Training and Education in Professional Psychology
2014, Vol. 8, No. 2, 83–94

1931-3918/14/$12.00 DOI: 10.1037/tep0000021

Implications of the Affordable Care Act for Education and Training in Professional Psychology

Ronald H. Rozensky
The University of Florida

With the ongoing implementation of the Patient Protection and Affordable Care Act (Public Law No: 111–148, March 23, 2010) and its impact on the evolving health care system, this article will focus on 4 broad domains of change that the education and training community in psychology must address to ensure that the next generations of health service psychologists are prepared to not just succeed, but lead those changes in health care. Interprofessionalism, workforce analysis and development (including practice settings), finances (reimbursement, health care cost offset, and advocacy), and professional accountability (including accreditation, competency, evidence-based care, specialization, identity and self-definition, and autonomy) will be discussed. Each domain reflects demands for both affordable care and enhanced accountability in the developing health care system. Recommendations for curricular content and clinical training modifications are offered.

Keywords: Affordable Care Act, professional psychology, health service psychology, interprofessionalism, education and training

Things do not change; we change.—Henry David Thoreau

The entire health care workforce must be prepared for the changes coming to the patient care system of the future; a system that increasingly will be accountability-focused, evidence-based, and team-based, within an integrated, patient-centered practice environment with a goal of enhanced access to quality care. Health care providers from all disciplines will be expected to learn, master, and utilize defined, discipline-specific and shared interprofessional competencies—from prevention to primary to tertiary care—for patients, families, and populations across the life span (Institute of Medicine [IOM], 2001; Rozensky, 2012; Wilson, Rozensky, & Weiss, 2010).

Evolving modifications to the health care delivery system in the United States, as prescribed by the Patient Protection and Affordable Care Act (ACA; Public Law No: 111–148, Mar 23, 2010) and supported as constitutional by the U.S. Supreme Court (*National Federation of Independent Business v. Sebelius*, 2012) will have a profound effect on the education and training of future generations of health service psychologists. Whatever else might happen politically over time regarding the ACA, changes in health care are to be anticipated and must be responded to by the education and training community. The ACA is the reality that currently confronts us in the profession. Rozensky (2013) has noted that "those who have dedicated their careers to the education and training of the professional psychology workforce have as their ultimate goal the provision of quality health care services; services within the general practice of psychology or in one of its recognized specialties" (p. 704). He then concludes his review of the education and training system in professional psychology by stating:

> "The State of Psychological Education and Training is Strong. Much has been done by leadership across the education and training community to ensure we indeed are educating a competent workforce of psychologists who are critical thinkers, creators of new knowledge, and providers of quality care. At the national level, leadership in psychology must ensure our profession is seen as a viable member of the health care system with evidence-based, cost efficient services provided by well qualified, highly credentialed health service psychologists. At the local education and training level, faculty and staff must attend to the requirements of our health care system, based on the ACA, to ensure that course work and practical training make certain that our students possess the strongest credentials needed to succeed in the patient-centered, interprofessional, team-based health care system that demands high quality, accountable health care" (p. 714).

The purpose of this article is to detail some of the issues within the ACA that will impact the pedagogy of professional psychology education, its knowledge base and science, and clinical training as health service providers.

Preparing the Next Generations of Professional Psychologists for the Upcoming Changes to the Health Care System

Given the upcoming implementation of the ACA and its impact on the evolving health care system, this article will focus on four broad domains of change that the education and community in psychology must address to ensure that the next generations of health service psychologists are prepared to not just succeed, but

RONALD H. ROZENSKY, PhD, received his PhD in clinical psychology from the University of Pittsburgh. He is professor in the Department of Clinical and Health Psychology where he served as chair for eight years. He is past chair of the U.S. Health Resources and Services Administration's Advisory Committee on Interdisciplinary Community-Based Linkages.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Ronald H. Rozensky, Department of Clinical and Health Psychology, College of Public Health and Health Professions, University of Florida, P. O. Box 100165, Gainesville, FL 32610. E-mail: rozensky@phhp.ufl.edu

lead those changes. We will discuss (a) interprofessionalism, (b) workforce analysis and development including issues related to actual practice settings, (c) health care finances (reimbursement, health care cost offset, and advocacy), and (d) professional accountability (including accreditation, competency, evidence-based care, specialization, identity and self-definition, and professional autonomy). These domains are based upon 15 action steps required to build the future of professional psychology (Rozensky, 2011) and reflect the demands for both affordable care and enhanced accountability in the developing health care system. Recommendations for curricular content and clinical training modifications are offered to help prepare students for these upcoming changes.

The General Context of Health Care Reform for Professional Psychology

Oscar Wilde is purported to have said, "The only thing worse than being talked about is *not* being talked about." Well, psychology is safely included, and 'talked about,' within the ACA. Psychology is defined as a health care profession; is mentioned in sections of the Act that discuss research and evaluation; and referenced in sections that recommend education and training funding. Psychological services are described for several patient populations as well.

While the 906 pages of the Act (found at http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf) might be less than stimulating reading for many, reviewing sections wherein psychology specifically is mentioned helps set a general picture of where and how psychology is seen currently as a health care profession. Understanding the ACAs general tone of accountability, focus on interprofessional education and practice, and expectations for cost effectiveness provide strong opportunities for psychology to step up and take leadership roles nationally and at the local level as well as suggest specific content areas for those planning educational and training programming for the preparation of psychologists. Similarly, it is important to remain up-to-date with ongoing health care reform issues including the many, many pages of Federal implementing regulations and state-specific rules that can have an impact on definitions of psychology's scope of practice, range of clinical services, and reimbursement that may well be relevant to graduate training programs, internships, and postdoctoral fellowships that bill for their direct patient care activities. This information, and understanding, will also be helpful in modifying educational materials designed to prepare students soon to enter the health care workforce. Tracking those issues and evolving rules can be challenging, but equally important, to each member of the education and training community and their students and trainees. Distilled discussions, such as at http://www.apa.org/health-reform/ can be helpful in the pursuit of information needed for strategic program planning and keeping practice-related curriculum materials current and relevant for tomorrow.

Internal Consistency Within Psychology Education and Training

In his review of quality education in professional psychology, Rozensky (2013) described how, over the past decade, there has been a de facto restructuring of the education and training sequence for health service psychologists resulting in a more consistent approach than the difficulties encountered when (historically) defining a common core curriculum for the field that resulted in a "thousand flowers blooming" during the latter part of the past millennium (as described by Benjamin, 2001). This new found consistency is important in the era of systemic expectations for accountability in health care (cf., DeLeon & Kazdin, 2010). Clearly stating *how* psychologists are academically prepared for practice, their *defined* competencies, and their scope of practice assures that professional psychology is seen as similar to other health care professions in presenting a consistent picture to policymakers and health care administrators who will be deciding who participates in the upcoming system and who and how much they get reimbursed for those services. The ACAs call for accountability will require a more consistent self-definition for professional psychology; the education and training community has the responsibility to help the next generations learn and operationalize that self-definition.

