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Interprofessional Education: Preparing Psychologists for Success in Integrated Primary Care

Barbara Cubic · Janette Mance · Jeri N. Turgesen · Jennifer D. Lamanna

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Abstract Rapidly occurring changes in the healthcare arena mean time is of the essence for psychology to formalize a strategic plan for training in primary care settings. The current article articulates factors affecting models of integrated care in Academic Health Centers (AHCs) and describes ways to identify and utilize resources at AHCs to develop interprofessional educational and clinical integrated care opportunities. The paper asserts that interprofessional educational experiences between psychology and other healthcare providers are vital to insure professionals value one another's disciplines in health care reform endeavors, most notably the patient-centered initiatives. The paper highlights ways to create shared values and common goals between primary care providers and psychologists, which are needed for trainee internalization of integrated care precepts. A developmental perspective to training from pre-doctoral, internship and postdoctoral levels for psychologists in integrated care is described. Lastly, a call to action is given for the field to develop more opportunities for psychology trainees to receive education and training within practica, internships and postdoctoral fellowships in primary care settings to address the reality that most patients seek their mental health treatment in primary care settings.

Keywords Integrated care · Interprofessional education · Professionalism · Primary care · Psychology · Training and education

Introduction

Psychology is faced with the challenge of transforming traditional education and training models in a manner that continues to create highly competent psychologists while also insuring that the discipline can be on the forefront of a rapidly developing and changing healthcare system. This evolution in education and training is critical for psychologists to be included in new healthcare delivery models to provide assessment and interventions for the significant number of patients who are unable, or unwilling due to stigma, to access needed mental health care if not seen in primary care. Subsequently, psychologists must examine our own educational system in order to find ways in which future psychologists will be prepared to provide better, more accessible services to our patients. Adapting educational and training models within psychology will move psychologists from being carved out as specialists within the mental health field to full partners within the healthcare field, more effectively meeting the needs of those we serve.

Defined by the Institute of Medicine [IOM] as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Donaldson, Yordy, Lohr, & Vanselow

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B. Cubic (✉) · J. Mance · J. N. Turgesen · J. D. Lamanna
Department of Psychiatry and Behavioral Science, Eastern Virginia Medical School, 825 Fairfax Avenue, Norfolk, VA 23507, USA
e-mail: cubicba@evms.edu

B. Cubic
Department of Family and Community Medicine, Eastern Virginia Medical School, 825 Fairfax Avenue, Norfolk, VA 23507, USA

1996) primary care is foundational to health care access and reduction of health care disparities within the United States. Yet, in recent years the primary care system has struggled due to high patient care demands, low revenue generation, and workforce attrition, as well as poor recruitment of new primary care providers (Meyers & Clancy, 2009; Salsberg, Rockey, Rivers, Brotherton, & Jackson, 2008).

A recent primary care workforce investment of $250 million from the Affordable Care Act's Prevention and Public Health Fund in primary care professional training was established to counteract this trend. The Affordable Care Act itself encourages the transformation of the health care delivery system through support of the patient centered medical home [PCMH] http://www.acponline.org/running_practice/pcmh/understanding/guidelines_pcmh.pdf. Thus, the PCMH is seen as a model for *redesigned primary care*. The PCMH focuses on an interdisciplinary team clinical approach and is highly relevant to psychology. While PCMH models do not explicitly include psychologists or other mental health professionals, the presence of behaviorists are implied. PCMHs must provide screening for mental health, substance abuse, and health behaviors as well as have evidence-based protocols in place for three common illnesses, one of which must be related to unhealthy behaviors (e.g., over-eating and lack of exercise that contributes to obesity) or a mental health or substance abuse condition. Subsequently, practices not integrating behaviorists on interdisciplinary teams may have difficulty meeting standards http://www.ncqa.org/tabid/631/Default.aspx.

