach teams to improve functioning	Proactively helps team members better understand their interpersonal and communication styles Uses psychological skills to address malfunctioning team behavior Identifies team interactions that facilitate or hamper collaborative care Offers an in-service about behaviors that facilitate or impede team functioning in offering patient centered care
	4A.5 Demonstrates awareness, sensitivity and skills in working professionally with diverse individuals	Communicates effectively with team members and patients in a manner that is sensitive to power differentials that may be present in a clinical setting Helps patients communicate with

Cluster 4. Relationships

Competencies	Essential Component(s)	Behavioral Anchors
		health care professionals who have cultural backgrounds different from their own
4B <u>Building and Sustaining Relationships in Primary Care</u>	4B.1 Understands the importance of communicating clearly, concisely, respectfully in a manner that is understandable and meaningful to various audiences (e.g., clinicians, patients, staff)	Uses language appropriate to patient's and clinician's education and culture Uses visual aids to enhance a patient and family's understanding of a recent diagnosis Works with immigrant patients and families through an interpreter to develop and explain treatment plan in a manner consistent with their cultural values and educational background
	4B.2 Negotiates resolution of conflict between clinicians, staff, patients, and systems	Facilitates team process when there are professional disagreements by focusing on shared goals Recognizes and manages power differentials between team members and between patients and providers
	4B.3 Able to set appropriate boundaries for patients, families, clinicians, and teams	Advises patients and their families about availability, and limits, of behavioral health services after hours and informs patients of alternative resources that are available to them (e.g., on-call service, crisis hotlines, AA sponsors, Emergency Department) Communicates with the team how to access behavioral health services when the PC psychologist is not

Cluster 4. Relationships

Competencies	Essential Component(s)	Behavioral Anchors
		available

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
5A.<u>Practice Management</u>	5A.1 Meets the needs of the patients, their families, other team members, and the setting, taking into consideration the model of behavioral health/PC integration used, resources available, and time constraints within the setting	Relies on a needs assessment to allocate clinical services or develop new services Distributes care in a manner best suited for the patient and the population (e.g., tracks percent of time spent in brief assessments/interventions, family systems-based interventions, and detailed assessments/interventions) Implements and schedules clinical services in a manner that fits effectively with a PC model of service delivery (e.g., provides preventative services when patients present for well visits, plans for intervals [e.g., 4-6 weeks] between appointments when warranted)
	5A.2 Applies principles of population based care along a continuum from prevention and wellness, to subclinical problems, to acute and chronic clinical needs	Focuses assessment and interventions across the continuum of health and illness, providing acute services, targeting prevention of illness, health promotion, and risk reduction for physical and mental/behavioral health issues, including substance use disorders Follows an evidence-based and evidence-informed models of assessment and intervention across consultations (e.g., uses Assess, Advise, Agree, Assist, Arrange model, Glasgow, Emont & Miller, 2006; Whitlock, Orleans, Pender &

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		Allan, 2002) Implements screening for substance use disorders and applies brief interventions for substance use related disorders in PC (e.g., motivational interviewing)
	5A.3 Operates at a variety of paces consistent with the needs and realities of PC	Uses appointment time efficiently (e.g., in a 30-minute appointment identifies problem, degree of functional impairment, and symptoms early in the visit Summarizes to patient and family, when possible, an understanding of problem (e.g., in 2-3 minutes) at the appropriate level, depth, and specificity for each patient in the context of their cultural beliefs Allocates time based on patient need (i.e., not wedded to 50-minute hours) Provides lengthier assessments and interventions on select cases when indicated (e.g., crisis situations, patients with low health literacy, cognitive limitations, repetitive problems) Conducts assessments of patients with severe problems, such as persistent mental illness, intoxication, resistance to examination, addiction to prescription medication, and disruptive behaviors

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		Conducts assessments of social crises, such as dealing with homelessness and abusive situations Initiates and reviews the behavioral change plan at each appointment
	5A.4 Can co-interview, co-assess, and co-intervene with other PC providers	Co-interviews a patient with diabetes by conducting the interview with a dietician Works with the pediatrician and respiratory therapist in a joint effort to develop a plan to improve a child's adherence to an asthma treatment regimen Collaboratively creates treatment plans with other relevant PC professionals Co-facilitates assessment effectively with other health care professionals Co-conducts medical group visits with PC providers
	5A.5 Understands how payment for services may influence the type of services and treatment provided	Informs a parent that a recommended developmental screen is not covered by insurance Uses Health and Behavior Codes when applicable