Specific details of the evolution of education and training in professional psychology are beyond the scope of this article and can be found in Rozensky (2013). However, within the context of this brief discussion of internal consistency vis-à-vis the ACA, it should be noted that there now exists quality educational standards for teaching of psychology in high schools (http://www.apa.org/education/k12/national-standards.aspx), a stepwise curriculum in community colleges (American Psychological Association [APA], 2008a) and *Principles for Quality Undergraduate Education in Psychology* (http://www.apa.org/education/undergrad/principles.aspx) that lead to quality students seeking quality advanced training. *A Blueprint for Health Service Psychology Education and Training* (Health Service Psychology Education Collaborative (HSPEC, 2013) calls for minimal qualifications to enter doctoral education and training in health service psychology and challenges the field to define and utilize "clearly articulated and understood" (p. 1) competencies for provision of health services, the integration of science and practice to implement evidence-based treatment, and the adoption of a national standard for accreditation. APAs (2012) policy, *Education and Training Guidelines: A Taxonomy for Education and Training in Professional Health Services Specialties.* facilitates clear, consistent use of terminology and definitions for describing programmatic, specialized education and training opportunities at the doctoral, internship, postdoctoral, and postlicensure stages. This *Taxonomy* acknowledges, and was built on the expectations of broad and general training for health services providers as expected for accredited programs in professional psychology (cf. http://www.apa.org/ed/accreditation/about/policies/doctoral.aspx). It provides a structure for language to be utilized, in a consistent manner across all recognized specialties in professional psychology, to recommend what a program must provide for its students or trainees, in academic and clinical activities, to be consistent with national expectations put forth by each specialty. While respecting local academic freedom, these documents provide each education and training program with a set of guidelines for consistently describing the structure and sequence across all stages of training in professional psychology.

There has been a call for competency-based education across all levels of education from high school through specialty training and lifelong learning in professional psychology (Hatcher, Fouad, Grus, Campbell, McCutcheon, & Leahy, 2013; Kaslow, Grus, Campbell, Fouad, Hatcher, & Rodolfa, 2009; Roberts, Borden,

Christiansen, & Lopez, 2005). As an organizing concept, competency-based education helps professional psychology chart its education and training expectations on the same type of trajectory as other health care disciplines thus ensuring that psychology is seen as a consistent member of the accountable, health care team; members of the team who all focus on a culture of competency (Roberts et al., 2005) with both discipline-specific and shared, team-based competencies.

Review, assimilation, and accommodation of these consistent operational definitions within education and training will help the field of professional psychology, in general, and local education and training programs in particular, prepare for the upcoming changes to health care. The following four domains can be used, conceptually and practically, to structure the concepts and opportunities within the sequence of training described above.

Interprofessionalism

The ACA specifically recognizes the impact of interprofessional education, training, and care on quality health care and cost effectiveness (cf., Section 3502, *Establishing Community Health Teams to Support The Patient-Centered Medical Home*). The ACA states that funding can be made available to establish community-based, interprofessional (primary) health care teams that may include behavioral and mental health providers (including psychologists). Interprofessional, integrated disease prevention and health promotion services (including funding for clinical teaching settings such as academic health science centers and community-based teaching health centers) and interprofessional models of health care (including integration of physical and behavioral/mental health services) also are detailed in the Act.

The IOM (2013) has made it clear that interprofessional education (IPE) is not "smudging together the professions and saying they're all the same," but is "about learning together to ultimately improve health and the safety of patients" (p. 2–1). Federal policy recommendations support "the integration of interprofessional education into health professions education as a means of assuring a more collaborative health care workforce" of the future (Wilson et al., 2010, p. 210). This collaborative education reflects "an enlightened new professionalism that can lead to better services and consequent improvements in the health of patients and populations" (Frenk et al., 2010, p. 1954). Interprofessionality is a developmental step for all health care disciplines that moves beyond disjointed practices and is defined as "the development of a cohesive practice *between* professionals from different disciplines" (D'Amour & Oandasan, 2005, p. 9). This includes shared competencies developed during professional education and training (Schuetz, Mann, & Evertt, 2010) then utilized in actual practice in integrated, team-based health care systems (Interprofessional Education Collaborative [IEC], 2011). The key to success of this team-based focus is that competencies are shared across disciplines and include values and ethics, clarification of independent and shared roles and responsibilities for collaborative practice, interprofessional communication skills, and competencies that enhance team work and team-based care.

The curriculum for the education and training of health service psychologists should include development of competencies for true interprofessional health care (IEC, 2011; Interprofessional Education Collaborative Expert Panel, 2011) for what has been referred to as traditional mental or behavioral health services and in providing assessment and treatment of patients with medical diagnoses. Further, contemporary curricula should include a focus on interprofessional communication skills (including developing skills and comfort with the use of electronic health records) and verbal and electronic sharing of clinical information about patients within teams. In the patient-centered health care system promulgated by the ACA, this also includes skills needed to routinely explain to patients the importance of sharing sensitive mental health and psychologically focused information with whole health care team to enhance continuity, and thus quality care (Shackak & Jadad, 2010).

For those education and training programs focused on traditional mental health or psychological services (and research), using the Taxonomy (APA, 2012), presented above, to describe clearly what additional specialty training opportunities exist within a given program, beyond the broad and general, will be helpful in clarifying student expectations. Incorporated in that program description should be how *interprofessionalism* will be built into the opportunities for students' knowledge acquisition and what practical, interprofessional clinical training opportunities exist. Looking at definitions of the "interprofessional" experience, where interprofessional refers to a team-based interaction of more than just two disciplines becomes an important challenge to programs that have had students interact only with say, a consulting psychiatrist or social worker. Those programs must consider how to broaden trainee interprofessional opportunities within traditional mental health or psychological education. Similarly, for programs with a specialty focus that includes working with medical patients as health, rehabilitation, pediatric, or neuro-psychologists, it will be important to ensure program curriculum and clinical training opportunities include both the academic preparation and skills development to become a competent member of the interprofessional, integrated, patient care team.

Two federally funded programs with an interprofessional focus, the Graduate Psychology Education Program (GPE) and the Mental and Behavioral Health Education and Training Grant (MBHET) illustrate opportunities and the importance of keeping current on the implications of the ACA for available training dollars, program content required to seek funding, and the implications of that type of funded training on future education, training, and services. The GPE funds programs whose graduate training includes students receiving interdisciplinary training from, and with other health professions to help prepare them to effectively provide integrated, quality health care for vulnerable populations (http://www.apa.org/about/gr/education/news/2012/2013-budget.aspx). The MBHET (authorized through Title VII and amended by Section 5306(a) of the ACA; http://bhpr.hrsa.gov/grants/mentalbehavioral/mbhet.html) provides funding for internships in professional psychology where training occurs in preparation for work with vulnerable populations and, once again, in the context of working directly on teams with multiple disciplines.

One additional interprofessional opportunity for the education and training community to provide as a standard element of graduate education for the next generations of psychologist is team science.

> "Team science is a collaborative effort to address a scientific challenge that leverages the strengths and expertise of professionals

> trained in different fields. Although traditional single-investigator driven approaches are ideal for many scientific endeavors, coordinated teams of investigators with diverse skills and knowledge may be especially helpful for studies of complex social problems with multiple causes" (http://www.teamsciencetoolkit.cancer.gov/Public/WhatIsTS.aspx; Falk–Krzesinski et al., 2010).

This type of cross-discipline team work speaks directly to where scientific funding will be targeted in the interprofessional health care system of tomorrow. Such experience will help ready early career psychologists for the new health care environment by participating in research, training, and community-based translational initiatives as members and leaders of team science.

Work Force and Practice Settings

Workforce. Rozensky, Grus, Belar, Nelson, and Kohout (2007) advocated for a national, systematic, workforce analysis program to provide an ongoing, data-based approach to better understanding the population's need for psychological services. This information would help inform those planning education and training programs to prepare the future psychology workforce for practice opportunities and targeted service delivery venues the workforce data suggests should be included in their curriculum.