Complementing this shift to the PCMH is the increased emphasis across medical specialties in the integration of physical and mental health (e.g. commonly referred to as integrated care) and an emphasis on interprofessionalism across all health care arenas. Neither is a new concept, but the momentum behind both has increased exponentially. As early as 1965 in its famous Coggeshall Report the Association of American Medical Colleges indicated "the concept of medicine as a single discipline concerned with only the restoration of individual health from the diseased state should be replaced by the concept of 'health professions' working in concert to maintain and increase the health of society as well as the individual" (Coggeshall, 1965). Additionally, educators have recognized for years that the "distinction between medical and psychological is arbitrary and has more to do with the focus and socialization of practitioner training than with the reality of patient care" (Twilling et al., 2000).

Now, more than ever, Academic Health Centers (AHCs) are challenged to address education and training and deliver patient care in a manner that is patient-centered, evidence-based, team-delivered, and uses best practices related to informatics and quality improvement. The most efficient route for meeting these challenges is offering interdisciplinary training opportunities, where professionals train with other disciplines (e.g. psychology, primary care) to meet their core competencies, while simultaneously developing team-based competencies. The training model to create the health care professional of the future should foster a common vision for team-based care. It should acknowledge the varying roles of all disciplines in healthcare, enhance communication patterns between professionals and with patients and families, and apply relationship-building values and team dynamics in order to deliver patient- and population-centered care that is safe, timely, efficient, effective and equitable (Interprofessional Education Collaborative Expert Panel [IPEC], 2011).

In alignment with the changes that are being recommended in health care, education and training, this paper describes the interdisciplinary training of psychology trainees and family medicine residents at the Eastern Virginia Medical School (EVMS). This overview serves as a model of interprofessional education, designed to prepare a workforce for integrated care. The paper further comments on the developmental sequence of training that could occur from pre-doctoral, internship and postdoctoral levels to prepare psychologists for the future, and reviews the results of a survey of the family medicine residents at EVMS who train regularly with psychology trainees.

EVMS Interprofessional Training of Family Medicine Residents and Psychology Trainees

The EVMS Clinical Psychology Internship Program has existed since 1976–1977 and has been accredited by the American Psychological Association (APA) for 35 years. There are currently 4 internship lines. The internship program has a longstanding history of utilizing training models that have evolved over time to embed psychology trainees within settings that provide residency education (e.g. family medicine, pediatrics, physical medicine and rehabilitation), creating a paradigm shift emphasizing interprofessional education and practice. This paper focuses on the training with family medicine residents.

The EVMS Clinical Psychology Internship Program's main goal is to create a psychology workforce prepared to provide integrated care in PCMHs. The program subscribes to a practitioner-scholar training model focused on preparing psychology interns to provide evidence-based assessments and treatments within the context of environments that require interprofessional interactions. Specific goals include the development of skills in assessment and psychotherapy with a wide range of client populations, through involvement in diversified inpatient and outpatient settings where residency education is also primary. Interns

are expected to develop leadership and consultative skills within an academic medical center and learn to function effectively in interprofessional relationships. Interns are offered the opportunity for professional development through attendance at seminars and workshops and optional opportunities for involvement in clinical research projects. Clinical settings are based in healthcare environments and provide an opportunity to integrate ethical, cultural and administrative considerations.

The major rotation training opportunities (3 days/week) are in *Adult Medical Inpatient*, *Pediatric Behavioral Medicine*, and *Integrated Primary Care*. These major rotations are supplemented by minor rotations (1 day/week) in other inpatient and outpatient services (e.g. integrated outpatient primary care, pain management, obesity/bariatrics, geriatrics, inpatient family medicine, sleep disorders, neuropsychology) and the provision of psychotherapy through an Outpatient Training Clinic. This affords each intern diversity in terms of patient exposure. Didactics cover assessment, therapy, consultation, multicultural, ethical and professional development topics with emphasis on interdisciplinary treatment models.