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
	5A.6 Communicates information that addresses a patient's needs, improves PC practice and allows for research (when IRB approved) without revealing unnecessary confidential information	Writes clear, concise EHR notes focused on referral problem, frequency, duration (acute or long-term), functional impairment, and short specific recommendations Ensures notes are accessible to the PC team and considers that they may be accessible to the patient Phrases information regarding highly personal patient information with sensitivity to patient preferences and treatment needs Types notes in EHR while assessing patient (as appropriate) or as soon thereafter as possible Recognizes the limitations of free text health care patient notes, and uses templates/structured not within the EHR when applicable
	5A.7 Uses most up to date technology and methods to guide clinical service delivery	Establishes systems to direct patients to web based protocols (e.g., electronic smoking cessation programs, chronic disease based interventions) Encourages patients and families to use the patient portal of the EHR Provides telehealth when indicated and appropriate Stays aware of "meaningful use" (i.e., financial incentives to medical clinicians for covering particular

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		priority areas such as smoking in EHR documentation)
5B. <u>Assessment</u>	5B.1 Selects and implements screening methods using evidence-based assessment measures to identify patients at risk or in need of specialized services	Reviews EHR core behavioral risk measures to determine where to focus screenings Assists PC team in selecting measures to include in routine appointments to identify common presenting problems (e.g., depression, anxiety, substance use disorders, sleep difficulties, disruptive behavior) Recognizes signs of cognitive impairment (e.g., dementia, TBI), evaluates with brief assessment tools with norms appropriate to the population, and refers for more comprehensive cognitive evaluation as indicated
	5B.2 Ensures that psychological assessments for the PC setting are utilized, administered, and interpreted in a manner that maintains test integrity	Understands strengths and limitations of screening tools designed for specialty mental health services when adapted for PC Appropriately uses the most up to date data bases (e.g., Cochrane, DynaMed, Essential Evidence Plus, Epocrates, Lexi-Comp, TRIP, UpToDate, AHRQ Atlas on Outcome Measures in Integrated Primary Care) to ensure the best evidence-based assessments are conducted, taking into consideration normative data
	5B.3 Uses assessment questions and measures geared towards current functioning,	Assesses how the patient's physical condition (e.g., Body Mass Index, HbA1c, out of range lab values),

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
	while simultaneously incorporating psychological, behavioral, and physical components of health and well being	thoughts, emotions, behaviors, habits, interpersonal relationships and environment influence the identified problem and functioning Uses assessment strategy that can be tied to a behavioral change plan Gears questions towards current problem Incorporates motivational interviewing techniques into assessment Appropriately uses a variety of assessment measures appropriate for PC
	5B.4 Identifies patient's needs and rationale for appointment rapidly	Quickly identifies problem, degree of functional impairment, and symptoms using focused interviewing skills Uses brief screening tools to determine areas in need of attention during current visit Succinctly summarizes understanding of problem to the patient Aligns PC clinician's concern with patient's concern Discerns when to refer patients to specialized care and/or further assessment or other health resources (e.g., outpatient

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		psychiatry department, partial/full hospitalization program, emergency care, substance abuse rehab)
	5B.5 Assesses pertinent behavioral risk factors	Conducts an evidence-based suicide assessment on all patients identified with depressed mood Identifies the health risks for a child with asthma residing with a smoker Uses a reliable method to assess substance use
	5B.6 Involves input of significant others in the assessment process as indicated	Obtains information from caregivers in the assessment process Seeks feedback from a couple simultaneously about how they can work together to ensure compliance with a post-operative bariatric surgery lifestyle Actively solicits information from outside sources as needed (e.g., interviews a teacher to obtain data to assist in the assessment of a child with a disruptive behavior problem)
	5B.7 Evaluates and uses intrapersonal, family, and community strengths, resilience, and wellness to inform understanding of patient's needs and to promote health	Uses interview and assessment measures that include evaluation of psychosocial (e.g., personality, health beliefs, family) strengths Effectively questions patient about support system, spiritual resources, and links to community resources Employs prescreening methods of family resources

