The Patient-Centered Medical Home: Unprecedented Workforce Growth Potential for Professional Psychology

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Changes in the health care system and a renewed focus on patient-centered medical homes, which integrate behavioral health services into primary care, present professional psychologists with unprecedented workforce and growth opportunities. However, the profession must act immediately to take full advantage of these emerging opportunities. Although many conceptualize integrated primary care as including mental health services in primary care, in practice, the role of the primary care behavioral professional extends far beyond mental health concerns. The authors suggest two key domains of action: First, in order to serve optimally as behavioral health professionals and leaders in primary care, psychologists must receive training in clinical health psychology. Second, psychologists need to increase knowledge and skills in the conduct of translational research in “real-world” clinical settings. The discussion centers on delineating the imperatives the profession must address and offers general suggestions for possible approaches, which ideally will form the basis for specific models of professional preparation. What is abundantly clear is that, as the face of health care changes, professional psychology must respond swiftly and appropriately not only to remain viable, but to thrive.

Keywords: primary care, health psychology, training, health care, research

Although primary care will continue to be both the foundation of the US health care system (Croghan & Brown, 2010) and the most likely first “port of call” for patients seeking treatment for any health problem (McDaniel, Hargrove, Belar, Schroeder, & Freeman, 2003, p. 65), the way in which such care is delivered is changing. Likewise, “training for mental health services alone, although very important, will not be sufficient” in the face of such changes (Belar, 2004). Integrated primary care, which brings together medical and behavioral health care in a primary care setting, continues to evolve with the advent of the patient-centered medical home (PCMH) and ongoing legislative reforms in health care.

Premised on a model of healthcare for the whole person (Kaslow et al., 2007; Levant & Heldring, 2007), the PCMH seeks to deliver care that is patient-centered, comprehensive, coordinated, accessible, and continuously improved through a systems-based approach to quality and safety (http://www.pcmh.ahrq.gov/)

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Two core principles of the PCMH support the integral role of psychology: (a) treatment of the whole person, and (b) care that is integrated within the medical home and across health care service disciplines. Each patient has a personal physician who serves as a team leader and is responsible for providing or arranging for patient care with other professionals on the care team. The psychologist, serving as a behavioral health consultant and/or direct service provider, is a key team member. The role of behavioral health in this model is considered inseparable from other aspects of a patient’s care (http://www.pcpcc.net/behavioral-health).

Building such a robust primary care delivery platform requires significant workforce development, which provides unprecedented opportunities for professional psychologists who are trained in clinical health psychology, who have much of the requisite expertise that is uniquely suited to delivering healthcare for the whole person. In fact, psychologists trained to serve in integrated primary health care settings are heralded as model health care providers for the 21st century (Levant, 2004, 2005).

Although many administrators, healthcare and behavioral health providers conceptualize integrated primary care as including mental health services in primary care (Croghan & Brown, 2010; Mauer, 2008), in practice, the role of the primary care behavioral professional extends far beyond mental health concerns. Behavioral health professionals must be prepared to incorporate myriad interventions routinely to address behavioral medicine issues, including chronic illness management, modification of disease risk through health behavior change, and adherence to prescribed medical and behavioral regimens (Beacham, Hoodin, Sieber, Ponkshe, & Goodie, 2008; Blount, 2003; Hoodin, Beacham, Alschuler, & Bierenbaum, 2008; Pruitt, Klapow, Epping-Jordan, & Dresselhaus, 1998).

Psychologists, particularly clinical health psychologists, already provide patients in primary care settings with mental health and behavioral medicine intervention services “...such as prevention, diagnosis, evaluation, assessment, treatment and management services. Typically, psychologists design, implement, and evaluate behavioral interventions to address the patient’s treatment compliance in the management of acute and chronic health conditions such as diabetes, heart disease, obesity, cancer, and depression” (http://www.apapracticecentral.org/advocacy/medical/health-care-reform.aspx, para. 5, Feb. 2009). Because of this unique role, professional psychologists and their services, the APA asserted, should be fully integrated into any legislative initiative that strengthens the role of primary care in the health system. With this declaration, the APA sought to set the stage for professional psychology to become an integral player and leader in the evolution of health care reform and the PCMH.