The integrated primary care training began in 1995 with the Department of Family and Community Medicine at EVMS. Two years of funding was originally received for one FTE psychology internship position a year, which placed an intern at Ghent Family Practice (GFP) in a co-located practice model. When this model did not meet the needs of patients, the residency training program, psychology interns, or providers, opportunities for a more integrated care model were explored. Subsequent developments that included new funding in 2002 from Health Resources and Services Administration (HRSA) Graduate Psychology Education (GPE), allowed training of psychology interns and family medicine residents to expand further through placing psychology interns with family medicine residents in inpatient and outpatient settings. The converted model trained two psychology interns (out of a program of 6-8 interns) in primary care settings each year, placing these interns side-by-side with family medicine attending physicians and residents. Real-time supervision by the clinical psychology supervisor was provided during medical rounds and through the precepting office used by the physicians. Family medicine residents and interns were encouraged to work as a team to create individualized clinical plans for patients that were integrating behavioral sciences and primary care medicine.

In 2007, the training model evolved further so that all interns within the program completed a major or minor rotation in integrated care, in which there was again side-by-side training with the residents.

In 2010, the internship further revamped its entire training model to center its primary focus on creating a workforce for PCMHs. In this further evolution of the training model, all interns were placed in settings that focused on interprofessional education and interdisciplinary care, and all interns completed majors or minor rotations in integrated primary care. Additionally, graduate students from the Virginia Consortium Program in Clinical Psychology (VCPCP), an APA accredited Psy.D. program, and a post-doctoral fellowship in integrated care were added, so that still another tier of graduate clinical psychology education could occur. This expansion of interdisciplinary education across training levels in clinical psychology additionally provided psychology interns opportunities to supervise less experienced graduate students in integrated care. For the current academic year, five VCPCP psychology graduate students are training in integrated care practica.

This comprehensive integrated care training model at EVMS has unique characteristics that encourage mutual respect and shared values across the disciplines involved (see Cubic & Gatewood, 2008; Bluestein & Cubic, 2009, for further details about the EVMS training model). It enhances cooperation in team-based patient care delivery and advances the trainees' skills in managing unique ethical dilemmas specific to interprofessional patient/population centered care situations. The three different psychology training programs involved (doctoral, internship, postdoctoral fellowship) are all housed within the Department of Psychiatry and Behavioral Sciences which has a strong psychology division (9 full time psychologists) internally while also utilizing psychologists involved in other departments within the institution and community faculty.

Within the primary care settings psychology trainees at all training levels are an integral part of all activities behaviorists play in family medicine residencies. Services are provided in both inpatient and outpatient settings with supervision from psychologists familiar with integrated care and the training of family medicine residents. Warm handoffs (e.g. real time transfers of patient care between the primary care provider and the psychologist while the patient is present for their primary care appointment) are welcomed and an evidence-based, population-based model of care is implemented. When feasible, psychology trainees develop therapy and psychoeducational groups, and engage in clinical research (especially patient centered outcomes research, http://www.pcori.org/pcorinput.html), staff development, and program development.

Primary clinical activities performed by the psychology trainees are consultations, brief assessments, and brief cognitive behavioral therapy or interpersonal therapy interventions. All interventions are aimed at addressing the behavioral (especially those related to health), psychological and substance abuse needs of primary care patients. Within the inpatient setting, two treatment contacts are the norm and within the outpatient setting generally six treatment contacts or less occur. Complex assessments take no

more than one hour, and regular treatment and follow-up appointments are offered in 15 to 30 minute intervals. Additionally, the psychology trainees provide care management and triage services for patients who need additional services.

Psychology trainees engage in interprofessional education, especially in relation to assisting residents in meeting Accreditation Council for Graduate Medical Education (ACGME) competencies. Trainees also teach other psychology trainees, allied health professionals, nurses, and administrative staff. Psychology trainees teach didactics within psychology and the family medicine seminar series and participate in behavioral case conferences, primary care rounds [where discussions related to health care reform occur], and ethical case conferences, specifically focused on the challenges that arise when psychologists work with health care providers. Joint precepting and supervision by psychology and family medicine faculty for both psychology trainees and family medicine residents occurs. Additionally, workshops are offered at least annually for both faculty and trainees regarding cultural diversity and addressing the unique needs of primary care patients. Lastly, psychology trainees write papers or give presentations about medical conditions and psychology resources/interventions that can be of assistance to the patient and provider.