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		Employs information gained from evaluation in development of a health care plan
	5B.8 Monitors patients longitudinally, as indicated, to identify changes in presenting problems and effectiveness of recommended interventions	Works collaboratively with PC team to perform on-going assessment of fluctuations in presenting problem and of emerging problems Conducts follow-up assessment to evaluate effectiveness of recommended interventions
5C. <u>Intervention</u>	5C.1 Focuses patient recommendations and interventions on functional outcomes and symptom reduction in a targeted manner	Uses evidence-based interventions to improve functioning in areas such as meeting school and work responsibilities, improving quality of social interactions, decreasing disruptive behaviors, improving sleep, decreasing pain, reducing anxiety, improving mood, and improving exercise and nutrition
	5C.2 Offers interventions that encourage proper use of health care resources	Meets routinely with a patient with somatization disorder to decrease frequency of urgent care visits Employs methods such as "Teach Back" to assure patient understanding of health care instructions (Schillinger, Piette, Grumbach, et. al., 2003) Uses Motivational Interviewing to encourage a patient to attend diabetes education programs and to engage in proactive health behaviors
	5C.3 Effectively uses current	Implements evidence-based

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
	evidence-based interventions appropriate for PC to treat health and mental health-related issues	interventions (e.g., CBT, Parent Child Interaction Therapy, Motivational Interviewing, Family Psychoeducation, Problem Solving Therapy) Focuses on patient self-care, symptom reduction, and functional improvement with interventions such as deep breathing, cue controlled relaxation, cognitive disputation, sleep hygiene, stimulus control, increased exercise, problem solving, assertive communication, disease -management
	5C.4 Offers and solicits evidence-based interventions that can be reinforced and monitored by all PC team members	Shares and solicits information about behavioral interventions in a manner that encourages endorsement and support by the PC team (e.g., interventions increase physical activity by walking 20 minutes daily on 5 out of 7 days, use of relaxation or diaphragmatic breathing 3 times per day, and once at bedtime) Effectively engages family members in the intervention
	5C.5 Uses biopsychosocial model to provide effective patient education and communication	Describes to the patient the relevant factors (e.g., physical, behavioral, cognitive, environmental, social) that can affect pain with consideration of their health literacy level and in the context of their cultural and religious beliefs Based on the patient's health literacy level and personal history

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		with breast cancer, educates the patient about genetic testing for breast cancer and assists the patient in decision making about whether to undergo genetic testing. Provides empirical evidence whenever possible to the patient about how the interventions offered will lead to functional improvement
	5C.6 Targets evidence-based interventions to improve chronic care management	Uses behavioral intervention strategies to improve a patient's diabetes self -management Uses validated parent and teacher observational scales to determine the impact of a ADHD medication trial Conducts services such as ADHD screen during well child care visits Collaborates with PC team to provide clinical behavioral health visits, groups, and enhanced medical visits, focused on pain, prenatal care, diabetes, wellness etc. Participates in group medical visits Ties treatments offered to condition registries
	5C.7 Offers interventions that are inclusive of the family system	Involves spouse in nutritional planning for patient with diabetes Provides psychoeducation and supportive counseling to family caregivers of a patient with

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		Alzheimer's Disease Involves immediate and extended family members in creating behavioral changes, supporting healthier behaviors, and improving adherence
	5C.8 Provides responsive care along the continuum of prevention and wellness promotion	Develops psychoeducational materials for common parental concerns Participates in Health Fairs Develops information for websites
	5C.9 Bridges appropriately between behavioral services offered in PC and specialty mental health and community resources	Refers patient to specialty behavioral or mental health care when the intensity of service needed is beyond the scope of PC Develops efficient ongoing communication strategies between the PC provider and referral source to insure ongoing collaboration Uses community resources as applicable (e.g., substance abuse support programs, psychoeducational groups, support groups, parenting resources, and cultural and spiritual resource centers)
5D. <u>Clinical Consultation</u>	5D.1 Assists in the development of standardized and reliable processes for consultative serves for PC psychology	Assists the PC team regarding when and how to incorporate a PC psychology provider into the process of care Uses empirical literature to develop parameters for when consultations