That recommendation for an organized workforce study of psychology was put forth in the context of helping to understand and alleviate what has been called the 'internship match imbalance' in professional psychology where more students are produced than can find accredited internship training sites. Grus, McCutcheon, and Berry (2011) detailed the history of that imbalance and the Herculean efforts done and being done to manage that issue. They do note, however, "results of a comprehensive workforce analysis have not been presented to date" (p. 199). Rozensky (2013) once again reiterated the need for such data to help address the imbalance. It remains unclear how many psychologists actually are needed, and in which specific work settings they will need to practice, to meet the genuine health care service requirements of the general population.

No matter the specifics of the needed data, logically there will be an increase in demand for psychological services in the future given the ACAs focus on decreasing the number of uninsured citizens, thus increasing the diversity and numbers of those seeking health care. This is reinforced by data illustrating that the population is aging and there is an increase in chronic illnesses in the general population and,

> "We must have an accurate accounting of the current psychology workforce and an understanding of its readiness for the upcoming changes to the health care system. We must have a clear picture of the future demands for psychological services so the field can prepare the accurate number of psychologists needed, with the requisite special-(ist) skills required, by health care reform" (Rozensky, 2011, p. 8).

Because this workforce analysis has not happened on the national level, it would be important for the education and training community in professional psychology to work together to advocate with the APA Center for Workforce Studies (CWS) for such a series of workforce studies to provide the necessary data to support its educational mission. This is a nontrivial demand given the robust workforce activities of all other health care disciplines and how they each assertively use their workforce data to both plan for educating their students and to advocate for funding for both education and training and for reimbursement for their services (cf. Auerbach, Staiger, Muench, & Buerhaus, 2013; Bennett & Phillips, 2010; Brown, 2012; Kirkwood, Kosty, Bajorin, Bruinooge, & Goldstein, 2013). Data will speak loudly in an accountable care system.

Practice settings. The ACA describes two specific organizational structures in the evolving health care system, the Accountable Care Organization (ACO; CMS Office of Legislation, 2010; Fisher, Staiger, Bynum, & Gottlieb, 2007) and the Patient Centered Medical (or Health care) Home (PCMH; Agency for Health care Research & Quality, 2013; Nutting, Crabtree, Miller, Stange, Stewart, & Jaen, 2011). These two administrative and clinical structures will become the future *institutionally* based, interprofessional health care practice settings.

While there always will be a market for independent practice (Rozensky, 2011), the APA (2009) CWS reported on a survey of health service psychologists that found the majority of psychologists (54.5%) have a primary place of employment in an institutional setting, with 45.5% in independent practice. With the ACA, the trend is expected to continue toward *more* involvement in institutional practice settings (Rozensky, 2011). Professional psychology training programs, at all levels, will need to affiliate with local administrative structures like ACOs and PCMHs so that they provide training opportunities for their students; especially as the prominence of these organizations expand in the delivery of integrated, coordinated care with their focus on accountability for quality and cost containment.

Much has been written about the PCMH as the home of primary care services. There is an equally long tradition of psychologists' training for (McDaniel, Belar, Schroeder, Hargrove, & Freeman, 2002) and practicing in that environment with patients who present with either, or both, mental health and physical health problems (Frank, McDaniel, Bray, & Heldring, 2004; Gunn & Blount, 2009; Newman & Rozensky, 1995). The IOM (2001) described how integrated care, within an ACO or PCMH, demands continuity of care that is patient-centered and based on a shared interprofessionalism. Kelly and Coons (2012) present a series of challenges and questions about practicing psychology within integrated care settings asking whether such a setting "is the right approach and professional home" for a given psychologist (p. 593). It is recommended that education and training programs in professional psychology add those questions to their process of due diligence as they review their own curriculum and clinical practicum opportunities. Given the ACAs focus on interprofessionalism, this should help when considering if, when in the sequence of training, and how to prepare students academically and clinically for competent, integrated, interprofessional practice in those settings.

Finances (Health Care Cost Offset, Reimbursement, and Advocacy)

Health care cost saving. When psychological services are studied, health care costs savings should be a key research variable in any, and all, applied treatment (efficacy or effectiveness studies) or translational services research (Rozensky, 2011). Translational studies that compare the relative costs for outcomes of various treatment programs can help policymakers determine where to get the 'biggest bang for the buck' (e.g., Blount et al., 2007; Cum-

mings, O'Donohue, & Ferguson, 2002; Janicke, Sallinen, Perri, Lutes, Silverstein, & Brumback, 2009; Orszag & Emanuel, 2010) and can be used at the local level to advocate for inclusion of psychological services and reimbursement. Academic programs should consider encouraging students, when appropriate, to add such cost savings data as a dependent variable in masters and doctoral-level treatment research projects. At the least, both at the graduate program and internship levels, such cost offset analyses should be included as a program evaluation competency so that when in the workforce, rank-and-file psychologists can bring those skills to the local practice arena and provide data to help support provision of efficient, as well as effective, patient care that is sure to include psychological services. Such learning opportunities establish an evidence-based foundation for professional advocacy, on a national and local level, and ensure that psychology students see this type of advocacy as a key competency as both scientists and practitioners.

Reimbursement. Some degree of awareness of how health care systems work administratively and financially should be included in education of psychologists who will find themselves as part of the health care workforce. While it certainly is not necessary to become a bona fide health care administrator, some understanding of how dollars flow in the new health care system will be useful. Nordal (2012) noted that it behooves clinicians to think about how prepared they are to meet the financial changes and challenges of this new system to succeed. How is the education and training community ensuring psychologists are receiving that preparation?

For example, Rittenhouse, Shortell, and Fisher (2009) described how ACOs will align financial incentives and clinical accountability across the health care continuum with the PCMH focusing on primary care services as the underpinning for local delivery systems. According to Fisher et al. (2007), ACOs will be based on an extended hospital professional staff model to assure continuity of care and meeting of the ACO mandate, financial *accountability*. This then requires the practicing psychologist to recognize what it means to participate in organizational practices that utilize risk-sharing financial incentives and *global payments* to the local health care system that are in turn passed on to individual providers (Nutting et al., 2011). Curriculum should include some working knowledge of these concepts as well as some applied examples of how such a system might work and how psychologists must position themselves for reimbursement when entering the workforce. There is a plethora of books, articles, and Web sites providing guidance on such financial matters for psychologists. The Web site www.psychologycoding.com, maintained by Antonio Puente, Ph.D., long time champion of psychology's inclusion in health care reimbursement, contains a downloadable, 660 slide Power Point presentation useful in educating faculty, staff, and students about these matters. Information on diagnostic coding, billing, and documenting health psychology services in the context of the ACA would make an excellent addition to any program's curriculum.

Advocacy. Rozensky (2013) argued that professional advocacy should be an integral part of the quality education and training system in professional psychology with a program goal to provide a vehicle for learning how to use data from psychological science to help support the future of the field. He unabashedly states that this will develop a future cadre of proud psychology chauvinists able to utilize data for the common good and the good of the field. Nothing wrong with being proud of one's field and telling others about it; especially when speaking up can help ensure that health care psychology has dollars to support training of psychologists as scientists and health care providers whose services actually are included in the health care system, are understood by policymakers as efficient and effective, deemed worthy of appropriate reimbursement, and routinely are made available to patients who can utilize such services.