Providing a Sequential Training Approach for Psychology Trainees

Primary care physicians are on the front line of patient intervention, and treat conditions ranging from the physical to the psychological on a daily basis. With their primary training focused on biological issues, physicians often feel ill equipped when presented with psychological or mental health problems. However, up to 70% of the medical appointments made with a primary care physician are for problems stemming from psychosocial issues (Gatchel & Oordt, 2003). Additionally, primary care physicians provide 67% of all psychotropic medications and 90% of the ten most common complaints in primary care have no organic basis (James, 2006). Unfortunately, our health care system is arranged in such a manner that patients are required to go to one location to receive services for their physical problems and a separate location for their psychological, mental and behavioral problems. This dichotomy between mental and physical health can lead to suboptimal treatment in either of these areas, both of which are integral to a patient's well-being and experience.

One of the ways psychologists can work to effectively meet the needs of patients from a population based approach is through the integration of mental health into primary care clinics. To do so, the future psychology workforce needs training opportunities in integrated care. Subsequently, guidelines need to be developed for education and training at the doctoral, internship and postdoctoral fellowship levels which allow for integrated primary care psychology to be a major area of study or emphasis for those most interested in the field while others are offered less intensive experiences in integrated care or at least exposure to the area.

The training sequence used at EVMS follows a logical progression to add integrated care experiences at levels that fit trainees' development. In doing so, education and training builds on the clinical service delivery models of interdisciplinary medical and behavioral collaboration described in the literature.

At the Graduate Student Level

Most psychology graduate programs now offer some degree of training in the application of behavioral principles to medical patients and settings. However, in contrast to the recommendations made by Talen, Fraser, and Cauley (2002), advising graduate programs to place primary care psychology into the generalist training received by all students, even when doctoral psychology students receive coursework in health psychology or behavioral medicine, rarely are there placements available for practicum in medical settings, and even fewer in integrated care environments (Cubic & Beecham, in press).

Functioning successfully in primary care settings at the doctoral level requires general and health-related psychological knowledge, the ability to provide brief psychological assessment, consultation and intervention, and interdisciplinary collaboration skills and close supervision. In keeping with the goal of establishing interprofessional competencies (IPEC, 2011), integrated care psychology trainees must also form positive interprofessional interactions with other health professionals and thus graduate students need to see supervisors role modeling these relationships and discussing how to interact professionally and effectively with providers from other disciplines in supervision. Fortunately, for doctoral students the development of a new skill set is possible through feedback from an invested group of primary care clinicians, in need of assistance with the psychosocial and mental health needs that their patients present with on a daily basis. Additionally, close supervision from a psychologist knowledgeable about integrated care and invested in training and the success of the practicum site, can mentor and help teach psychology graduate students a unique skill set not traditionally incorporated in the graduate level curriculum.

At the graduate level students also need to participate in didactics on integrated care models and the brief assessments and treatments required and engage in "real-time"

role plays prior to beginning integrated care placements with actual patients. Regular on-site, real time supervision from psychologists within the primary care settings is necessary. In addition, students should participate in vertical clinical team group supervision, consultation and didactic sessions conducted by the doctoral program faculty member throughout their placement. On integrated care rotations graduate student trainees can develop direct, specific interview techniques and learn to work quickly and condense conceptualizations of client functioning to a simple sentence or two, matching the tempo of the busy physicians with whom they work, all while striving to maintain a high level of rapport with the patients served. With time, doctoral students will quickly find themselves loving every aspect of the care they are providing for patients and the training process. The passion and excitement for integrated care will likely be continually reinforced by the type of clientele seen and the recognition that the majority of patients seen would never have presented for therapy services outside of their physician's office. There is an extension of trust that is offered to the psychology student working within the clinic when they are introduced by the patient's physician as a team member who will be coordinating a portion of their care in collaboration with the medical team that builds trainee confidence.