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		should be triggered (e.g., diagnosis of a chronic pain triggers an evaluation for pain management)
	5D.2 Clarifies, focuses on, and responds to consultation question raised, in an efficient manner	Conducts a thorough health record review of the referred patient Includes other PC team members in response to consultation question Expands on consultation question when information discovered warrants investigation of additional areas Identifies chronic and acute diagnoses and current treatments Communicates specifically regarding initial consultation question to other PC professionals
	5D.3 Helps PC team conceptualize challenging patients in a manner that enhances patient care	Collaborates with other PC team members to ensure the entire healthcare team interacts more effectively and efficiently with patients and their support systems Is readily available to PC team to discuss ways to interact effectively with patients with challenging interpersonal styles (e.g., patients with personality disorders) and complicated cases (e.g., significant co-morbidities, family dysfunction, limited intellect, low health literacy) Provides knowledge about behavioral and psychological matters to other team members

Cluster 5. Application

Competencies	Essential Component(s)	Behavioral Anchors
		Convenes case conferences as needed on complex cases Involves other resources as needed
	5D.4 Tailors recommendations to work pace and environment of PC	Gives PC providers actionable recommendations that are brief, concrete, and evidence-based Provides immediate (e.g., same day), brief feedback to the consulting PC provider avoiding psychological jargon Able to provide brief interventions (typically 15-30 minute interaction) using extant models in the literature
	5D.5 Follows up with other PC clinicians as indicated	Uses oral and or written communication effectively Conveys and receives both urgent and routine clinical information to PC team members, using appropriate infrastructure/clinic procedures (e.g., face-to-face, email communication, assigning tasks in EHR, consults, chart notes)
	5D6 Ensures integrity of the consultation process when algorithm-based automated triggers for consultation occur	Can effectively explain to a patient the rationale for the consultation that has been automatically triggered Completes feedback loop with PC provider following consultation

Cluster 6. Education

Competencies	Essential Component(s)	Behavioral Anchors
6A <u>Teaching</u>	6A.1 Understands and is able to apply teaching strategies about PC psychology	Develops a portfolio of educational strategies to demonstrate and teach PC psychology competencies Develops curriculum and training materials addressing specific psychological and social issues encountered in PC Modifies teaching strategies based on learner's needs (e.g., discipline-specific training, level of familiarity with behavioral health concerns, skill level of provider, etc.) Provides training and supervision to psychology trainees in PC psychology
	6A.2 Completes needs assessment and understands teaching approaches used by other health professions about behavioral health issues	Adapts to and is familiar with training models of other disciplines' trainees present in PC Able to coach physicians and staff in patient- and family-centered care behaviors Adapts teaching methods used by other disciplines for integrated care training (e.g., structured direct observation with checklists for ratings, Objective Structured Clinical Examinations (OSCEs), use of standardized patient observation and feedback, etc) Contributes on competencies for

Cluster 6. Education

Competencies	Essential Component(s)	Behavioral Anchors
		physicians based on Accreditation Council for Graduate Medical Education (ACGME) requirements Provides training to other health care professionals in integrated care Provides training to all staff on the role of a psychologist in PC Provides ongoing training/ supervision to raise the psychological awareness of the entire health care team, recognizing that all team members treat some aspects of behavioral health concerns
	6A.2 Knowledge of strategies to evaluate effectiveness of teaching methods and procedures in PC psychology	Obtains summative and formative feedback Discusses the strengths and weakness of different assessment methods
	6A.3 Understands importance of and facilitates teaching of psychology trainees by other health care professionals	Implements opportunities for psychology trainees to observe and participate in clinical activities with other health care professionals Encourages teaching activities for psychology trainees by physicians and other health care professionals
	6A.4 Educates and trains psychologists regarding (physical and mental) health promotion, disease prevention, and management of acute and chronic disease across the lifespan to prepare psychologists	Develops materials addressing the natural history of type 2 diabetes from prevention, diagnosis, disease management, and complications Develops materials addressing the challenges faced by families with a

