Overview

On September 19, 2008 during the first round of APA's Fall Consolidated Meetings in Washington, DC, the APA Education Government Relations Office and the APA Committee on Rural Health (CRH) hosted an all-day meeting on the role of psychologists and trainees in Federally Qualified Health Centers (FQHCs). This meeting, the Primary Care Association Initiative, was designed to facilitate the development of psychologist positions and psychology training programs in federally qualified health centers including community health centers and rural health clinics. These health centers are organized in states and regions of the country as Primary Care Associations (PCA) under the oversight of the HHS's Bureau of Primary Health Care (BPHC) and its national organization, the National Association of Community Health Centers (NACHC). Our goal was to work with BPHC, NACHC and the PCAs to increase the demand for psychologists and psychology trainees for delivering integrated health care at the health centers throughout the nation. The goals of the meeting were to: 1) Learn what has worked to create positions for psychologists and psychology trainees in FQHCs; 2) create an action plan to work with state Primary Care Associations to promote integrated care and new positions for psychologists and psychology trainees; and 3) build the foundation for a partnership among state, provincial and territorial psychological associations (SPTAs), state primary care associations, relevant federal agencies and national organizations, and the American Psychological Association to further the initiative.

CRH has taken a strong interest in integrated care because it seems likely to be a part of any significant healthcare reform policy. This model is appropriate for rural psychology practice and would meet the needs of many urban areas as well. An integrated care model brings psychologists into primary care and attempts to seamlessly provide both mental/behavioral health services along with traditional primary care medicine. At its most basic, integrated care can involve the co-location of mental health services in a primary care physician's office; in models with a higher degree of collaboration, the psychologist works as part of the team with the physician, nurses, and other staff, providing brief behavioral health interventions and consulting directly with the team on treatment plans. It has been stated that the primary care system in America is the de facto mental health system. In rural areas where psychologists and other mental health professionals are less densely located, it is even more important to provide services where most people will be willing, able, and likely to receive them.

Attending were key APA members with interest and expertise in rural health, integrated health care, training programs, and those in underserved communities represented by the Public Interest Directorate Committee on Socioeconomic Status. Other invited guests included Gina Capra, a representative for the US Bureau of Primary Health Care (BPHC) in the Health Resources and
1. Make the case for integrated/collaborative care to PCAs and ultimately CHCs
   a. This problem has largely been addressed by NACHC, BPHC, and the most current research on the benefits of integrated care.
   b. Some PCAs are working towards integrated care; in these situations, the problem is mostly in connected appropriately trained psychologists with CHCs and justifying hiring a psychologist versus mid-level professionals.
   c. For PCAs who are not onboard, there is a wealth of information provided by NACHC, BPHC, and others on the benefits of integrated care.
      - http://www.integratedprimarycare.com/

   Many PCAs are unfamiliar with collaborative or integrated care models. APA should encourage BPHC and NACHC to continue to provide incentives to behavioral health in primary care and to fund and distribute current research on the benefits of integrated care.

2. Justify hiring a psychologist versus a mid-level mental health provider
   a. The difference in annual salary and benefits is relatively small within the personnel budget of a health clinic, so any persuasive argument would need to show how psychologists can add value to the bottom line of a CHC.
   b. Need to differentiate the work of a behavioral health consultant from the full scope of practice and value-added benefits of licensed psychologists (program development and evaluation, chronic disease management, etc).
   c. Need to show that psychologists on the staff of a CHC:
      - increase access for underserved populations,
      - improve treatment and outcomes of patients with chronic conditions,
      - decrease after-hours calls and free up the family physician’s time,
      - assist in meeting HEDIS and pay-for-performance indicators,
      - help to increase revenues,
      - improve program development capabilities,
      - decrease emergency room visits,
      - are prepared for the CHC environment (particularly telehealth and tele-mental health), and
      - participate in collaborative projects (i.e. depression collaboratives and chronic illness collaboratives funded by HRSA).

   Changes that would allow billing for post-doctoral psychologists would increase the value of psychologists in CHCs.