Setting the stage matters little, however, if the curtain never goes up. Unfortunately, few psychologists have adequate academic training or workplace experience in clinical health psychology, particularly in primary care, to carry out their professional duties adeptly in the fast-paced setting of a PCMH that involves many diverse types of patients. The good news is that PCMHs, with 50 multistakeholder pilot projects underway in at least 18 states as of this writing (http://www.pcpcc.net/pilots), as well as numerous other governmental and public initiatives, are expected to continue to emerge within the next five years. Such changes present professional psychologists with the potential for unprecedented growth.

Here, we examine the developing opportunities for professional psychology in the context of the PCMH and projected workforce shortages. We then suggest two complementary and parallel domains of action for maximizing the profession’s ability to take advantage of these burgeoning opportunities: (a) provide primary care clinical and research training opportunities for professional psychologists that align with the PCMH model, and (b) apply the results of translational research to training.

### Developing Opportunities for Professional Psychology

The recent reemergence of generalist medicine and the revitalization of the PCMH concept create tremendous opportunities for primary care psychology (Blount & Miller, 2009; Bray, 2010; McDaniel et al., 2003), particularly in the face of projected work shortages stemming from the anticipated widespread implementation of the PCMH model. Such shortages are likely because of the recent expansion of the National Committee for Quality Assurance (NCQA) accreditation standards, which propose that a primary care practice seeking designation as a PCMH should provide screening for mental health, substance abuse, and health behaviors. Additionally, each practice must have evidence-based protocols for three common illnesses, and one of these illnesses must be related to unhealthy behaviors (e.g., obesity) or a mental health or substance abuse condition (http://www.ncqa.org/tabid/631/Default.aspx). Thus, a practice that does not integrate behavioral health professionals on the interdisciplinary health care team may have difficulty meeting the updated standards in order to be designated as a PCMH (Croghan & Brown, 2010; Dickinson & Miller, 2010; Hunter & Goodie, 2010).

The new standards and the expanding prominence of the PCMH, on one hand, mean good news for psychologists who are competent to serve as health care providers and leaders in these settings. On the other hand, increasingly wider implementation of behavioral health services in primary care creates a looming workforce and educational shortfall (Blount & Miller, 2009; Hunter & Goodie, 2010; O’Donohue, Cummings, & Cummings, 2009). This shortage, if not addressed in the near term, will exert considerable pressure on: (a) professional psychologists who have not been trained to practice in primary care settings, (b) soon-to-be clinical psychology graduates who are entering the workforce without a grounding in primary care practice, and (c) clinical psychology programs, which will need to modify their curricula to meet the changing demands of the marketplace.

The projected workforce shortage will be exacerbated further as more public and private sector pilot projects commence. Various national behavioral health programs and PCMH initiatives already are increasing the demand for psychologists who are trained in primary care, or will increase that demand in the near future. The Veterans Administration (VA), for example, requires that its medical centers and large community-based outpatient clinics (i.e., those that see more than 10,000 unique veterans each year) have integrated mental health services that operate full-time in their primary care clinics (Veterans Health Administration, 2008, p. 34). In addition, the VA recently funded 153 health behavior coordinator (HBC) positions to serve major VA medical centers and community-based outpatient clinics. In addition to a primary focus
on training and coaching medical staff to enhance patient-centered communication skills, the HBCs also have direct patient care contact for health behavior issues, such as supporting the MOVE! Weight Management program (http://www.move.va.gov) and tobacco cessation efforts (M. Dundon, personal communication, March 17, 2011). Notably, the VA sought clinical psychologists with additional training and experience in health psychology to fill many of these positions (http://www.prevention.va.gov/Health-POWER_Prevention_News_Spring_2010_HelthPromotion.asp). In addition to the foregoing, the VA seeks psychologists to fill integrated home-based primary care positions serving older veterans (Veterans Health Administration, 2008).