Cluster 6. Education

Competencies	Essential Component(s)	Behavioral Anchors
	for integrated PC in varied settings	child who has type 1 diabetes from infancy to young adulthood Assists in the identification of a resource pool of exemplar faculty consultants Creates mentoring networks across institutions
	6A.5 Participates in the education and training of multiple stakeholders in the larger health care system about PC psychology	Presents at a community health care forum on a common behavioral health issue Provides training to PC team members on the role of psychologists in addressing mental and behavioral health concerns Presents at hospital wide staff meetings such as grand rounds regarding PC psychology initiatives
6B <u>Supervision</u>	6B.1 Understands the ethical, legal, and contextual issues of the supervisor role in PC	Ensures that PC psychology training standards meets all accreditation requirements Outlines competency expectations for PC psychology and regularly provides feedback to trainees on progress Assists trainees in balancing role flexibility and limits of clinical competence
	6B.2 Applies a range of methods to the supervision of psychology trainees	Supervises in a variety of ways, including case discussion, direct observation, and precepting Creates opportunities for

Cluster 6. Education

Competencies	Essential Component(s)	Behavioral Anchors
		psychology trainees to receive supervision from colleagues from other disciplines Trains non-mental health providers in appropriate behavioral health interventions Provides education; fosters skill development and training for trainees from a variety of disciplines Creates opportunities for trainees to educate, supervise, and train other health care professionals Able to use technology (e.g., telesupervision) effectively to allow supervision of trainees in integrated PC settings when appropriate and/or necessary

*Essential Components refer to the knowledge/skills/attitudes that make up the competency.
** Sample behavioral anchors are included that demonstrate the essential components. These samples are not all inclusive.

Summary

The distinct elements of the PC setting, the diversity of patients with a range of undiagnosed problems, and the biopsychosocial nature of these problems, offer psychologists an opportunity to provide needed and effective services for a wide range of patients and their families. Consequently, psychology training programs must prepare the next generation of psychologists to focus effectively on wellness, prevention and health promotion; acute and chronic condition management; family participation in health care; care coordination with professionals from other disciplines; and ways to improve access to health care. Psychologists will be providing services for a higher volume of patients as more individuals are insured in 2014 with implementation of the Affordable Care Act (ACA). They will need to be competent in team based care and be able to focus on linkages between health and behavior to meet societal needs including providing services to an increasingly diverse and aging population. Clear guidance about those competencies has not been available until now for psychologists interested in practicing in the PC setting. It is expected that the competencies articulated can provide a guide to multiple stakeholders and will be widely disseminated and serve as a single, comprehensive resource with multiple purposes. Further, it is hoped that the organizations that have vetted the document will advocate for attainment of these competencies among professional psychologists working in PC settings.

Regarding the competencies contained in this document, education and training programs, faculty, clinical supervisors and trainees should be encouraged to use them in their efforts to assure that psychology education and training programs are appropriately preparing the next generation for service in integrated interdisciplinary PC. It also expected that the

competencies will inform clinical and administrative leaders interested in the unique role a PC psychologist can play in PC comprehensive service delivery; and scientist engage in needed clinical and educational research and program evaluation to inform educational and clinical policy in the PC setting.

The competencies for PC psychology represent the timely development of a significant resource in an area of practice that is expanding and changing rapidly. While this competency document provides a roadmap for the near future, it remains a living document to be re-examined at frequent intervals in order to be responsive to the changing healthcare landscape and evolving opportunities for psychology within collaborative and comprehensive patient care.

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Appendix A: Definitions of Key Terms

Accountable Care Organization (ACO)

A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. (U.S. Department of Health and Human Services, n.d.)

Care Management

Specific type of service, often disease specific (e.g., depression, congestive heart failure) whereby a behavioral health clinician, usually a nurse or social worker provides early assessment and intervention, care facilitation, and ongoing follow-up (e.g., Belnap et al., 2006).

Co-located Care

Behavioral health (BH) and primary care (PC) providers (i.e., physicians, nurse practitioners) delivering care in the same practice but without a common framework or practice to integrate that care (Peek, 2012).

Collaborative Care

An overarching term describing ongoing communication between clinicians (e.g., behavioral health and PC) over time that results in a shared treatment plan for patients. The term implies collaboration with patients and their families as well as collaboration amongst the treatment team (Peek, 2012).

