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A Healthy New World: Emergent Opportunities for Clinical Psychologists in the Patient Protection and Affordable Care Act

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Abstract

The Patient Protection and Affordable Care Act (ACA) is radically transforming the health and mental health care landscape. Emergent opportunities exist for clinical psychologists to redefine their role in healthcare. We reflect on the Chor and colleagues article (this issue) elucidating key issues for psychologists, and present additional recommendations for consideration. Specifically, we highlight three points: (1) moving beyond just training and hoping; (2) recovery, not just symptom reduction; and (3) it's a healthy new world. Under each of these points, we suggest tactics for how to achieve these goals.

Chor and colleagues have done an excellent job of deciphering the veritable tome that is the Patient Protection and Affordable Care Act (ACA), numbering more than 2300 pages in length. Specifically, they have elucidated some key issues for clinical psychologists to consider in light of the changes that will be wrought by the ACA. This radical transformation in federal health care legislation provides a unique opportunity for psychologists to redefine their role in the health care setting and ensure that they can continue to contribute. Using the platform provided by Chor and colleagues, we comment on the opportunities for psychologists going forward, as well as suggest *strategies for how to realize the goals of the ACA*.

Our intention is to reflect on the main points presented by Chor and colleagues, and suggest additional but not exhaustive possibilities for consideration. Specifically, we will elaborate on three main points: (1) moving beyond just training and hoping; (2) recovery, not just symptom reduction; and (3) it's a healthy new world. Under each of these points, we will briefly discuss the issue, followed by a section on tactics for how to achieve these goals.

Moving beyond just training and hoping

Issue

As Chor and colleagues suggest, the ACA calls for two actionable goals that are relevant to training of psychologists: (1) prioritizing the use of evidence-based practices, and (2) emphasizing interdisciplinary teams. These goals give rise to three critical issues. First, we need a mandate for pre-doctoral graduate programs to include training in evidence-based practices. Second, we need to ensure that training efforts, such as continuing education seminars, designed to train post-doctoral psychologists in evidence-based practices, include more than one contact (i.e., ongoing support; Nadeem, Gleacher, & Beidas, 2013). Third, we need to offer training both at the pre- and post-doctoral level in emergent areas in which psychologists typically are not well-versed, such as interdisciplinary teams and community- and population-level assessment and intervention.

Evidence suggests many psychology training programs do not emphasize evidence-based practices. In a large national survey of psychology training programs, it was found that few programs required both didactic training and clinical supervision in evidence-based practices, and that much of the required training was not evidence-based (Weissman et al., 2006). Most trainees in clinical psychology programs therefore are graduating without the skills they will need to practice in the era of the ACA, creating a critical workforce problem. The major accrediting body in clinical psychology is the American Psychological Association (APA) Committee on Accreditation. Although it recommends that training programs be based on science, each program is free to select its philosophy of training, even if it is not congruent with evidence-based practice (American Psychological Association Committee on Accreditation, 2006). While there are several descriptions of the perils of not mandating that training be based on science (see McFall, 1991), these calls to action have not been heeded.

The ACA will also result in a need for training in areas that are not traditionally well-represented in clinical psychology. Two primary areas that will need buttressing include serving as a member of an interdisciplinary team (Manderscheid, 2014a) and learning how to use community- and population-level assessment and interventions (Manderscheid, 2013a). Given the ACA's emphasis on interdisciplinary teams of health professionals, psychologists must learn how to function alongside other health professionals, including primary care physicians, nurse practitioners, nurses, social workers, other allied health professionals, peer specialists, consumers, and family members (Manderscheid, in press). This stands in stark contrast to the typical psychotherapy model, which involves individual sessions behind closed doors, where the psychologist operates in isolation. The ACA encourages interdisciplinary functioning through patient centered medical homes (PCMHs) operated by Accountable Care Organizations (ACOs). PCMHs integrate primary and behavioral health care, so that people can have all of their health care needs addressed by one entity (Manderscheid, 2014b; Manderscheid, in press). For example, a youth with asthma and an anxiety disorder can visit one place to receive care rather than having to visit multiple specialty locations. A key issue for consideration is how decisions will be made about the role of different individuals on interdisciplinary teams. Not everyone can be a

generalist (e.g., primary care doctors) and; clearly, a place still exists for specialty practice (Comer & Barlow, 2014).