Under a major initiative that could substantially increase workforce opportunities for clinical health psychologists, the U.S. Department of Defense is projected to hire more than 400 behavioral health personnel from fiscal year 2012 to fiscal year 2016 to work full-time in PCMHs. This initiative stipulates that PCMH sites that have up to 7499 enrolled beneficiaries will have a minimum of one full-time behavioral health professional, and those sites that have 7500 or more enrollees will have a behavioral health professional in addition to a care manager delivering services within the PCMH site (United States Army Medical Command Headquarters, 2011). Because these positions may be filled with nursing, psychiatry, psychology, psychiatric nurse practitioner, or social work personnel, however, the greatest opportunities will accrue to those who possess the requisite skill set for these settings.

Finally, although no new initiatives are currently underway with respect to the more than 6,000 community or federally qualified health centers nationwide (http://findahealthcenter.hrsa.gov/Search_HCC.aspx?byCounty = 1), many of these centers offer ideal settings for psychology training in primary care behavioral health to address health care disparities among patients who have the fewest resources and the greatest behavioral health care needs (DeLeon, Kenkel, & Belar, 2007). Psychologists in these settings can be vital members of primary care-based initiatives by providing (a) interdisciplinary training opportunities and supervision, (b) direct service delivery, and/or (c) leadership in developing, implementing, and evaluating programmatic initiatives designed to enhance population-based health outcomes. Notwithstanding all that psychologists can offer in these settings, only a small number of these centers currently employ psychologists to develop behavioral health programs and provide related services. If psychologists are to take full advantage of the potential workforce opportunities, the onus is on the discipline to demonstrate unequivocally the added value that psychologists can offer in these settings, especially considering that less “expensive” mental health professionals may seek and be sought to fill these positions (Thielke, Thompson, & Stuart, 2011).

How Professional Psychology Can Maximize Workforce Opportunities

Given that the number of major and minor primary care rotations is continually increasing, one might assume that the number of new psychology graduates could handily meet the growing primary care workforce need. There are two problems with this assumption. First, the majority of psychology interns or graduates will not have had adequate clinical health psychology preparation for such primary care setting. Second, rotations in “integrated” primary care provide widely variable experiences—in part because, although many sites define themselves as integrated, in practice there often is very little that differentiates these sites from others using more traditional models of service delivery (Hoodin et al., 2008).

Hoodin and colleagues also found that, regardless of the service delivery model employed, the sites it surveyed regularly fielded, in addition to mental health issues, a wide array of behavioral medicine presenting problems. Notwithstanding the survey’s small scale, the results underscore the need for behavioral health personnel to receive both primary care and clinical health psychology training to meet “whole” patient and program needs in the PCMH adequately.

The number of psychologists who are optimally trained in this way is decidedly sparse. A Google search of clinical psychology/primary care doctoral programs identified just 12 such programs (7 PhD, 5 PsyD). Although there are currently 80 clinical health psychology programs (Larkin, 2009), we were unable to search the APA Division 38 Web site (http://www.health-psych.org/ProgramSearch.cfm) for programs that offer additional training in primary care, because primary care is not currently a listed search term. A search of the APPIC internships using the combined search terms of health psychology and primary care major rotations returned just 99 results (http://www.appic.org/directory/search_dol_internships.aspx). If a program that combines training in clinical health psychology and primary care is considered ideal preparation for psychologists in PCMHs and other integrated care settings, then the number of optimally trained entry-level professional psychologists entering the workforce each year is sorely inadequate to meet the impending demand for primary care positions.

Consequently, efforts to maximize workforce opportunities necessarily must focus on the scope and availability of training programs that emphasize clinical health psychology and primary care. What follows are suggestions for actions that professional psychology would do well to consider implementing with respect to such programs in order to take advantage of these emerging opportunities. These suggestions are intended as a starting point and ideally will promote thoughtful discussion about ways that professional psychology can navigate the ever-changing health care landscape; a comprehensive model that outlines goals, strategies, and recommendations for implementation is beyond the scope of this paper.