Comprehensive Care

An important principle of PC, in which clinicians are accountable for meeting the large majority of each patient's physical and mental health needs (Agency for Healthcare Research and Quality, n.d.).

Coordinated Care

Behavioral health providers and PC physicians practice separately within their respective systems. Information regarding mutual patients is exchanged as needed, and collaboration is limited outside of the initial referral (Blount, 2003).

Health and Behavior Codes

Billing codes designed to capture behavioral services provided to patients to address physical health problems. There are six health and behavior codes, two for assessment procedures and four that reflect intervention services (American Psychological Association Practice Organization, 2007).

Healthcare (or Medical) Neighborhood

The heathcare neighborhood is defined as a Patient Centered Health (or Medical) Home and the constellation of other clinicians and teams providing health care services to patients and families within it, along with community and social service organizations and state and local public health agencies (adapted from Taylor, Lake, Nysenbaum, Peterson & Meyers, 2011).

Integrated Care

Tightly integrated on-site teamwork with unified care plan. Often connotes organizational integration as well, perhaps involving social and other services (Blount, 2003; Blount, Scchoenbaum, Kessler, Rollman, Marshall, O'Donohue & Peek, 2007).

Integrated program: An organizational structure that ensures staff and linkages with other programs to address all patient needs (Peek, 2012).

Integrated system: Organizational structure that supports array of programs for individuals with different needs through funding, credentialing, licensing, data collection/reporting, needs assessment, planning, and other operational functions (Peek, 2012).

Integrated Primary Care

Combines medical and behavioral health services for the spectrum of problems that patients bring to primary medical care. Because most patients in PC have a physical ailment affected by stress, problems maintaining healthy lifestyles, or a psychological disorder, it is clinically effective and cost-effective to make behavioral health providers part of PC. Patients can feel that for any problem they bring, they have come to the right place. Teamwork of mental health and medical providers is an embodiment of the biopsychosocial model. (see www.integratedprimarycare.com)

Primary Care Behavioral Health

"Recent term for new relationships emerging between specialty mental health services and PC." "Primary behavioral health care refers to at least three related activities: (1) behavioral health care delivered by PC clinicians, (2) specialty behavioral health care delivered in the PC setting, and (3) innovative programs that integrate elements of PC and specialty behavioral health care into new formats." (Sabin & Borus, 2001).

Patient-Centered

“Care that is respectful of and responsive to individual patient preferences, needs, and guides all clinical decisions." (Institute of Medicine, 2001)

Patient-Centered Medical (Health) Home (PCMH)

The Patient-Centered Medical Home is not simply a place but refers to an organizational model to deliver the core functions of PC, including: patient-centered, comprehensive, coordinated care, access, quality and safety. (adapted from: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association, (2007).

Population Based Care

A population health perspective encompasses the ability to assess the health needs of a specific population; implement and evaluate interventions to improve health of that population; and provide care for the individual patient in the context of the culture, health status, and heath needs of the populations of which the patient is a member (Association of American Medical Colleges, 1999).

Appendix B: Roster of Inter- Organizational Work Group Members and Organizations Represented

APA Division 20, Adult Development and Aging

Sara Honn Qualls, PhD
Director, Gerontology Center
Kraemer Family Professor of Aging Studies and Professor of Psychology
Gerontology Center, 1434 N. Hancock Ave.,
Colorado Springs, CO 80903
Phone: (719) 667-0187
Fax: (719) 471-2800
Email: squalls@uccs.edu

Michele J. Karel, PhD
Program Coordinator, Home-Based Primary Care Mental Health Initiative
Mental Health Services, VA Central Office
Associate Professor, Department of Psychiatry, Harvard Medical School
Phone: (617) 429-0279
Email: Michele.Karel@va.gov

APA Division 38, Health Psychology

Annette Stanton, PhD
Department of Psychology
1285 Franz Hall
Box 951563, UCLA
Los Angeles, CA 90095-0001
Email: astanton@ucla.edu

Barbara Cubic, PhD
Department of Psychiatry and Behavioral Sciences and Department of Family and Community Medicine Eastern Virginia Medical School
825 Fairfax Avenue
Norfolk, Virginia 23507
Phone: (757) 446-5888
Fax: 757-446-5918
Email: cubicba@evms.edu