At the Psychology Internship Level

As a predoctoral intern, trainees can be intentional about seeking a site that will offer training specifically in the area of integrated care. A growing number of sites are available with a focus and an emphasis on the development of the skills needed to effectively and collaboratively work in integrated care settings. Thus, the internship year adds another opportunity for a unique experience to finesse skills and gain advanced instruction in how to effectively work within a time limited session and provide specific, focused interventions and feedback, both to patients and to medical residents. The type of training received becomes multilayered in nature with the psychology intern receiving and also providing formative feedback about work with patients, as the intern often can be made simultaneously responsible for providing feedback to medical students and residents during observations of their behavioral health skills.

In essence everyone is able to work to the top of their degree using the skills that each profession is specifically trained in to collaboratively improve the overall health, wellbeing and functioning of the clients served. The information learned is also reciprocal. As the psychology intern teaches the medical residents about mental health and improving adherence, the psychology intern gleans a vast amount of information on the biomedical side of health and illness from the family medicine residents. This reciprocal knowledge base further allows the psychology intern to provide an increased level of understanding and improved care for their patients.

At the internship level, the supervising licensed clinical psychologist may not be as readily available to the intern at all times, thus the intern often grows by functioning independently during the work day. This arrangement allows the intern to develop a level of autonomy, while also allowing for training under supervision. The independence requires the psychology intern to be able to interact with treatment teams to provide comprehensive care to patients. These collaborations are formed with physicians at all levels of training (attending, resident, medical student), nurses, social workers, clinical care coordinators, and physical/occupational therapists, in congruence with the interprofessional competencies (IPEC, 2011).

In addition, a working knowledge of a wide variety of medical conditions, treatments and medications is developed. Because psychologists often do not receive formal training in medical issues psychology interns may improve integration of their services within the context of medical considerations (Eby, Chin, Rollock, Schwartz, & Worrell 2011), by relying on "on-the-spot" training from other trainees (e.g., medical students and residents). The psychology intern learns to be flexible with scheduling. The logistics of the primary care environment (whether outpatient or inpatient) make the traditional 50-minute session nearly impossible. Sessions tend to be brief and occur in the context of medical settings (e.g. exam rooms, hospital rooms). In the inpatient setting, patients also experience some level of sedation due to the various medications presenting another challenge to psychological assessment or intervention. Given that psychology trainees are often trained to work within a 50-minute session in a private office during their graduate school experience, operating in the manner described above may be a challenge to which to adapt (Pomerantz, Corson, & Detzer 2009).

Psychology interns also learn to work with family caregivers. Caregivers can be easily integrated into interventions done for outpatients if the session can occur when they are visiting inpatients or accompanying outpatients to appointments. However, having family caregivers present may limit confidentiality, and the patient may not be willing to share psychological constructs with a family member present. Nevertheless, when done properly the integration of family caregivers into the patient's care and forming an alliance between family caregivers and primary care providers to improves patient outcomes and reduces caregiver burden (Palos & Hare, 2011).

In addition to the challenges mentioned above, perhaps the biggest challenge faced by psychology interns is their role as psychology providers in areas outside of clinical care delivery. For many psychology providers, this is

relatively "new territory" (Pomerantz et al., 2009). Most medical providers are not accustomed to the presence of psychology providers on teams and a strategic plan for education and training in integrated care has only recently been recommended (APA Primary Care Training Task Force, 2011).