The ACA also focuses on community- and population-level assessment and interventions (Manderscheid, 2013a). This approach departs from the type of training that psychologists receive in implementing clinical interventions one-to-one. The future, according to the ACA and in line with the 'Public Health Action Plan to Integrate Mental Health Promotion and Mental Illness Prevention with Chronic Disease Prevention' (Centers for Disease Control and Prevention, 2012), includes applying a public health model to mental health promotion and mental illness prevention. This includes community- and population-level interventions such as the Triple-P parenting program (see Prinz et al., 2009). These types of interventions differ in their intervention target and focus. The typical intervention target of psychotherapy is one person whereas the intervention target of a community- and population-level intervention is everyone in a community or population. Further, the intervention focus will move towards health promotion rather than disease treatment (Manderscheid, 2013a). Successful implementation of such interventions will require understanding the social and physical determinants of health so that we can intervene long before mental health difficulties emerge (Manderscheid, in press).

Strategies

Training in evidence-based practices, being part of an interdisciplinary team, and community- and population-level assessment and interventions, at the pre- and post-doctoral level are critical components of what psychologists must learn if they want to stay relevant in the era of the ACA. Innovative thinking and planning around how to best train both pre- and postdoctoral level psychologists is needed. Strategic planning on how to operate in the era of the ACA should be informed by joint strategic meetings with stakeholders (e.g., primary care doctors, nurses, psychologists, social workers, peer specialists, family members, consumers) to understand what will be needed to meet the challenges of the ACA. Whenever possible, psychologists should seek out training opportunities in PCMHs that are implementing public health approaches and in interdisciplinary teams at the practicum, internship, and post-doctoral level. Finally, we recommend that one-time training opportunities cease being the mainstay of continuing education and that new innovative training methodologies be developed that include experiential learning (Beidas, Edmunds, Marcus, & Kendall, 2012), multiple contacts (e.g., ongoing support; Nadeem et al., 2013), and use technology (Beidas, Koerner, Weingardt, & Kendall, 2010).

As the ACA is implemented, psychologists working in specialty mental health settings should approach their leadership to consider how to take advantage of these new models of care. Specialty mental health settings will need to connect with ACOs to identify how they can become part of or manage Behavioral Health Health Homes (BHHH), as well as liaise with primary care PCMHs. Additionally, another very important opportunity exists within federally qualified health centers (FQHCs), which are receiving more than \$57 million to implement behavioral health programs where none exist. Rather than competing with specialty mental health settings, specialty mental health providers should contract with these sites to provide behavioral health services *in situ*.

Recovery, Not Just Symptom Reduction

Issue

The ACA emphasizes a whole-person approach that dovetails nicely with recovery oriented approaches. Recovery refers to a process that moves individuals struggling with mental health or substance use problems toward a full life in the community (Farkas, 2007). To date, psychology's mainstay in intervention development and evaluation has been oriented towards a symptom-reduction approach (Frisch, 1998). Measurement of success must be expanded to include a primary focus on recovery and fostering a full life in the community, and associated outcomes such as hope, healing, empowerment, and social connections (Jacobson & Greeley, 2001). Furthermore, consistent with both a recovery approach and the ACA, more emphasis will be placed on peer specialists – individuals who have progressed through recovery themselves who can support others (Druss et al., 2010; Manderscheid, 2013b).

Strategies

To achieve the intended goals of the ACA and recovery oriented care, systems will need to commit resources to a recovery oriented approach. A number of cities and states including Philadelphia (Clay, 2013) and Connecticut (Davidson et al., 2007) have transformed their mental health systems by using a recovery-oriented approach (e.g., hiring peer specialists, committing to evidence-based practices). To plan for wider implementation of a recovery oriented approach, strategic meetings between peer supporters, wellness coaches, social services, and psychologists should occur to discuss recovery and life in the community. Psychologist trainees will need to seek out training opportunities in recovery-oriented care systems, and graduate programs will need to include training in the recovery model. For implementation, psychologists will need to seek out practice opportunities in systems that are recovery-oriented within PCMHs, where wellness is a large part of the practice.