APA Division 54, Society for Pediatric Psychology

Lynne Sturm, PhD

Riley Child Development Center – LEND Program
Department of Pediatrics, Indiana School of Medicine
702 Riley Hospital Drive, Rm. 5837
Indianapolis, IN 46202
Phone: 317-944-8167
Fax: 317-944-9760
Email: lsturm@iupui.edu

Terry Stancin, PhD
Professor of Pediatrics, Psychiatry and Psychology,
Case Western Reserve University
Vice-Chair of Research in Psychiatry and
Director of Child and Adolescent Psychiatry and Psychology
MetroHealth Medical Center
Cleveland, OH 44109-1998
Phone: (216) 778-4917
Fax: (216) 778-8840
Email: tstancin@metrohealth.org

Association of Psychologists in Academic Health Centers (APAHC)

Kathryn Sanders, PhD
Assistant Professor & Director of Training, Clinical Health Psychology Postdoctoral Fellowship
Department of Psychiatry VA Connecticut Healthcare System & Yale University School of Medicine
950 Campbell Ave -116B
West Haven, CT 06516
Phone: (203) 932-5711
Fax: (203) 937-4951
Email: Kathryn.sanders@va.gov

Catherine Schuman, PhD
Assistant Professor & Director of Behavioral Medicine and Behavioral Medicine Training
Cambridge Health Alliance Department of Psychiatry Harvard Medical School Malden Family Med. Center 195 Canal Street, Suite 105 Malden, MA 02148
Phone: (781) 338-0036
Fax: (781) 338-0170
Email: cshuman@challiance.org

Collaborative Family Healthcare Association (CFHA)

Christopher Hunter, PhD, ABPP
Defense Health Headquarters
7700 Arlington, BLVD
Falls Church, VA 22042

Phone: (703) 681-0079
Email: Christopher.Hunter@tma.osd.mil

Benjamin F. Miller, PsyD
Assistant Professor
Department of Family Medicine
University of Colorado Denver School of Medicine
Phone: (303) 724-9706
Email: benjamin.miller@ucdenver.edu

Council of Directors of Clinical Health Psychology Training Programs

Justin Nash, PhD
1 Hoppin St Ste 314
Providence, RI 02903-4141
Phone: (401) 793-8009
Email: justin_nash@brown.edu

Kevin T. Larkin, PhD
Department of Psychology
West Virginia University
Morgantown, WV 26506-6040
Phone: (304) 293-1700
Email: Kevin.Larkin@mail.wvu.edu

Society of Behavioral Medicine (SBM)

Rodger S. Kessler, PhD, ABPP
Vermont College of Medicine
CCTS
89 Beaumont Court
Given Courtyard 4th Floor
Burlington, VT 05405
Phone: (802) 656-8250
Fax: (802) 656-4576
Email: rodger.kessler@vtmednet.org

Society of the Teachers of Family Medicine

Susan McDaniel, PhD **(Work Group Chair)**
777 Clinton Ave S
Rochester, NY 14620-1448
Phone: (585) 275-2783
Email: SusanH2_McDaniel@URMC.Rochester.edu

VA Training Council

Steve McCutcheon, PhD
VA Puget Sound Health Care System
1660 South Columbian Way
Mental Health Service (116)
Seattle, WA 98108
Phone: (206) 764-2895
Email: Stephen.McCutcheon@va.gov

Lisa K. Kearney, PhD
National Integrated Care Coordinator
VA Central Office – Mental Health Operations (10NC5)
5441 Babcock Road, Suite 300
San Antonio, TX 78240
Phone: (210) 694-6222
E-mail: Lisa.Kearney3@va.gov

APA Education Directorate Staff

Catherine Grus, PhD
American Psychological Association
750 First Street, NE
Washington, DC 20002
Phone: (202) 336-5961
Fax: (202) 842-9046
E-mail: cgrus@apa.org

Jan-Sheri Morris
American Psychological Association
750 First Street, NE
Washington, DC 20002
Phone: (202) 336-5855
Fax: (202) 842-9046
E-mail: jmorris@apa.org

Appendix C: Key Documents used by the Work Group

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