Space does not allow a complete discussion of the details of an advocacy curriculum or actual strategies used to ensure psychology is included as a recognized health service profession in the ACA. The education and training community is encouraged to use APAs *Advancing Psychology Education and Training: A Psychologist's Guide to Federal Advocacy Training* and other available guides focused on science and public interest to build their advocacy curricula (http://www.apa.org/about/gr/advocacy/guide.aspx). While now out of print, *A Sample Curriculum for Advocacy Training* has always provided a good foundation for such a curriculum and soon should be replaced online with an enhanced version (http://www.apa.org/ed/). Additional information regarding how professional advocacy actually has been used to ensure that psychology continues to have funding for education, training, scientific research, and clinical reimbursement for health care services (cf. http://www.apaedat.org/; http://www.apapracticecentral.org/advocacy/index.aspx) also should be reviewed and included in the professional development curriculum at all stages of training.

At the local level, academic programs are encouraged to collaborate with their state psychological associations to provide students the opportunity for hands on experience visiting their state capital or meeting with elected federal officials. Being able to work with psychologists, already experienced in "lobbying," and using their data-based knowledge to try their hand at actually advocating for quality health care, can be a sobering, yet exhilarating experience. Being able to speak for the importance of psychological services, for funding for education, training, and the scientific study of the human condition, ensures the next generations experience building a bridge between the laboratory and clinic to the day-to-day social concerns of society at large. They are participating in building psychology's future and the betterment of the human condition.

For success within the local services system, advocacy training should include building skills needed within health care organizations to competently present the data required to ensure psychological services are included as part of integrated care *and* reimbursed. Advocacy training also should include development of skills to speak competently to the media (Dunwoody, Brossard, & Dudo, 2009) given that the media can influence opinion and funding; once again with the goal that our services and science are understood clearly as contributing to society.

Professional Accountability

"America's health care system is methodically entering into the 21st Century with society's leaders steadily developing the expectation of possessing an unprecedented availability of documented *accountability*" (italics added; DeLeon & Kazdin, 2010, p. 314). There are several action steps the education and training commu-

nity can take, across several domains of professional accountability, that will help both professional psychology as a field, and individual psychologists, be prepared to meet these expectations. The very names *patient protection* and "*accountable* care organization," and the focus on accountability in the ACA, offers guidance for the education and training community when considering where to put effort into curriculum change preparing students for the philosophical focus on professional accountability in health care as well as the changes in the physical practice environment.

As the health care system evolves toward enhanced accountability, professional psychology must continue to expand its scientific data describing how psychological services are both evidence-based—with positive clinical outcomes and documented robust effect size—and actually contribute to cost savings (medical or health care cost offset) that are expected or required within the new health care system (Blount et al., 2007; Chiles, Lambert, & Hatch, 1999; Tovian, 2004). The individual psychologist must be able to describe and utilize evidence-based practices and document cost offset at the local level to be a viable player "at the table" as the range of services is defined and local reimbursement rubrics established.

Accreditation and accountability. One of the expectations stemming from the increased demands for accountability in the ACA will be that those individuals who provide patient care in the health care system must document coming from a quality education and training background. One of the face valid measures of quality education is accredited education and training (Rozensky, 2013). Rozensky (2011) reported on a brief survey of health care members of the Association of Specialized and Professional Accreditors that found that psychology was the *only* doctoral level health profession that allowed some individuals from nonaccredited education and training programs to sit for licensing. Belar (2011) described how colleagues in other health professions often were surprised by this lack of required accreditation as a national standard in psychology. This changed in 2013 when the APA approved a new policy requiring APA accreditation of all doctoral or internship programs and accredited education as prerequisite for licensure (APA, 2013). Being from nonaccredited training will not be acceptable in the new, more highly accountable health care system where legally organized provider groups must assure the quality of each provider practicing in their groups. Professional psychology has now acknowledged that it values the same level of *credentialing standards* as all other disciplines on the health care team—this is a major step for the profession in assuring our graduates will be part of organized, accountable health care especially given that ACOs will be built upon the foundations of hospital medical or professional staff structures (Elliot et al., 2007)—with their comprehensive credentialing and privileging requirements (Rozensky, 2006, 2011).

Competency and accountability. Interprofessional and team based competencies discussed earlier are key concepts within the ACA. Again, education and training programs in professional psychology must incorporate development of those competencies in their curricula; a broadening of the culture of competency that is the zeitgeist of contemporary psychology (Roberts et al., 2005). A comprehensive set of Competency Benchmarks, across levels of training in professional psychology (Fouad et al., 2009), was designed to explicates the broad and general criteria for competent trainee performance. These benchmarks should be incorporated across all training programs as the foundation upon which to build competencies for specific activities. Hatcher, Fouad, Grus, Campbell, McCutcheon, and Leahy (2013) refined this benchmarking by developing of a competencies rating form for use by educators, supervisors, and trainees. This measurement tool reorganizes the original Benchmarks to promote clarity, consistency, and functionality in everyday use across programs looking at broad and general competencies.

Beyond broad and general competencies and the ACAs focus on interprofessional, team based competencies, three other specific areas should be reviewed by all education and training programs to make certain they too are incorporated in curricula preparing the next generations practicing in ACA driven health care. One set of competencies focuses on health service psychologists; another set on psychologists practicing in primary care; and a third elaborates issues of cultural competency.

Two documents provide guidance germane to the competencies expected of all psychologists providing services in the health care system. The Health Service Psychology Education Collaborative (HSPEC, 2013) published *A Blueprint for Health Service Psychology Education and Training* acknowledging the extent to which psychologists are providing quality health care services *across* the full range of contemporary patient care settings. This document describes the scientific, professional, ethical, relational, and practice competencies needed to succeed as health service providers. Next, given the importance of the PCMH in the ACA, The Interorganizational Work Group on Competencies for Primary Care Psychology Practice (IWG, 2013) formulated a set of six broad-based competency domains for primary care psychologists: science, systems, professionalism, relationships, application, and education.

> "These [primary care] 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 [primary care] psychologists" (p. 8).

Finally, given the increasing numbers and diversity of patients who will be covered by the ACA, psychology also should redouble its already robust efforts to ensure psychology is preparing a culturally competent workforce of health service psychologists (APA, 2008b; Comas–Diaz, 2011). Given ACAs focus on decreasing the number of uninsured citizens, programs should ensure their curricula includes opportunities for acquisition of the knowledge and skills needed to provide quality care to this growing population of diverse individuals able now to seek (affordable) health care. This will greatly support one of the important aspects of the evolving health care system and continue to ensure psychology leadership in addressing cultural competence.

Evidence-based care and accountability. Section 937 of the ACA discusses building research capacity and the dissemination of information regarding comparative clinical effectiveness research to all health care providers. Evidence-based health care has long been the sine qua non of quality health care (IOM, 2001) and the ACA states that the Secretary of Health and Human Services may only use evidence, and findings from studies conducted under

section 1181 of the Social Security Act, to make determination of services coverage. Thus, evidence-based health care is a major tenet of accountability within the ACA. The Patient-Centered Outcomes Research Institute (http://www.pcori.org/), mandated by the Act, "helps people make informed health care decisions, and improves health care delivery and outcomes, by producing and promoting high integrity, evidence-based information that comes from research guided by patients, caregivers and the broader health care community" (http://www.pcori.org/) and is a source of funding for comparative clinical effectiveness research projects.

