Implications of the Affordable Care Act and HealthCare Reform

For Quality Education in Professional Psychology: Developing a Quality Workforce

Association of Psychology Postdoctoral and Internship Centers
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Educational Objectives

Participants will be able to:

1. **Describe** the implications of the *Affordable Care Act* (including patient centered healthcare home & accountable care organizations) on **quality education** in professional psychology and the future of psychology’s role in healthcare;

2. **Discuss** the implications of societal and scientific trends on psychology’s workforce development and future;

3. **Understand** the impact of the growing call for “interprofessionalism” in healthcare on psychology’s education & training system and its implications for **quality** healthcare within integrated, “accountable care” organizations.
Take home messages

1. Affordable Care Act will change healthcare practices (even with SCOTUS).
2. Interprofessional, team-based care will be expected.
3. Integrated care will expand and require interprofessional competencies:
   a. Interprofessional (integrated) education, training, practice, science
   b. Integration of biomedical, mental health, and health behaviors models
4. Professional Psychology must adjust its training model, the balance of mental & behavioral health, and its lifelong learning opportunities. Competencies
5. Psychology must do a better job understanding our workforce development -- We need a data-based plan for the future!
   a. Understanding the real demand for services vs supply of psychologists
      1) Where will we be practicing? And what will we be doing?
   b. We MUST use this information to advocate for training & practice $$!
6. Policy development in professional psychology must focus on issues of accountability and quality as defined by “healthcare reform”:
   a. Preparation for, and practice in, a team-based healthcare world;
   b. Implications of accountable care organizations and a quality focus on credentials review including “accreditation” and “specialization;”
   c. Evidence-based services;
   d. Team-based reimbursement leading to pay for individual provider performance.
Affordable Care
Accountable Care
Accountability
Quality

Defined Competencies (individual & team)
Interprofessional, team-based care
Credentials review including accreditation and specialization
Evidence-based services
Integrated care (bio-psycho-social)
Things we all must do

Accountability means (quality)

We must work together to assure
(1) all programs are accredited,
(2) interprofessional competencies are agreed upon,
(3) specialization is part of the future of practice,
(4) ethical expansion of practice to “health service provider” is addressed via program changes and lifelong learning. NO dabbling ...

Interprofessionalism (“integration”)

Individual interprofessional competencies
Team-based interprofessional competencies

Workforce Analysis (the future & its impact ($))

All of Psychology must work together to understand REAL workforce needs (demand vs supply)
... accreditation may well be the ultimate benchmark indicating at least minimal quality (Boelen & Woollard, 2009)

Credentialing of staff will assure that these systems of care only include the highest qualified providers as part of their system of care; an easily reviewable measure a priori. That is, credentialing will require graduation from accredited education and training programs which to many suggests that providers have met (at least minimal) defined standards of training (Rozensky, 2011). There also will be an increasing expectation of specialty board certification — already routine expectations of hospital-based healthcare providers on the “professional staff” (Rozensky, 2012).
IN AN EFFORT TO REDUCE HEALTH CARE COSTS, THE SURGEON GENERAL TODAY ANNOUNCED THAT THE FOLLOWING CONDITIONS ARE NO LONGER TO BE CONSIDERED DISEASES....
“O.K., you be the doctor, and I’ll be the Secretary of Health and Human Services.”
Health expenditure per capita, public and private expenditure, OECD countries, 2007

Public expenditure on health
Private expenditure on health

(1) 2006, (2) 2005. Data for Belgium, Denmark and the Netherlands are current expenditures (excluding investment). Source OECD Health Data 2009, June 09.

Data are expressed in U.S. dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalize the cost of a given “basket” of goods and services in different countries.
One Hundred Eleventh Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday, the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Patient Protection and Affordable Care Act”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Soc. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS
Subtitle A—Immediate Improvements in Health Care Coverage for All Americans
District Court says "Mandate" is constitutional.
Changes to the healthcare delivery system, as detailed in the 

*Patient Protection and Affordable Care Act*  
(ACA; Public Law No: 111-148, Mar 23, 2010:),

--- no matter what the SCOTUS says --

will continue to focus on the growing expectation that  
interprofessional healthcare organizations (that is, patient center healthcare homes & accountable care organizations) will become the nexus of the delivery of efficient, cost effective, and quality healthcare services.

How prepared are we for “accountable” care?
How many times is psychology, psychologist, or psychologists included in the Patient Protection & Affordable Care Act?