Provide primary care clinical and research learning opportunities. Placing traditionally trained mental health clinicians directly into primary care settings with no significant and specific training often results in programmatic failure. Whereas existing health psychology programs and curricula may serve as the ideal home for primary care training, they have been criticized as “tend[ing] to prepare graduates for specialty research and practice in medical settings rather than . . . [for] the pace, culture, and broad spectrum of needs in primary care” (Blount & Miller, 2009, p. 113; Thielke et al., 2011). Despite the substantial overlap in the competency-based guidelines for behavioral health and primary care providers (Strosahl, 2005), the knowledge-based and application competencies in clinical health psychology (France et al., 2008; Masters, France, & Thorn, 2009), and the core areas of knowledge and skill for primary care psychology (McDaniel et al., 2003), the environments in which they are applied differ markedly.
By recognizing the inherent value of competencies in primary as well as specialty, secondary, and tertiary care medicine, clinical health psychology programs can become the iconic training venue for the next generation of PCMH behavioral health clinical and research professionals.

Weaving a primary care component into the clinical health psychology curricula undoubtedly will spark debate about whether such training should be considered “broad and general” training or “specialty” training that should be managed at the internship and postdoctoral stages of professional development. Given that this debate likely will continue well past the culmination of the projected primary care workforce shortage, program faculty might consider the relative cost of continuing “business as usual”—that is, relegating primary care learning opportunities to the latter part of psychologists’ training. Our goal is not to debate whether such training is “broad and general” or “specialty” in nature, but to consider the practical implications of failing to respond in a timely way to the health care service delivery shifts and impending workforce demands.

Some of those who supervise and oversee primary care internship and postdoctoral programs have commented that incoming trainees who have had at least some exposure to primary care models or settings have a more expeditious learning curve than do those who have not (L. Kearney, personal communication, January 24, 2011). In the case of other internships with primary care rotations, applicants without at least some primary care exposure may not be considered viable candidates. In light of the soaring applicant demand and competition for these internships, applicants considering primary care training opportunities in the latter part of psychologists’ training. Our goal is not to debate whether such training is “broad and general” or “specialty” in nature, but to consider the practical implications of failing to respond in a timely way to the health care service delivery shifts and impending workforce demands.

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Standardization is needed with respect to integrated primary care models, therapeutic orientation, didactics, and metrics describing the training experiences, lest sites with vastly different referents still self-identify as fully integrated, as the Hoodin et al. (2008) survey of sites that offer integrated primary care predoctoral internships and postdoctoral fellowship training has demonstrated. There, the authors concluded, “We found ourselves likening primary care training to being, in the words of Forrest Gump, ‘like a box of chocolates. You never know what you’re gonna get’ ” (Hoodin, Aalschuler, Bierenbaum, & Beacham, 2011, p. 21; Thompson, Groom, Peters, & Roth, 1994). Obviously, much work remains with regard to coalescing operational definitions, common terms, practice, and, hence, training in integrated primary care (Hoodin et al., 2008; March; Hunter & Goodie, 2010; Miller, Mendenhall, & Malik, 2009).

Base models of primary care curriculum on program resources. One way for programs to consider inclusion of primary care learning opportunities in the curriculum is to think of activities along a training continuum. For example, the “Taxonomy for Education and Training in Professional Psychology” that APA’s Commission for the Recognition of Specialties and Proficiencies in Professional Psychology currently is preparing (http://www.apa.org/ed/graduate/specialize/annual-report-2007.pdf) suggests the consistent use of the terms exposure, experience, emphasis, and major emphasis area of study to describe increasing amounts of learning opportunities within each programmatic step in the sequence of professional psychology education and training (i.e., doctoral, internship, postdoctoral, postlicensure). "Used across all education and training programs, [these terms] will result in less confusion about the content and intensity of education and training opportunities available” (R. Rozensky, personal communication, February 27, 2011).

When integrating exposure and experience opportunities into the curriculum and practicum activities, doctoral training programs will need to consider four types of resources available to their respective programs: (a) faculty (access and expertise), (b) financial (available teaching or supervision remuneration), (c) student (numbers, knowledge, skills, and values/attitudes), and (d) medical/primary care clinic relationship and affiliation (see Figure 1).