It's a healthy new world

Issue

The ACA will radically reshape the healthcare landscape. New entities will be created and psychologists can be included or left behind. First, hospitals, FQHCs, and primary care practices are not the only potential operators of PCMHs. Behavioral health entities can also think about how to develop a BHHH (Manderscheid & Kathol, 2014). Understanding how to restructure agencies to allow for this type of radical change will be critical. Neither a PCMH nor a BHHH can operate a fee-for-service model with a behavioral health carve out (the current model). To operate a PCMH or BHHH effectively and efficiently, specialty mental health settings will need to move to an integrated case rate per person served. Case rates refer to a lump sum paid at the beginning of a fiscal year to cover the cost of a group of people (Centers for Medicare & Medicaid Services [CMS], 2014). For example, a PCMH or BHHH might be asked to serve 500 persons with schizophrenia, and would be given 10,000 dollars per person served, or 5,000,000 dollars. That PCMH or BHHH would be expected to serve all of these people within this budget which is intended to incentivize better care (as opposed to the current model which incentivizes more care; CMS, 2014). One of our largest

challenges is that these kinds of issues relate to system development and transformation. Traditional clinical psychology programs focus on clinical training and are bereft of policy and system transformation training.

Strategies

To plan for this large system transformation, graduate training programs need to incorporate curricula on system and policy development and transformation. Further, programs should be open to collaborating with other professionals with whom they have not frequently interacted to date (e.g., sociologists, consultants building PCMH or BHHH, business/operations professionals) to buttress skills that current faculty do not possess. Moving from a clinical intervention world to a system intervention world will not be without growing pains, but is necessary in this new landscape. Psychologists will do well seeking opportunities to work in PCMHs or BHHHs to have the opportunity to work with a broad array of consumers and to experiment with different strategies in system and policy development.

Concluding Remarks

We have a choice as psychologists and allied health professionals. We can stay relevant and be included as core players in the new landscape of health and mental healthcare or we can resist change and be left behind. Given the potential for psychologists to include their unique thumbprint on the new healthcare system that will emerge out of the ACA, it would be a shame for the latter option to be chosen.

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References

- American Psychological Association Committee on Accreditation. Guidelines and principles for accreditation of programs in professional psychology. 2006. Retrieved from <http://www.apa.org/ed/accreditation/intern.html>
- Beidas R, Edmunds J, Marcus S, Kendall P. Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services*. 2012; 63:660–665. [PubMed: 22549401]
- Beidas R, Koerner K, Weingardt K, Kendall P. Training research: Practical recommendations for maximum impact. *Administration and Policy in Mental Health and Mental Health Services Research*. 2010; 38:223–237. doi:10.1007/s10488-011-0338-z. [PubMed: 21380792]
- Beidas R, Kendall P. Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice*. 2010; 17:1–30. doi: 10.1111/j.1468-2850.2009.01187.x. [PubMed: 20877441]
- Centers for Disease Control and Prevention. Public Health Action Plan to integrate mental health promotion and mental illness prevention with chronic disease prevention, 2011–2015. U.S. Department of Health and Human Services; Atlanta: 2011.