3. Train primary care psychologists
   a. Primary care psychology requires some skill sets particular to the primary care setting such as brief behavioral health interventions. In order to promote primary care psychology, there need to be psychologist trained and willing to work in these settings. This subset of the psychology workforce is unknown.
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A. Facilitate the publishing of data on the impact of psychologists working in CHCs  
   (possibly at Cherokee Health Systems).
B. CRH and APA should encourage more data driven dissertations projects on primary care  
   psychology and more meaningful demonstration projects. It may also be time to update,  
   revise, and expand the curriculum on rural psychology.
C. The RuralPsych website could be a resource for psychologist-specific integrated care. For  
   example, Ben Miller knew of a psychologist who has put together a podcast for his  
   patients on behavioral health in primary care.
D. Share publications, resources, and contacts with key players in the FQHC program. APA  
   should track key issues, people, and movements in integrated care.

APA Policy and Action
A. Allocate resources and staff time at APA in such a way as to provide focused attention to  
   these issues. This may or may not require a policy statement.
B. Incorporate this agenda into the strategic plan.
C. CRH should work with other governance groups (especially APAGS, CECP, CSES) to  
   create a wide net of support and a wide variety of projects relating to this issue.
D. Highlight workforce shortages in psychology and family medicine to Congress. The  
   Center for Workforce Studies may be able to get this data.

Federal Policy and Partners
A. APA staff and CRH committee members should continue to meet and maintain contacts  
   with federal agency staff and NACHC. APA should present itself in all of these activities  
   as an association of primary care providers and insist on inclusion in all relevant meetings  
   and policy decisions.
B. Talk with the payers (CMS, insurance companies, managed care, etc) in order to advocate  
   for better, more flexible reimbursement mechanisms. States may be great partners in this.  
   Connections between SPTAs and FQHCs may be a good entry point (also APA and  
   NACHC).
C. Continue to work with members of Congress to increase the amount of money for the  
   Graduate Psychology Education (GPE) program.
D. Encourage BPHC and NACHC to continue to provide incentives for behavioral health in  
   primary care settings.

State Policy and Partners
A. Create a toolkit for psychologists to use to talk to their local PCAs. This should  
   operationally define the ideas coming out of this meeting so that psychologists and  
   SPTAs know how to talk with their local PCAs about these issues. Special attention  
   should be paid to self-marketing and differentiating psychologists from other behavioral  
   health specialists.
B. Facilitate discussions among key stakeholders, including SPTA leaders, primary care  
   associations, and payers.
C. Work with interested SPTAs on this issue. Make sure to keep the executive directors of  
   the state associations in the loop on important issues.
D. Promote interstate reciprocity for telehealth services as a way to better serve rural  
   communities.
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- Find out who is interested in integrated care in your area. All areas are different, but many groups of CHCs, community mental health centers, hospitals, and state payers and human services are starting to talk about integration of care.
- Determine where there is a need for primary care psychology.

D. Training primary care psychologists
- Use the documents prepared by CRH for training in primary care psychology
- Use the report from ETSU on their rural primary care psychology training program
- Find out if there are opportunities to train in primary care psychologists
- Work with CHCs and other primary care sites to set up training programs for psychology trainees.

Tennessee
- Katherine, Elaine, and Wally going to be at TN’s Convention (November)
- Meeting with State Association and other stakeholders

Maine
- Need handouts and other information on why psychologist should be in primary and information about funding these positions
- Need to bring folks together from Maine Primary Care Psychology, Primary Care researchers, and PCAs. Ben Miller and Parinda Khatri may be helpful.

New Mexico
- Support Elaine LeVine in bringing this to the NMPA executive committee.
- If there is support, refer to Maine ideas.

Timeline

Committee on Rural Health

A. The committee will prepare the two documents and make them available to the Rural Health Coordinators, SPTAs, and interested psychologists.
B. The following people will report back to CRH on progress made on PCA Initiative and integrated care:
- Tennessee – Wally Dixon, PhD, Tennessee RHC
- Maine – Diana Prescott, PhD, Maine RHC and John O’Brien, PhD, CRH Member
- New Mexico – Elaine LeVine, PhD, MPP, CAPP Member
- Hawaii – Rosie Adam-Terem, PhD, CRH Member