Based on the level of program resources, activities may range from applied evidence-based clinical assessment/intervention or effectiveness research assignments within existing course structure (Model 1) to comprehensive coursework (Model 2) and parallel practicum training (Model 3). Ultimately, practicum training and shared didactic experiences alongside psychology interns, postdoctoral fellows, and medical residents (Model 4) offers an experience akin to an emphasis area within a training program. The models presented offer training and exposure from the least to the most resource-intensive approaches. Notably, the curricular additions in each model parallel the overlapping competencies in clinical health psychology, and even the least resource-intensive activities, such as a primary-care–tailored research or clinical assignment or elective course, can offer meaningful exposure and experience. Of course, the most resource-intensive model is the longitudinal training model (Model 4) with multiple levels of programmatic and interdisciplinary learner outcomes (see Figure 1).

Certain training programs serve as excellent examples of how specifically tailored knowledge, skills, and attitudes or values competencies (France et al., 2008; Masters et al., 2009; McDaniel et al., 2003; Strosahl, 2005) can be incorporated into the course curriculum. In the clinical health psychology PhD program at the University of Colorado Denver, on completion of a primary care psychology course, students are eligible for placement in a primary care practicum rotation, where they engage in parallel clinical and didactic experiences with psychology interns, postdoctoral fellows, and medical residents. Another example is the PhD program at East Tennessee State University, where clinical psychology students not only complete a two-semester course sequence in primary care psychology, but also, in the first program year, shadow psychologists and other health care practitioners who
participate in multidisciplinary teams in health care settings (http://www.etsu.edu/cas/psychology/graduate/programs/clinicalphd/mission.aspx#Competencies).

Although newly trained psychologists likely will constitute the majority of professionals to meet the increasing workforce demand (Bray, 2010), currently practicing psychologists might retool their skill set for primary care settings through continuing education, independent study, or retraining. Online and brief certificate programs for behavioral health clinicians in primary care (e.g., University of Massachusetts, Fairleigh Dickinson University) offer avenues for retraining. Barring an established psychologist returning to complete one of the few existing postdoctoral fellowships in primary care, to our knowledge, no such retraining programs currently exist for doctoral level psychologists. If such programs did exist, they ideally would offer training in health psychology rather than prepare clinicians to work solely in mental health in primary care.

Support translational research methodologies. Clinical health psychologists traditionally have been trained to think and behave foremost as scientists. It is a cornerstone of what informs evidence-based practice. Therefore, we hold in highest regard the methodologies that reside at the top of the strength-of-evidence pyramid, namely, the randomized clinical trial. For myriad reasons, efficacy trial methodologies, which are higher in internal validity, win favor over less controlled, but closer to practice, clinical effectiveness (i.e., translational) research (Kessler & Glasgow, 2011; Kessler, Stafford, & Messier, 2009). If we likewise believe that changes in population health indicators can be best achieved through evidence-based interventions in primary care, we face a conundrum. One only need observe the lack of progress toward meeting the benchmarks of Healthy People, 2000, 2010, and now, 2020 (United States Department of Health and Human Services), to comprehend the ever-widening gap between clinical trial and application to achieve desired population-based outcomes (Akers, Estabrooks, & Davy, 2010; Glasgow, Lichtenstein, & Marcus, 2003; Kessler et al., 2009). Frontline practitioners have not incorporated into routine application effectively elegant, scientifically informed, and empirically supported interventions that have been examined in the context of highly controlled trials (Kessler & Glasgow, 2011). If effective evidence-based interventions in the service of eliciting positive patient, provider, and population-based outcomes is the overarching goal in primary care, then we should heed the observation, if we want more population-based outcomes is the overarching goal in primary care, to our knowledge, no such retraining programs currently exist for doctoral level psychologists. If such programs did exist, they ideally would offer training in health psychology rather than prepare clinicians to work solely in mental health in primary care.