Psychology has its own strong history of science supporting evidence-based health care (Goodheart, Kazdin, & Sternberg, 2006; McHugh & Barlow, 2010; Norcross, Beutler, & Levant, 2006); a history consistent with ACAs accountability goals. The very purpose of the scientist-practitioner tradition in health service psychology is reflected in Kazdin's (2008) statement, "The unifying goals of clinical research and practice are to increase our understanding of therapy and to improve patient care" (p. 151).

Each education and training program should make certain that it has within its core curriculum, and clinical training; evidence-based treatment, translational research, and evidence-based treatment services opportunities. Additionally, students should receive instruction on how to evaluate treatment as part of day-to-day practice and assure they understand the importance of evidence-based care as a core of contemporary health care and as a basic expectation of the ACA-driven health care system. The field of professional psychology should establish (similar to the broad-based Cochrane Collaborative; http://www.cochrane.org/about-us/evidence-based-health care in general health care) its own archive designed to highlight the best in evidence-based practices in psychology. This would then provide for (1) our students the best examples of science influencing quality psychological practices and positive health care outcomes across diagnoses, (2) those at the frontline of health care, a compendium of best practices to use to "market services" and clinically implement locally, and (3) for those who choose to advocate for the field of psychology at the state, federal, or local practice environment, a wide range of disease related and treatment outcome data to clearly demarcate quality psychological services (Rozensky & Janicke, 2012).

Specialization and accountability. As a key element of accountable health care, ACOs and PCMHs will expect documentation of specialization as a basic credential for each practicing psychologist once licensed. As an example, *Board Certification* is expected of all physicians in hospital settings, and, if ACOs will be based upon hospital-professional staff structures, then credentialing, to "be on staff" of the (institutional) health care setting of tomorrow, will be based on board certification of its high level providers (Rozensky, 2006, 2010, 2011). Rozensky (2012) noted that today's health care system will look toward, "enhanced accountability including explicit credentialing of providers; credentialing that will require graduation from accredited education programs and with an increasing expectation of specialty board certification" (p. 8).

Once again, this will illustrate how professional psychology is similar to other doctoral-level health care disciplines in its training, quality expectations, and service culture. This expectation is consistent with the prevailing views within contemporary Medicine where specialization is viewed as a means for assuring quality of care in an increasingly specialized health care world (Brennan et al., 2004) and as the standard of practice in organized health care.

The rapid growth of scientific and clinical information in health care demands more specialized knowledge, training, and practice because of the half-life, or diminishing durability of that knowledge (Drum & Blom, 2001; Dubin, 1972; Neimeyer, Taylor, & Rozensky, 2012). Specialization then reflects that an individual provider has chosen to maintain "currency in select areas of particular practice" (Neimeyer et al., 2012, p. 365) and has delimited the range of information they must acquire, renew, and maintain to remain current in their competence to practice (Kaslow, 2011; Rozensky, 2010). The picture that then emerges is one of increasing profusion of knowledge in professional psychology, together with the diminishing half-life of knowledge within it, leading to quality assurance by focused, specialized services.

Education and training programs in professional psychology should review the definitions of APAs recognized specialties in professional psychology (http://www.apa.org/ed/graduate/specialize/crsppp.aspx) and review the criteria for board certification as an individual specialist in one of those specialties (http://www.abpp.org). Kaslow, Graves, and Smith (2012) underscore the importance of specialization in psychology given the growing consumer demand for specialized care as a perceived marker of quality. Becoming board certified speaks directly to a criterion of accountability for quality services in the new health care system where board certification is seen as representing a peer-reviewed recognition of quality. Thus, to support the importance of this marker of quality, faculty and staff, where appropriate, should be—or become—board certified themselves as role models to psychology's students and trainees. Clinical curricula in doctoral programs, internships, and postdoctoral training should include opportunities focused on becoming board certified and programs should consider using a "mini ABPP examination" within any major area of study in each of the recognized specialties in professional psychology as a routine, summative measure of clinical competency in that specialty. This would help prepare each trainee for their future board certification examination and ultimately presenting their credential as "board certified" to their health care institution.

Autonomy, self-definition, and identity. Even as psychologists increasingly serve as team-oriented members of the evolving, interprofessional health care workforce, we must maintain our professional autonomy. Psychologists *must manage our own day-today scope of practice*, our own professional staff, and our own credentialing and privileges within any organized health care setting to ensure protecting our own academic freedom (Rozensky, 2004). To teach this to psychology's students and trainees, psychologists should insist on their own administrative departments in organized health care institutions, not serve as members of another discipline's department (i.e., not Psychiatry, Family Medicine, or Pediatrics). Instead, psychologists should be administratively "housed" in their own department and individual psychologists then can be *assigned*, by their own home psychology department, to provide team-based care for patients within a range of clinical service areas across the institution. Thus, psychologists will supervise and evaluate psychologists and advocate for themselves in the local hospital or services system when budgets are negotiated or financial times are lean. In this manner, psychologists control their own services and do not rely on others to represent them. They protect their scope of practice, self-definition as autono-

mously licensed providers, and their freedom to teach, research, and provide services based on the tenets of the field of psychology (Rozensky, 2004). Where psychologists provide doctoral level practicum and internship programs in institutional settings, becoming such an autonomous, self-governing administrative department is encouraged so that the field does not "rely on the kindness of strangers" for its future (Rozensky, 2004, p. 127) and witnesses to the importance of professional autonomy to our next generation.

It is increasingly important as the health care system becomes more interprofessionally focused that psychologists are seen as part-and-parcel of that system. This not only includes the interprofessional competencies discussed in this paper, and other requirements presented that ensure the profession is seen as similar to other high-level providers (accredited education, board certification, quality, or cost-effective care), but it must include speaking the contemporary language of health care. With the PATIENT Protection and Affordable Care Act providing structure to the health care system, and psychology's increased involvement in primary care settings (PATIENT Centered Health Care/Medical Home), and hospital-centered ACOs; psychology unmistakably is practicing in a *patient*-centered system. Thus, we must acknowledge that we treat "patients," not "clients" in the health care system. With all due, and heartfelt respect to the "client centered" tradition that helped build and shape professional psychology, we must use patient-centered language to communicate with referral sources, our interprofessional health care colleagues (often physicians and nurses who only discuss patients, not clients), and policymakers who pay for *patient* care services (Rozensky, 2011). The education and training community is encouraged to adopt only the term *patient* as our routine definition of those whom we serve, and help our next generations prepare to communicate in the language of the *patient* centered health care system when they are practicing as health service providers.

Recommendations

Enhanced interprofessional education, grounded in the knowledge, skills and attitudes of shared clinical competencies, across all health care professions, will assure continued success of psychological services in the era of ACA. This is especially true as we will see more and more psychologists working in institutional practice settings (Rozensky, 2011).

Thus, this question,

> "If (1) the overall field of health care is focused increasingly on interprofessionalism (e.g., IEC, 2011), and (2) interprofessional education, training and services are recognized in the ACA, and (3) ACOs and PCMHs will be the institutional practice venues of the future (4) based on interprofessional practice competencies, and (5) reimbursement for effective and efficient services will go to the 'system' (ACO or PCMH) to then reimburse each professional providing services in that system, then, (6) how do we assure that psychology [and each psychologist] is part of that future?" (Rozensky, 2011, p. 802).

To address that multifaceted question, the following recommendations are offered as actions steps for the education and training community to consider when planning curricula for the future.