What if it was ZERO?
(3) inserting after section 755 the following:

SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

“(a) GRANTS AUTHORIZED.—The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

“(1) baccalaureate, master’s, and doctoral degree programs of social work, as well as the development of faculty in social work;

“(2) accredited master’s, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

“(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding internships or other field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

“(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training of paraprofessional child and adolescent mental health workers.

“(b) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under this section, an institution shall demonstrate—

“(1) participation in the institutions’ programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations;

“(2) knowledge and understanding of the concerns of the individuals and groups described in subsection (a);

“(3) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency;

“(4) the institution will provide to the Secretary such data.
“Subpart II—Health Care Quality Improvement Programs

SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.

“(a) PURPOSE.—The purposes of this section are to—
“(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ‘best practices’) in health care quality, safety, and value; and
“(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.
“(b) GENERAL FUNCTIONS OF THE CENTER.—The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘Center’), or any other relevant agency or department designated by the Director, shall—
“(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;
“(2) conduct or support activities consistent with the purposes described in subsection (a), and for—
“(A) best practices for quality improvement practices in the delivery of health care services; and
“(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers in team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;
“(3) identify health care providers, including health care systems, single institutions, and individual providers, that—
“(A) deliver consistently high-quality, efficient health care services (as determined by the Secretary); and
“(B) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving health care delivery and result in improvements in health care quality, safety, and value;
The Affordable Care Act describes two types of organizational structures in this new system:

- Accountable Care Organizations (ACO) and
- Patient Centered Medical Home (PCMH).
Patient Center Health Care Home

- access, coordination and comprehensive care
- sustained personal relationship between patient and provider(s) – with patients actively engaged in a healthcare partnership.
- Will require risk-sharing, financial incentives
  - *global payments* to the “institutional practice” for all services provided.

Accountable Care Organizations

- Designed to *improve care and reduce costs*
- provide services to at least 5000 beneficiaries per ‘organization’
- a *structured group practice* of physicians & other healthcare professionals
- *built upon an extended hospital medical staff model*
- will make it easier to *measure performance* (accountability)
- Hold all healthcare professionals and hospitals *accountable for quality*, cost effective care.
The Carter Center’s Health Education Summit

“Five Prescriptions for Ensuring the Future of Primary Care”

1. **Teaching Context** – include social sciences in all healthcare professional education;

2. **Teaching Teamwork** – modify accreditation standards to include interprofessional practice;

3. **Teaching Integration** – include behavioral conditions in all healthcare education;

4. **Provide Resources** – use savings from population based approaches to fund interprofessional education;

5. **Measure Results** – use research approach to provide feedback to change practice.
Patient Centered Primary Care Collaborative
http://www.pcpcc.net/

... created in order to:

(1) facilitate improvements in patient-provider relations, and

(2) create a more effective and efficient model of healthcare delivery.
1. The role of the physician will change dramatically.
2. Patients must be engaged in their care.
3. ACOs will create winners and losers among providers. ($)
4. ACOs are a team sport.
5. Transparency will empower consumers and motivate providers.
6. ACOs will require health system redesign — not just tinkering with payment models.
7. ACO’s must be a dynamic learning organization.
8. An ounce of prevention is worth a pound of cure — and costs a lot less.
9. Expect a significant change in sites of care and delivery mechanisms - remote and virtual care will become the norm.
10. Primary care should be a major focus in the ACO environment.
True interprofessional services are going to be “institutionally-based” (organized healthcare) whether those services occur in a multi-story, multi-specialty, tertiary care, 500+ bed teaching hospital, a small community hospital, a rehabilitation facility, a mental health inpatient facility, a community health center, a primary care office serving as a PCMH, or an ACO integrating a hospital with multiple (“private”) office practices providing services to a defined, local population.

How does psychology prepare for this?
How does the education and training system in psychology interface with this evolving structure?
Interprofessionalism

Not ... multidisciplinary
Not ... interdisciplinary
But ... interprofessional
the entity; and
“(C) where practicable, better patient health outcomes and lower cost resulting from the assistance provided by
such entity.
“(2) EFFECT OF EVALUATION.—Based on the outcome of
the evaluation of the entity under paragraph (1), the Director
shall determine whether to renew a grant or contract with
such entity under this section.
“(f) COORDINATION.—The entities that receive grants or con-
tract under this section shall coordinate with HHS information
technology regional extension centers under section 3012(c)
and the primary care extension program established under section 399W
regarding the dissemination of quality improvement, system
delivery reform, and best practice information.”.