It is also important to note when psychology interns are training in integrated care, focusing much of their work in that area, it does not mean that a simultaneous passion for traditional therapy and specialty mental health cannot and does not exist. It is possible to balance intense, long-term therapy clients on top of an integrated case load. One of the most empowering aspects of the training that one receives in integrated care is the carry over that takes place in the development of skills in the area of long-term therapy. The work in short-term, brief, focused interventions within the fast paced primary care setting has a substantial impact on therapeutic skill. After operating in integrated care settings trainees will find that they are able to be more focused, intentional and direct in their traditional sessions in ways that may not have previously been possible. This is a natural extension of the ability to directly target the presenting concern, resulting in an ability to help patients process areas of distress at a different level than was previously possible. The short-term, focused work significantly enhances the quality, consistency and substance of the long-term therapy provided for patients.

The inpatient arena also provides a wealth of opportunities for psychology interns to work with primary care teams. With most inpatient admissions lasting 4–5 days on average (Centers for Disease Control and Prevention, 2010), psychology interns are required to utilize brief models of assessment and intervention. Generally these assessments and interventions are directly related to behavioral factors that contribute to medical problems (i.e., substance use, diet, exercise), treatment adherence, or the patients' hospital course. Ideally, the psychology intern can begin these interventions with the patient while in hospital, and educate primary care providers to continue these interventions either in the outpatient family medicine setting, or through outpatient psychotherapy if needed.

At the Postdoctoral Fellowship Level

The postdoctoral training year in integrated care is an invaluable component to the continued identity development of a psychologist working in integrated primary care. Many psychology trainees approach the postdoctoral year with experiences centered on the provision of patient care, and 'provider' is the core component of their professional identity. The experiences during the postdoctoral year should serve to expand their identity to include teacher and advocate for interdisciplinary, patient-centered treatment, and the integrated care movement. Therefore, the fellowship year needs to be flexible, and adapt to the evolving training needs of the fellow. Perceived gaps in prior training related to clinical skills should be addressed, but not at the expense of the continued growth of other skills used in integrated care. Opportunities for patient care and team collaboration should still be offered, but advanced opportunities to expand the identity of the fellow (i.e., teaching, supervision, and facilitating team functioning and program development) should be major elements of the fellowship year.

A graduate of the postdoctoral program should be able to operate independently as a licensed psychologist and be able to utilize his or her expertise to assist in the establishment of programs that facilitate patient-centered integrated care. An example of a potential program development opportunity is the implementation of a psychoeducation series for patients and providers that addresses common behavioral health concerns. With regard to supervision, many psychology trainees under the postdoctoral fellow's supervision begin their experiences with little specialized training in the provision of health psychology services (Perry & Boccaccini, 2009) and thus, have little understanding of the complex relationship between physical health and psychological well-being. An absence of training means some students/interns may lack the experience to operate effectively and confidently on an interdisciplinary treatment team that includes medical providers. They may also be unfamiliar in the provision of brief assessments and interventions in a medical setting. The fellow's role with these trainees as a supervisor includes helping trainees cultivate skills in practicing evidence-based psychology in a primary care environment. The fellow assists in refining brief interviewing skills to include medical history taking, choosing appropriate assessment instruments and interventions, and effectively communicating professional opinions and patient conceptualizations to team members. As the fellow's supervision is supervised by a licensed psychologist functioning in primary care the fellow can hone both general supervision skills and those relevant to preparing trainees for the primary care setting.

Medical students and residents are often unaware of the utility and value of a psychologist operating within an integrated care treatment team. They are often under educated on matters related to psychology (Butler et al., 2009) and the range of services a psychologist provides. Therefore, the training of medical residents in behavioral matters should focus on addressing these training gaps, especially given that such training has been shown to increase the residents' comfort in working with behavioral health specialists. For example, one recent study indicated that pediatric residency program graduates whose site instituted

an on-site integrated behavioral health model were more likely to report that their residency prepared them for collaborative practice with behavioral health professionals (Garfunkle et al., 2011).