Interprofessionalism

1. Utilize the language of interprofessional health care.
2. Develop interprofessional and team-based competencies.
3. Design curricula and clinical, practical experiences to build competencies in interprofessional, integrated care from health promotion to disease prevention to primary and tertiary care for both behavioral\mental health and physical\medical health services.
4. Utilize language consistent with the Patient Protection and Affordable Care Act, patient centered health care system, and the rest of the health care workforce (e.g., going forward, health service psychologists use the word "patient" vs. "client").

Workforce Analysis and Development

1. Design curricula and practical training opportunities (sites) to reflect the populations and practice venues of tomorrow.
2. Professional psychology must develop meaningful, national workforce analysis capabilities (Rozensky, 2011; Rozensky et al., 2007) so that we can predict how many psychologists are needed and where. This data then can be used to offer guidance to (a) students seeking training (is my specialty needed and where?), (b) programs wishing to provide targeted education to the next generation of health service psychologists, and (c) policymakers (local services systems, insurance executives, and government planners) who will provide financial support for education and practice.

Finances (Reimbursement, Health Care Cost Offset, and Advocacy)

1. Encourage student to include *cost offset data* in their treatment related efficacy and effectiveness research. Theses and dissertations that illustrate that psychological treatments actually save medical costs, while being clinically effective care, will support an evidence-based future that will include psychological health care programming that enhances affordability for all.
2. Design curricula that makes certain the next generation understands how patient care services will be reimbursed in the future including a working knowledge of local changes to Medicare, Medicaid, health insurance exchanges, and how 'pay for performance,' and global reimbursement might work including use of Health and Behavior Codes for biopsychosocial psychological services for patients with medical diagnoses.
3. Curricula or administrative opportunities during training should expose students to practice planning including how to establish a business relationship with, or integration within, the local ACO or PCMH. With mandated

inclusion of certified electronic health care record technology in health care systems, training must assure the students understand Federal regulations, local organizational expectations, professional ethics issues, and have technical skills related to day-to-day use of electronic health care records and electronic billing. Discussions such as at http://www.apa.org/health-reform can be helpful in keeping practice-related curriculum relevant when doing strategic program planning.

Professional Accountability

1. Education and training should take place *only* in APA accredited education and training programs (APA, 2013; Belar, 2011; Rozensky, 2013).

2. Competency-based education should be a focus of programs at all levels of training and for all venues of practice.

3. Students should be prepared to bring psychology's core competence in research and outcome measurement (program evaluation) to each health care setting; a robust role for psychologists.

4. Cultural competency should be highlighted in all programs given the increasing numbers and diversity of patients whose health care costs will be covered by the ACA.

5. Curricula and practical training should be evidence-based and students should be prepared to scientifically add to that literature, utilize evidence-based treatment on a day-to-day basis, and speak knowingly about its use locally or where policy is determined. As suggested earlier, the education and training community should advocate nationally for, and locally prepare, a Cochrane Collaborative-like archive (http://www.cochrane.org/about-us/evidence-based-healthcare) that includes the best in evidence-based practices research across health service psychology (Rozensky & Janicke, 2012).

6. Utilize APAs (2012) policy as guidance to consistently describe program content for education and training opportunities within the recognized specialties in professional psychology (beyond the broad and general training required of accredited programs) at all levels of training by utilizing specialty-specific educational guidelines as promulgated by each specialty. This enhances truth-in-advertising when describing program content to students.

7. All faculty or staff in your local program should be board certified given the expectation of board certification for those who practice in hospitals and organized health care settings (Rozensky (2006, 2011). A "mini ABPP exam" for any major area of study in one of the recognized specialties in professional psychology can become a routine, summative measure of clinical competency.

8. All psychological services in organized health care settings should be based in independent departments of psychology. While it is clearly important in the age of ACA for psychology to respect, and fervently participate in the interprofessional opportunities in tomorrow's health care system, we should do that from the secure foundation of our own administrative department that protects academic freedom, our scope of practice, and local psychology programs' and staff or faculty financial viability (Rozensky, 2004, 2011).

9. Education and training programs should revisit their curriculum and practical training and consider abandoning both the DSM system and the modifier "psychiatric" for disorders and consider using "psychological, mental health, or behavioral" disorders and the ICD in response to the controversies surrounding the adoption of the new *Diagnostic and Statistical Manual 5* (Whooley & Horwitz, 2013), and the more data-driven approach to enhancing clinical utility of diagnoses of mental and behavioral disorders in the upcoming World Health Organization's *International Classification of Diseases* (ICD-11; Roberts et al., 2012).

10. Students should be prepared to bring forward the evidence-based nature of psychological treatments' strong effect size and efficient and effective patient care services in a role as advocates for psychology and quality patient care. Cost savings and quality care arguments, backed with the data, to governmental policymakers and local ACO and PCMH administrators should ensure psychologists' place in "the home" (Rozensky, 2012). Our next generation should be experts in this approach.

11. Encourage students, faculty, and staff to develop their lifelong learning plans to remain current (competent) in the fast changing, evidence-based health care environment.

12. The education and training community in professional psychology should work together to host a discipline-wide conference to confirm foundational definitions of the field and plan together how to manage the changes to come during the implementation of the ACA.

Conclusion, or Pocius Potius, Change

While the changes coming to the U.S. health care system can seem daunting, they actually provide an opportunity for the broader psychological community of scientists, educators, scholars, and practitioners to highlight the day-to-day contributions of the field to the public's interest and psychological and physical well-being. From understanding normal child development, to learning in school, to adolescent transitions, to successful careers and healthy workplaces; from stress management to healthy aging or helping to manage problems experienced by older adults; from health promotion, to disease prevention, to adherence to health care treatments, to working with patients with a full ranges of medical diagnoses; from helping communities and individuals recover from trauma and disasters, to psychotherapeutic treatment of those living with ongoing psychological disorders, to helping enhance the quality of life of those with chronic medical illnesses—there is much that psychology offers society and the citizens whose lives will be impacted by the ACA.

Roberts (2005) has likened changes within the education and training community "to turning an ocean liner; it takes a plan, care, patience, and time. The inertia of the *status quo* prevents inappropriate sudden movements in the progress of the field while also unfortunately impeding appropriate and innovative adaptation to changes in the environment and within the field itself" (p. 1081). This reticence might be even louder when there is uncertainty about how the ACA is going to be implemented due the politics surrounding it. However, whether it is the current ACA, or some iteration of health care reform, changes detailed in this paper are coming. Roberts notes that psychology is at least a ship, thus maneuverable. We must stand on the bridge, look at our charts, and prepare to navigate through the changes ahead.

Throughout the history of the field, psychologists are "now and will continue to be members of the modern-day health care alliance" with success based on "science and service and the politics of competence,"—the day-to-day use of knowledge and skills in the interprofessional application of science to health care (Rozensky, Sweet, & Tovian, 1991, p. xv). The responsibility of the education and training community in professional psychology is to understand the evolving workforce demands and opportunities in our changing health care system, to understand the broad brush and nuanced changes in health care, and then utilize that understanding to prepare the next generations of health service psychologists for success given those changes.