§ 350. Establishing Community Health Teams to Support
the Patient-Centered Medical Home.
(a) IN GENERAL.—The Secretary of Health and Human Services
(referred to in this section as the “Secretary”) shall establish a
program to provide grants to or enter into contracts with eligible
entities to establish community-based interdisciplinarily, interprofes-
sional teams (referred to in this section as “health teams”) to
support primary care practices, including obstetrics and gynecology
practices, within the hospital service areas served by the eligible
entities. Grants or contracts shall be used to—
(1) establish health teams to provide support services to
primary care providers; and
(2) provide capitated payments to primary care providers
as determined by the Secretary.
(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or
contract under subsection (a), an entity shall—
(1)(A) be a State or State-designated entity; or
(B) be an Indian tribe or tribal organization, as defined
in section 4 of the Indian Health Care Improvement Act;
(2) submit a plan for achieving long-term financial sustain-
ability within 3 years;
(3) submit a plan for incorporating prevention initiatives
and patient education and care management resources into
the delivery of health care that is integrated with community-
based prevention and treatment resources, where available;
(4) ensure that the health team established by the entity

INTERPROFESSIONAL IS IN RED, REPEATEDLY!!!
INTEGRATED CARE IS IN HERE, REPEATEDLY!!
Definition of Interprofessional Professionalism

“Consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of altruism and caring, excellence, ethics, respect, communication, accountability to achieve optimal health and wellness in individuals and communities.”

In the context of promoting health and providing care as part of an interprofessional healthcare team, the professional engages in 43 behaviors defining interprofessional professionalism ...

a. demonstrates, ... interacts ..., engages ..., collaborates ...

b. topics from health promotion to treatment planning to multiculturalism ...
Interprofessional Education (IPE)

“... an enlightened new professionalism that can lead to better services and consequent improvements (quality) in the health of patients and populations.”

The BASIS of truly integrated practice

- **Interprofessionalism:**
  - development of shared competencies across disciplines
  - the application of those shared competencies in an integrated, team-based healthcare system.

- The **education of all health professionals collaboratively** for team-based, coordinated care, provides better clinical and financial performance reducing clinician workload.

- This has evolved further into a comprehensive approach to the implementation of interprofessional, team-based competencies (IEC, 2011).
So if,

(1) the overall field of healthcare will be focused increasingly on quality *interprofessional-based services*, and
(2) interprofessional education, training & services are *repeatedly* acknowledged in the *Affordable Care Act*, and
(3) ACOs and PCHCHs will be the *practice venues* of the future
(4) that will utilize defined, shared interprofessional, team-based clinical *competencies*, and
(5) *reimbursement for effective and efficient* services will go to the “local system” (ACO or PCHCH) that will in turn reimburse each professional providing services in that system, then …

(6) how then do we assure that psychology is part of that future? How do we change our curriculum?
Trend

“A trend is a pattern of change over time in something of importance to the observer”
(Some of the) **Trends** Driving Change

- **Changes in U.S. demographics:**
  - Increasingly diverse and older population, increase in chronic illnesses
- **Health Care Reform**
  - Integrated Care – “Patient Centered Health Care Home”
  - Accountable Care Organizations
- **23.8 million Veterans; VA 5% of all psychologists**
- **Changes in technology (cultural, educational, health care)**
  - Increased focus on accountability, regulation, quality assurance
    - Evidenced based treatment; credentialing, reimbursement
- **Within psychology**
  - Issues of professional identity & changes in training models
  - Numbers entering the field (true workforce analysis)
  - Cultural Diversity within Psychology itself
  - From a male to female dominated profession
  - Accreditation of all education & training programs (quality assurance)
  - Specialization (demand for board certification)

Workforce analysis is key to understanding how many members of a given profession are needed and where they should practice ... (the only way to truly understand the imbalance issues)

... looks at projections of worker supply versus forecasts for service demands (gap analysis).