Thus, the fellow's job with the medical trainees is to teach them to work collaboratively with behavioral health providers in providing primary care services. With regard to facilitating team collaboration and cohesion, psychologists possess a unique skill set that allows them to assist in the development of effective interpersonal communication among team members. Training in psychology endows psychologists with a greater understanding of team dynamics, and through this understanding the fellow can model appropriate interpersonal exchanges; sensitively and respectfully shaping the behaviors of team members. This allows for the establishment of group norms that foster cohesion and collaboration, while promoting treatment that is efficient, efficacious, and in the best interest of the patient. To operate in an integrated care model that provides mental health treatment, physicians need to acquire new technical and leadership skills that are not currently a part of the medical curricula (Croghan & Brown, 2010). To facilitate this goal, the fellow can precept with medical school faculty members and assist the residents and students in accurately identifying and screening for behavioral and mental health complaints. Further, the fellow can assist primary care providers in their understanding of the impact of psychosocial issues on overall health and compliance, and how to better define a referral question. The fellow educates the primary care trainees on how psychology can assist in increasing compliance, decreasing mental health symptoms, and support lifestyle changes. In this way, the primary care trainees are able to increase their general knowledge of psychological concerns and their comfort level in addressing these issues with patients. This type of training model fosters the ongoing advancement of the integrated care model.

Perspectives of Family Medicine Residents

There are three primary care residency training programs that currently cross train with EVMS psychology trainees. The first two residencies within the Department of Family and Community Medicine at EVMS have existed since 1975. They are accredited three-year programs which meet all training requirements of the American Board of Family Medicine, accepting approximately 5 residents per PGY year. The Ghent Family Medicine (GFP) Residency has 12 full time faculty and operates out of the academic health center and its nearby hospital. The Portsmouth Family Medicine (PFM) Residency has 9 full time faculty and is a community based program. The third primary care residency impacted by the training model described in this paper is a combined Internal Medicine-Family Medicine Residency operated out of the Departments of Family and Community Medicine and Internal Medicine at EVMS, a four year program leading to board certification in both disciplines that accepts 3 residents per PGY year.

In October of 2011, a 10 item survey was sent to all of the residents impacted by interdisciplinary training with psychology trainees at EVMS. A 53% response rate was obtained. The four items most directly related to the interprofessionalism competencies are shown in Fig. 1, demonstrating that the residents feel the presence of psychology trainees is valuable in improving communication, improving team dynamics, enhancing the resident's knowledge of their role and the role of other providers, and strengthening their ability to work with other professionals.

Summary and Conclusion

Integrated primary care is a unique and growing field for psychology. Healthcare reform and related legislation provides a new context in which to discuss the type and quality of training that psychology graduates receive as the field evaluates future directions of our profession (Bray, 2011). Training and mentorship in collaborative interdisciplinary care are unique and rare, rather many psychologists are more likely to be trained within their own respective silo resulting in an increased likelihood that they may take more of a competitive stance with other disciplines, rather than engaging in collaborative care (Blount & Miller, 2009). Effective work within a primary care setting necessitates a generalist model of training, with psychologists comfortable and competent to treat a wide range of presenting concerns. With advancing opportunities for psychologists within integrated primary care settings, interdisciplinary training will become more essential to ensure psychology remains on the forefront of healthcare service for patients. Thus, additional emphasis and training should be placed on the needed skills outlined by Bray, Frank, McDaniel and Heldring (2004) for success in primary care psychology to include: biological, cognitive, affective, sociocultural, behavioral and developmental aspects of health and disease; an understanding of health policy and healthcare systems; an understanding of common primary care problems and how to effectively assess those problems and apply interventions; effective interprofessional collaboration; and ethical legal and professional issues within primary care.