Efforts to inform and modify approaches to the conduct of translational research in real-world settings have increased over the past decade. To broaden how we think about effectiveness trials in order to improve “translatability” in meaningful ways, some practical and specific guidelines are outlined (Glasgow et al., 2003; Kessler & Glasgow, 2011). First, Glasgow et al. (2003) discuss the utility of Phase III (efficacy) and Phase IV (effectiveness) trials as logical and necessary extensions of well-controlled randomized clinical trials. Glasgow and colleagues outline specific “Recommendations for Funding Organizations to Accelerate Transfer of Research to Practice” (Glasgow et al., 2003, p. 1266). In fact, Kessler and Glasgow (2011) propose a “bold” step to facilitate a shift toward research with a “primary focus on pragmatic trials, feasibility, cost-effectiveness, generalizability, and external validity” (p. 16). They suggest that a 10-year moratorium on randomized controlled efficacy trials in health and health services research may be the only way to realize necessary changes. The authors reference the work of the Evidence-Based Behavioral Medicine Committee of the Society of Behavioral Medicine (Davidson et al., 2003) and, more recently, the CONSORT Pragmatic-Explanatory Work Group (Thorpe et al., 2009) in proposing to amend CONSORT reporting guidelines for more inclusive reporting of behavioral and comparative effectiveness intervention studies.

Psychology training programs and grant funding agencies can facilitate this process by broadening how they teach and support research methodologies. Supporting entities (i.e., training programs and funding agencies) must be willing to accept research designs that are characteristically high in external validity but that may sacrifice aspects of internal validity. One recommended approach is increased training in and use of the RE-AIM (Reach, Efficacy/Effectiveness, Adoption, Implementation and Maintenance) format, which can serve as a blueprint for efficacy and effectiveness studies at their inception (http://www.RE-AIM.org). In the first author’s experience, introducing this way of conceptualizing behavioral medicine programmatic outcome research for graduate students introduces a wider angle lens regarding research design. It heightens awareness of the positive implications of a priori planning for demonstration of multilevel effectiveness across multiple proximal and distal outcome domains (i.e., patient, provider, program, and policy).

Some training programs may regard these externally valid approaches as a bold step. Conversely, programs with a stronger practitioner training mission should consider the inclusion of translational research methodologies as a vital component in the clinical research curriculum. To this end, training programs can encourage such programmatic research projects as viable, and even desirable, methodologies in meeting program (i.e., thesis, dissertation) research requirements and can foster the development of a unique and pragmatic skill set.

Discussion

As the PCMH continues to evolve and to gain traction in primary care medical communities, those communities likely will consider behavioral health professionals essential members of the health care team. The result will be an expanding workforce need for professionals who are trained to serve in multiple capacities in primary care settings. Without the necessary education and train-
ing, however, psychologists will not be prepared to meet this need. Primary care communities will need a critical mass of psychologists who are appropriately trained in primary care not only to decrease the workforce shortage, but for numerous other reasons, which Belar (2007, para. 3) enumerated as the top 10 “primary reasons for education advocacy in primary care.” Among the most salient reasons are:

9. Primary care is the “de facto” mental health system in [the United States].

8. Psychology is more than a mental health profession; it is a health profession.

7. Federal recognition of psychology as a primary care profession is essential to psychology’s inclusion in an integrated health care system.

6. Psychologists need education and training to work competently in primary care.

4. If federal policy supports education and training for a profession, it is more likely to support federal policy that reimburses that profession for the services rendered.

2. Psychology education and training does meet national needs. And finally. . . .

1. It is the right thing to do!

Certainly, we recognize that training in primary care psychology is not well suited for every psychologist or psychology trainee. Psychologists who serve in primary care settings and on PCMH interdisciplinary teams under the direction of a physician leader may believe that their role will lead to an undesirable loss of professional autonomy (Gatchel & Oordt, 2003). Further, primary care training does not supplant widely accepted components of broad and general training in professional psychology. Even so, the integration of behavioral medicine into primary care has gained momentum and will only continue to accelerate. Failing to respond to these changes may render psychology an inert element in the 21st century health care equation (Levant, 2004).

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