> Change will *not* come if we wait for some other person,
>
> Or if we wait for some other time.
>
> We are the ones we've been waiting for.
>
> We are the change that we seek.
>
> —Barack Obama

References

Agency for Healthcare Research and Quality. (2013). *PCMH resource center*. Retrieved from www.apa.org/ed/resources.html

American Psychological Association. (2008a). *Teaching, learning, and assessing in a developmentally coherent curriculum*. Washington, DC: American Psychological Association, Board of Educational Affairs. Retrieved from www.apa.org/ed/resources.html

American Psychological Association. (2008b). *Report of the task force on the implementation of the multicultural guidelines*. Washington, DC: Author. Retrieved from http://www.apa.org/pi/

American Psychological Association. (2009). *2008 APA survey of psychology health service providers*. Retrieved from http://www.apa.org/workforce/publications/08-hsp/index.aspx

American Psychological Association. (2012). *Education and training guidelines: A Taxonomy for education and training in professional psychology health service specialties*. Retrieved from http://www.apa.org/ed/graduate/specialize/taxonomy.pdf

American Psychological Association. (2013). *Resolution on accreditation for programs that prepare psychologists to provide health services, APA Council of Representatives Agenda Book*. Washington, DC: Author.

Auerbach, D. I. Staiger, D. O., Muench, U., & Buerhaus, P. I. (2013). The nursing workforce in an era of health care reform. *New England Journal of Medicine, 368,* 1470–1472. doi:10.1056/NEJMp1301694

Belar, C. (2011). A developmental milestone. *Monitor on Psychology, 42,* 49.

Benjamin, L. T. (2001). American psychology's struggles with its curriculum: Should a thousand flowers bloom? *American Psychologist, 56,* 735–742. doi:10.1037/0003-066X.56.9.735

Bennett, K. L., & Phillips, J. P. (2010). Finding, recruiting, and sustaining the future primary care physician workforce: A new theoretical model of specialty choice process. *Academic Medicine, 85,* S81–S88. doi:10.1097/ACM.0b013e3181ed4bae

Blount, A., Schoenbaum, M., Kathol, R., Rollman, B. L., Thomas, M., O'Donohue, W., & Peek, C. J. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. *Professional Psychology: Research and Practice, 38,* 290–297, doi:10.1037/0735-7028.38.3.290

Brennan, T. A., Horwitz, R. I., Duffy, F. D., Cassel, C. K., Goode, L. D., & Lipner, R. Z. (2004). The role of physician specialty board certification status in the quality movement. *Journal of the American Medical Association, 292,* 1038–1043. doi:10.1001/jama.292.9.1038

Brown, L. J. (2012). Introduction and guide to the special issue on economic and workforce issues facing dentistry and dental education in the twenty-first century. *Journal of Dental Education, 76,* 965–972.

Chiles, J. A., Lambert, M., & Hatch, A. L. (1999). The impact of psychological interventions on medical cost offset: A meta-analytic review. *Clinical Psychology: Science and Practice, 6,* 204–220. doi:10.1093/clipsy.6.2.204

CMS Office of Legislation. (2010). *Medicare "Accountable Care Organizations" Shared Savings Programs–New Section 1899 of Title VIII*. http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp#TopOfPage

Comas–Dias, L. (2011). *Multicultural care: A clinician's guide to cultural competence*. Washington, DC: American Psychological Association. doi:10.1037/13491-000

Cummings, N. A., O'Donohue, W. T., & Ferguson, K. E. (Eds.). (2002). *The impact of medical cost offset on practice and research: Making it work for you. Foundation for Behavioral Health: Healthcare Utilization and Cost Series* (Vol. 5). Reno, NV: Context Press.

D'Amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care, 19,* 8–20. doi:10.1080/13561820500081604

DeLeon, P. H., & Kazdin, A. E. (2010). Public policy: Extending psychology's contributions to national priorities. *Rehabilitation Psychology, 55,* 311–319. doi:10.1037/a0020450

Drum, D. J., & Blom, B. E. (2001). The dynamics of specialization in professional psychology. *Professional Psychology: Research and Practice, 32,* 513–521. doi:10.1037/0735-7028.32.5.513

Dubin, S. S. (1972). Obsolescence or lifelong education: A choice for the professional. *American Psychologist, 27,* 486–498. doi:10.1037/h0033050

Dunwoody, S., Brossard, D., & Dudo, A. (2009). Socialization or rewards? Predicting U.S. scientist-media interactions. *Journalism & Mass Communication Quarterly, 86,* 299–314. doi:10.1177/107769900908600203

Falk–Krzesinski, H. J., Börner, K., Contractor, N., Fiore, S. M., Hall, K. L., Keyton, J., . . . Uzzi, B. (2010). Advancing the science of team science. *Clinical and Translational Science, 3,* 263–266 doi:10.1111/j.1752-8062.2010.00223.x

Fisher, E. S., Staiger, D. O., Bynum, J. P. W., & Gottlieb, D. J. (2007). Creating accountable care organizations: The extended hospital medical staff. *Health Affairs, 26,* w44–w57. doi:10.1377/hlthaff.26.1.w44

Fouad, N. A., Grus, C. L., Hatcher, R. L., Kaslow, N. J. Hutchings, P. S., Madson, M. B., Collins, F. L., & Crossman, R. E. (2009). Competency benchmarks: A model for understanding and measuring competency in professional psychology across training levels. *Training and Education in Professional Psychology, 3,* S5–S26. doi:10.1037/a0015832

Frank, R., McDaniel, S. H., Bray, J. H., & Heldring, M. (Eds.). (2004). *Primary care psychology*. Washington, DC: American Psychological Association Publications. doi:10.1037/10651-000

Frenk, J., Chen, L., Bhutta, Z. A., Cohen, N. C., Evans, T., Fineberg, H., . . . Zurayk, H. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet, 376,* 1923–1958. doi:10.1016/S0140-6736(10)61854-5

Goodheart, C. D., Kazdin, A. E., & Sternberg, R. J (Eds.). (2006). *Evidence-based psychotherapy: Where practice and research meet*. Washington, DC: American Psychological Association. doi:10.1037/11423-000

Grus, C. L., McCutcheon, S. T., & Berry, S. L. (2011). Actions by professional psychology education and training groups to mitigate the internship imbalance. *Training and Education in Professional Psychology, 5,* 193–201. doi:10.1037/a0026101

Gunn, W. B., & Blount, A. (2009). Primary care mental health: A new frontier for psychology. *Journal of Clinical Psychology, 65,* 235–252. doi:10.1002/jclp.20499

Hatcher, R. L., Fouad, N. A., Grus, C. L., Campbell, L. F., McCutcheon, S. R., & Leahy, K. L. (2013). Competency benchmarks: Practical steps toward a culture of competency. *Training and Education in Professional Psychology, 7,* 84–91. doi:10.1037/a0029401

Health Service Psychology Education Collaborative. (2013, August). Professional psychology in health care services: A blueprint for education and training. *American Psychologist*. Advance online publication. doi:10.1037/a0033265.

Interorganizational Work Group on Competencies for Primary Care Psychology Practice. (2013). *Competencies for psychology practice in primary care*. Retrieved from http://www.apa.org/ed/resources/competencies-practice.pdf

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. IOM, PDF report brief summary. Retrieved from http://www.nap.edu/books/0309072808/html/

Institute of Medicine. (2013). *Interprofessional education for collaboration: Learning how to improve health from interprofessional models across the continuum of education to practice: Workshop summary*. Washington, DC: The National Academies Press.

Interprofessional Education Collaborative. (2011). *Team-based competencies: Building a shared foundation for education and clinical practice: Conference proceedings*. February 16–17. Washington, DC: Interprofessional Education Collaborative.

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, DC: Interprofessional Education Collaborative.