Psychology needs to create a strategic plan for the education and training of future psychologists in primary care settings because these are the environments that many future psychologists will be employed. Rapid changes in

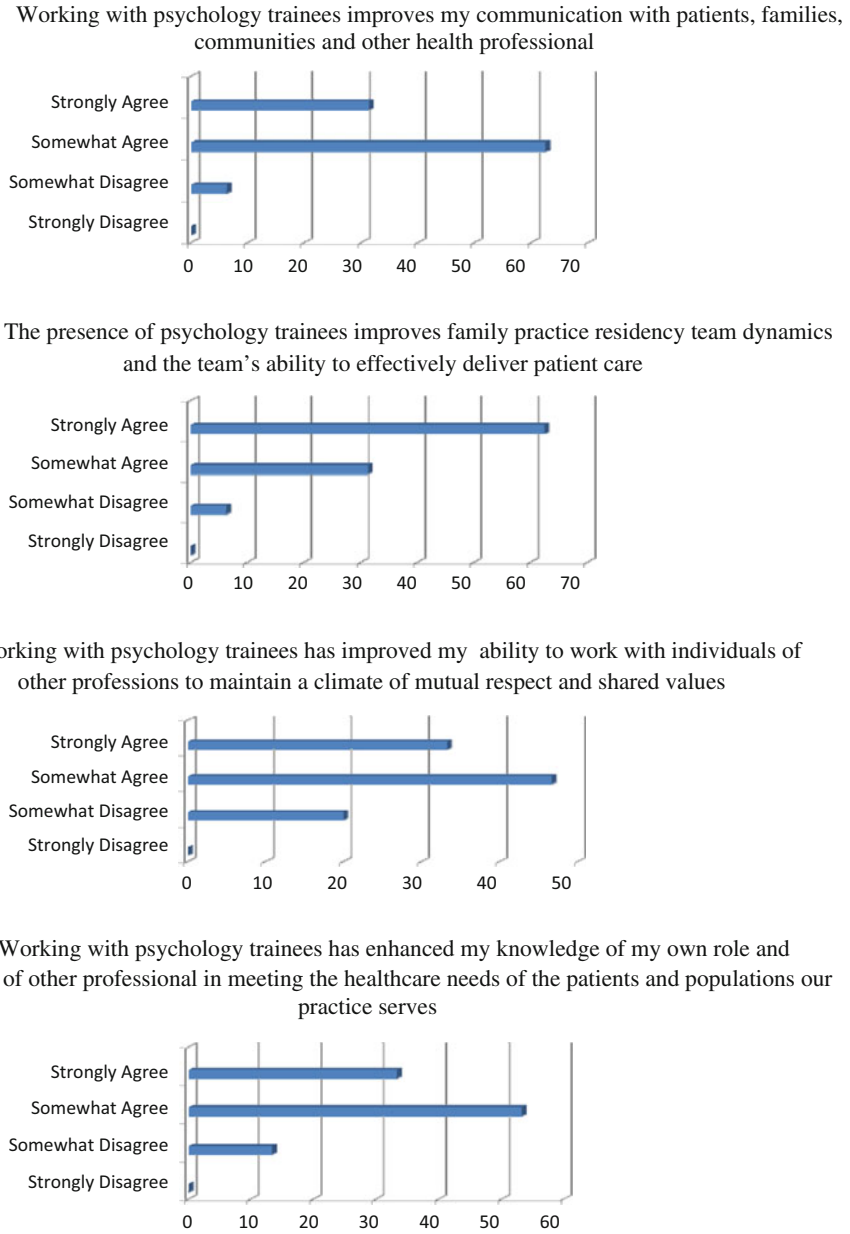

Fig. 1 Survey results reflecting the perceptions of EVMS Ghent Family Medicine, Portsmouth Family Medicine and Combined Internal Medicine-Family Medicine residents about the impact of training with psychology trainees in integrated care

health care also suggest that the time is ripe for educating other professionals about the value of psychologists in health care reform endeavors, especially patient centered initiatives. This paper hopes to serve as a call to action to the field to develop more opportunities for psychology trainees to receive education and training within practica, internships and postdoctoral fellowships in primary care settings and in interprofessionalism, to address the reality that most patients seek their mental health treatment in primary care. These educational endeavors need to pay close attention to developing experiences that create the shared values and common goals between primary care providers and psychologists needed for trainee internalization of integrated care precepts.

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