.... integrated with “... assumptions ... based on trends or possible trends observed in the social, technical, economic, and political sectors of society” and the profession itself

(Rozensky, Grus, Belar, Nelson, & Kohut, 2007; p 240)
Reported Work Settings

- 45.5% -- private practice
- 54.5% -- institutional work environments
  - 12.4% hospital setting (including public, private, military, VA, general medical/surgical, and mental health hospitals)
  - 11.2% human service settings (student counseling centers, nursing homes, outpatient clinics, community health centers, and rehabilitation facilities)
  - 7.3% in business, military and other governmental agencies
  - 4.8% work in managed care organizations
  - 4.6% in medical schools
  - 3.4% in various primary and secondary education settings,
  - 10.8% in the Academe.

(44,000 surveys distributed to APA members and a random sample of non-APA members, 6266 were returned; 14.2%; APA CWS, 2009)
Healthy People 2020 (National Health Agenda)

Improving health behaviors is one of four overarching goals – and includes promoting quality of life, healthy development, & healthy behaviors across the lifespan.

The 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act

Financial incentives to providers who show evidence of outreach for the provision of preventive services and chronic disease management (hallmarks of health behavior change).

Advisory Committee on Interdisciplinary, Community Based Linkages, 10th Report to Congress, 2010
Leading Health Indicators

1. Physical Activity
2. Overweight and Obesity
3. Tobacco Use
4. Substance Abuse
5. Responsible Sexual Behavior
6. Mental Health
7. Injury and Violence
8. Environmental Quality
9. Immunization
10. Access to Health Care

HOW does psychology integrate mental and behavioral health in its education and training??
Being “integrated” does not mean doing what you always did ... vis-à-vis workplace culture, communication, clinical skills, diagnoses, treatment ...
Both health and illness behaviors affect morbidity, mortality, and healthcare costs.

Smoking cigarettes; leading a sedentary lifestyle; eating high caloric and high fat foods; and not following prescribed health regimes are examples of detrimental health behaviors that interfere with health maintenance, significantly increase the risk for many chronic diseases, and interfere with recovery from illness.
Competency-based Education

Refers to an individual’s capabilities and demonstrated ability to understand and do certain tasks in an appropriate and effective manner consistent with the expectations for a person qualified by education and training in a particular profession or specialty thereof.

1. APA Ethics
   
   **2.01 Boundaries of Competence**
   (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence

2. What are the boundaries of competency in the new healthcare system?
   
   a. Half life of information and quality assurance (accountability)
      1) accredited education ?
      2) specialization ? (mental and behavioral health)

3. If you come from a “traditional” clinical or counseling graduate program that focused on “mental health” issues, how do you know you are competent to be part of an integrated, primary care team and see not only patients with Major Depressive Disorder, BUT, patients who have been diagnoses with, say, cancer, heart disease, or infertility?
“Psychologists are recognized as **Health Service Providers** if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic and therapeutic intervention services relative to the **psychological and physical health of consumers** based on:

1) **having completed scientific and professional training resulting in a doctoral degree in psychology**;
2) **having completed an internship and supervised experience in health care settings**; and
3) **having been licensed as psychologists at the independent practice level.**”

(APA, 1996; Revised Recognition of Health Service Providers as approved by the APA Council of Representatives)
How do we assure our students can communicate in the broader healthcare team?

Especially those from traditional mental health focused training . . . .

A Template for Self-Assessment of Readiness for Delivery of Services to Patients with Medical-Surgical Problems

“Preparing the Interprofessional Workforce to Address Health Behaviors: Ensuring a High Quality and Cost-Effective Healthcare System”
Congress should appropriate and HRSA should

✓ fund interprofessional education & training demonstration projects to prepare healthcare faculty and providers from all healthcare disciplines to work in collaborative teams to address health behavior assessment, treatment, and enhancement of patient health behavior self-management across the lifespan.

✓ fund the development of health professions’ curricula – comprehensive, interprofessional models for health behavior assessment, treatment, & enhancement of patient self-management.

✓ increase funding to existing, successful, interprofessional healthcare education & training programs to work in concert with Healthy People 2020’s goal of promoting healthy behaviors.
H. R. 3590—509

be historically black colleges or universities or other minority-serving institutions.

(d) PRIORITY.

“(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

“(A) are accredited by the Council on Social Work Education;

“(B) have a graduation rate of not less than 80 percent for social work students; and

“(C) exhibit an ability to recruit social workers from the place social workers in areas with a high need and high demand population.

“(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

“(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

“(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

“(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

“(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;
Teaching Health Centers

• Teaching health centers are community-based primary care training programs committed to preparing health professionals to serve the health needs of the community.