Janicke, D. M., Sallinen, B. J., Perri, M. G., Lutes, L. D., Silverstein, J. H., & Brumback, B. (2009). Comparison of program costs for parent-only and family-based interventions for pediatric obesity in medically underserved rural settings. *The Journal of Rural Health, 25,* 326–330. doi:10.1111/j.1748-0361.2009.00238.x

Kaslow, N. J. (2011, March). *Specializing in psychology: What it means for health care reform*. Paper presented at the Association of Psychologists in Academic Health Centers Conference, Boston, MA.

Kaslow, N. J., Graves, C. C., & Smith, C. O. (2012). Specialization in psychology and health care reform. *Journal of Clinical Psychology in Medical Settings, 19,* 12–21. doi:10.1007/s10880-011-9273-0

Kaslow, N. J., Grus, C. L., Campbell, L. F., Fouad, N. A., Hatcher, R. L., & Rodolfa, E. R. (2009). Competency assessment toolkit for professional psychology. *Training and Education in Professional Psychology, 3,* S27–S45. doi:10.1037/a0015833

Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist, 63,* 146–159. doi:10.1037/0003-066X.63.3.146

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

Kirkwood, M. K., Kosty, M. P., Bajorin, D. F., Bruinooge, S. S., & Goldstein, M. A. (2013). Tracking the workforce: The American Society of Clinical Oncology Workforce information system. *Journal of Oncology Practice, 9,* 3–8. doi:10.1200/JOP.2012.000827

McDaniel, S. H., Belar, C. D., Schroeder, C., Hargrove, H. S., & Freeman, E. L. (2002). A training curriculum for professional psychologists in primary care. *Professional Psychology: Research and Practice, 33,* 65–72. doi:10.1037/0735-7028.33.1.65

McHugh, K. R., & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist, 65,* 73–84. doi:10.1037/a0018121

National Federation of Independent Business v. Sebelius, No. 11–393, 2012 U.S. LEXIS 4876 (June 28, 2012).

Neimeyer, G. J., Taylor, J. M., & Rozensky, R. H. (2012). The diminishing durability of knowledge in professional psychology: A Delphi poll of specialties and proficiencies. *Professional Psychology: Research and Practice, 43,* 364–371. doi:10.1037/a0028698

Newman, R. J., & Rozensky, R. H. (1995). Psychology and primary care: Evolving traditions. *Journal of Clinical Psychology in Medical Settings, 2,* 3–6. doi:10.1007/BF01988623

Norcross, J. C., Beutler, L. E., & Levant, R. F (Eds.). (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. Washington, DC: American Psychological Association. doi:10.1037/11265-000

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

Nutting, P. A., Crabtree, B. F., Miller, W. L., Stange, K. C., Stewart, E., & Jaen, C. (2011). Transforming physician practices to patient-centered medical homes: Lessons from the National Demonstration Project. *Health Affairs, 30,* 3, 439–445. doi:10.1377/hlthaff.2010.0159

Orszag, P. R., & Emanuel, E. J. (2010). Health care reform and cost control. *The New England Journal of Medicine, 363,* 601–603. doi:10.1056/NEJMp1006571

Public Law No. 111–148, 111th Congress: Patient Protection and Affordable Care Act. (2010). 124 STAT. 119. Retrieved from www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

Rittenhouse, D. R., Shortell, S. M., & Fisher, E. S. (2009). Primary care and accountable care–two essential elements of delivery system reform. *New England Journal of Medicine, 361,* 2301–2303. doi:10.1056/NEJMp0909327

Roberts, M. C. (2005). Perspectives on education and training in clinical psychology: Integrating reactions. *Journal of Clinical Psychology, 61,* 1077–1082. doi:10.1002/jclp.20140

Roberts, M. C., Borden, K. A., Christiansen, M. D., & Lopez, S. J. (2005). Fostering a culture shift: Assessment of competence in the education and careers of professional psychologists. *Professional Psychology: Research and Practice, 36,* 355–361. doi:10.1037/0735-7028.36.4.355

Roberts, M. C., Reed, G. M., Medina–Mora, M. E., Keeley, J. W., Sharan, P., Johnson, D. K., . . . Saxena, S. (2012). A global clinicians' map of mental disorders to improve ICD-11: Analysing meta-structure to enhance clinical utility. *International Review of Psychiatry, 24,* 578–590. doi:10.3109/09540261.2012.736368

Rozensky, R. H. (2004). Freestanding psychology: The only way in academic health centers. *Journal of Clinical Psychology in Medical Settings, 11,* 2, 127–133. doi:10.1023/B:JOCS.0000025724.09384.3d

Rozensky, R. H. (2006). Psychologists treating medically ill patients: Seeking credentials in organized healthcare settings for routine or inci-

dental practice. *Professional Psychology: Research and Practice, 37,* 260–263. doi:10.1037/0735-7028.37.3.260

Rozensky, R. H. (2010, September). *Specialization and specialists in professional psychology and the role of lifelong learning*. Paper presented at the APA Educational Leadership Conference, Washington, DC.

Rozensky, R. H. (2011). The institution of the institutional practice of psychology: Health care reform and psychology's future workforce. *American Psychologist, 66,* 797–808. doi:10.1037/a0025074

Rozensky, R. H. (2012). Health care reform: Preparing the psychological workforce. *Journal of Clinical Psychology in Medical Settings, 19,* 5–11. doi:10.1007/s10880-011-9287-7

Rozensky, R. H. (2013). Quality education in professional psychology: Flowers blooming, Flexner, and the future. *American Psychologist, 68,* 703–716. doi:10.1037/a0033771.

Rozensky, R. H., Grus, C. L., Belar, C. D., Nelson, P. D., & Kohout, J. L. (2007). Using workforce analysis to answer questions related to the internship imbalance and career pipeline in professional psychology. *Training and Education in Professional Psychology, 1,* 238–248. doi:10.1037/1931-3918.1.4.238

Rozensky, R. H., & Janicke, D. M. (2012). Commentary: Health care reform and psychology's workforce: Preparing for the future of pediatric psychology. *Journal of Pediatric Psychology, 37,* 359–368. doi:10.1093/jpepsy/jsr111

Rozensky, R. H., Sweet, J. J., & Tovian, S. M. (1991). Forward. In J. J. Sweet, R. H. Rozensky, and S. M. Tovian (Eds.), *Handbook of Clinical Psychology in Medical Settings* (pp. xi–xv). New York, NY: Plenum Press.

Schuetz, B., Mann, E., & Evertt, W. (2010). Educating health professionals collaboratively for team-based primary care. *Health Affairs, 29,* 1476–1480. doi:10.1377/hlthaff.2010.0052

Shachak, A., & Jadad, A. R. (2010). Electronic health records in the age of social networks and global telecommunications. *Journal of the American Medical Association, 303,* 452–453. doi:10.1001/jama.2010.63

Tovian, S. M. (2004). Health services and health care economics: The health psychology marketplace. *Health Psychology, 23,* 138–141. doi:10.1037/0278-6133.23.2.138

Whooley, O., & Horwitz, A. V. (2013). The paradox of professional success: Grand ambition, furious resistance, and the derailment of the *DSM-5* revision process. In J. Paris & J. Philips (Eds.). *Making the DSM-5* (pp. 75–92). New York, NY: Springer. doi:10.1007/978-1-4614-6504-1_6

Wilson, S. L., Rozensky, R. H., & Weiss, J. (2010). The advisory committee on interdisciplinary community-based linkages and the federal role in advocating for interprofessional education. *Journal of Allied Health, 39,* 210–215.

Received June 25, 2013
Revision received August 29, 2013
Accepted August 29, 2013 ■