• By moving primary care training into the community, THCs are on the leading edge of innovative educational programming dedicated to ensuring a relevant and sufficient supply of health workforce professionals.
Trend
Patient Protection & Affordable Care Act
What is MEDICAL COST OFFSET?

Chiles, Lambert, & Hatch (1999), for example, in a meta-analysis, found that, across 91 studies, behavioral medicine interventions averaged a 20% cost savings in medical care (even when counting cost of psychological interventions!).

Health expenditure per capita, public and private expenditure, OECD countries, 2007

Data are expressed in U.S. dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalize the cost of a given "basket" of goods and services in different countries.
Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA, 2005).
✓ HealthCare or Patient Centered Medical Home
✓ Cost offset
✓ Team Based Care
✓ Interprofessional Professionalism
✓ Health Promotion and Disease Prevention
✓ Patients with Chronic Illnesses
✓ Evidence-based Practice
✓ The Digital Age (electronic healthcare records, telehealth, online education\libraries)

✓ ACCOUNTABILITY !!!  Is QUALITY
Trend

✓ ACCOUNTABILITY!!! Is QUALITY
1395x(aa).

“(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.— The term ‘frontier health professional shortage area’ means an area—

(A) with a population density less than 6 persons per square mile within the service area by which the population to access care is excessive.

(B) with respect to which the distance or time of travel to the population to access care is excessive.

“(19) GRADUATE PSYCHOLOGY.—The term ‘graduate psychology’ means an accredited program in professional psychology.

“(20) HEALTH DISPARITY POPULATION.—The term ‘health disparity population’ has the meaning given such term in section 903(d)(1).

“(21) HEALTH LITERACY.—The term ‘health literacy’ means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.

“(22) MENTAL HEALTH SERVICE PROVIDER.—The term ‘mental health service professional’ means an individual with a graduate or postgraduate degree from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.

“(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term ‘one-stop delivery system’ means a one-stop delivery system described in section 134(c) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)).

“(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term ‘paraprofessional child and adolescent mental health worker’ means an individual who is not a mental or behavioral health service professional, but who works at the first stage of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.

“(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms ‘racial and ethnic minority group’ and ‘racial and ethnic minority population’ mean the meaning given the term ‘racial and ethnic minority group’ in section 1701.

Accredited Program in Professional Psychology...
Trends (within Psychology)

- Cultural and Gender Diversity
- Accreditation as a required, first step to quality
- Specialization (must be supported and embraced as an organizing function in our field – key in reform)
- Integrated Care (the “discovery” of primary care)
- Identity as Psychologist -- New Applied and Scientific Subfields (“Neuroscientist” vs Psychologist)
- PATIENT not client (it is the PATIENT Protection ... Act)
- Work Force:
  - Number of New Doctorates (correct number?)
  - Internship Match “Imbalance”
    - Supply, demand, bottleneck? Do you know? Workforce study
1. Do real Work Force Analysis (equivalent resources to other professions)
2. Update Task Force Recommendations on Training in Health Psych
3. Greater Demonstration of Cost Offset, Clinical Significance, Patient Satisfaction; teach more Program Evaluation
4. Develop a Database of Evidence Based Treatments (our own Cochrane Collaborative in health psychology)
5. Expand Professional Psychology’s role in Integrating Behavioral and Physical Health Care in Primary Care Settings
6. Establish Greater Linkages & Collaborations with Public Health
7. Advocacy – learn it, do it, model it, teach it
8. Board Certification – specialization; encourage it, do it
9. Affirm Psychology’s Identity & Build Administrative Structures that Allow for **Maximum Autonomy** and Freedom
10. Coordinate Efforts within Psychology and across disciplines
    (Rozensky & Janicke, 2012)
Things to do

Accountability means \textit{(quality)}

We must work together to assure
(1) all programs are accredited,
(2) interprofessional competencies are agreed upon,
(3) specialization is part of the future of practice,
(4) ethical expansion of practice to “health service provider” is addressed via program changes and lifelong learning. NO dabbling ...

Interprofessionalism \textit{(“integration”)}

\textit{Individual} interprofessional competencies
\textit{Team-based} interprofessional competencies

Workforce Analysis \textit{(the future \& its impact (\$))}

All of Psychology must work together to understand REAL workforce needs (demand \textit{vs} supply)
“Is not disease the rule of existence?...
Disease is not the accident of the individual, nor even of the generation, but of life itself”

--- Henry David Thoreau