- Centers for Medicare & Medicaid Services. Bundled payment for care improvement (BPCI) initiative: General information. 2014. Retrieved from <http://innovation.cms.gov/initiatives/bundled-payments/>
- Chor K, Olin S, Hoagwood K. Training and education in clinical psychology in the context of the Patient Protection and Affordable Care Act. *Clinical Psychology: Science and Practice*. (this issue).
- Chorpita, BF.; Weisz, JR. MATCH-ADTC: Modular Approach to Therapy for Children (MATCH) with anxiety, depression, trauma, or conduct problems. PracticeWise; Satellite Beach, FL: 2009.
- Clay R. Embracing recovery. *Monitor on Psychology*. 2013; 44:52.
- Comer JS, Barlow DH. The occasional case against broad dissemination and implementation: Retaining a role for specialty care in the delivery of psychological treatments. *American Psychologist*. 2014; 69:1–18. doi:10.1037/a0033582. [PubMed: 23915401]
- Davidson L, Tondora J, O'Connell M, Kirk T, Rockholtz P, Evans A. Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*. 2007; 31:23–31. doi:10.2975/31.1.2007.23.31. [PubMed: 17694712]
- Druss B, Zhao L, von Esenwein S, Bona J, Fricks L, Jenkins-Tucker S, Lorig K. The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness. *Schizophrenia Research*. 118:264–270. [PubMed: 20185272]
- Farkas M. The vision of recovery today: What it is and what it means for services. *World Psychiatry*. 2007; 6:68–74. [PubMed: 18235855]
- Farmer A, Legare F, Turcot L, Grimshaw J, Harvey E, McGowan J, Wolf F. Printed educational materials: Effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews*. 2008; 16
- Frisch M. Quality of life therapy and assessment in health care. *Clinical Psychology: Science and Practice*. 1998; 5:19–40. doi:10.1111/j.1468-2850.1998.tb00132.x.
- Glisson C, Schoenwald S. The ARC organizational and community intervention strategy for implementing evidence-based children's mental health treatments. *Mental Health Services Research*. 2005; 7:243–259. doi:10.1007/s11020-005-7456-1. [PubMed: 16320107]
- Herschell A, McNeil C, McNeil D. Clinical child psychology's progress in disseminating empirically supported treatments. *Clinical Psychology: Science and Practice*. 2006; 11:267–288. doi:10.1093/clipsy.bph082.
- Jacobson N, Greenley D. What is recovery? A conceptual model and explication. *Psychiatric Services*. 2001; 52:482–485. [PubMed: 11274493]
- Kendall, PC.; Hedtke, KA. *Cognitive-Behavioral Therapy for Anxious Children/Therapist Manual*. 3rd Edition. Workbook Publishing; Ardmore, PA: 2006. (Child/Individual treatment manual)
- Manderscheid, R. Fostering an ounce of prevention, many people at a time [blog post]. 2013a. Retrieved from <http://www.behavioral.net/blogs/ron-manderscheid/fostering-ounce-prevention-many-people-time>
- Manderscheid, R. Essential new roles for peers and service recipients in the whole-health era [blog post]. 2013b. Retrieved from <http://www.behavioral.net/blogs/ronmanderscheid/essential-new-roles-peers-and-service-recipients-whole-health-era>
- Manderscheid, R. Headline 2014: Full service integration has arrived [blog post]. 2014a. Retrieved from <http://www.behavioral.net/blogs/ron-manderscheid/headline-2014-full-service-integration-has-arrived>
- Manderscheid R. Care integration is an imperative in county service systems. *National Association of Counties News*. 2014b
- Manderscheid R. The Affordable Care Act: Overview and implications for county and city behavioral health and intellectual/developmental disability programs. *Journal of Social Work in Disability and Rehabilitation*. (in press).
- Manderscheid R, Kathol R. Fostering sustainable, integrated, medical and behavioral health services in medical settings. *Annals of Internal Medicine*. 2014; 160:61–65. [PubMed: 24573665]
- McFall R. Manifesto for a science of clinical psychology. *The Clinical Psychologist*. 1991; 44:75–88.
- Nadeem E, Gleacher A, Beidas R. Consultation as an implementation strategy for evidence-based practices across multiple contexts: Unpacking the black box. *Administration and Policy in Mental Health and Mental Health Services Research*. 2013; 40:439–450. doi:10.1007/s10488-013-0502-8. [PubMed: 23716145]

- Powell B, McMillen J, Proctor E, Carpenter C, Griffey R, Bunger A, York J. A compilation of strategies for implementing clinical innovations in health and mental health. *Medical Care Research Review*. 2012; 69:123–157. doi:10.1177/1077558711430690. [PubMed: 22203646]
- Prinz R, Sanders M, Shapiro C, Whitaker D, Lutzker J. Population-based prevention of child maltreatment: The U. S. Triple P system population trial. *Prevention Science*. 2009; 10:1–12. doi: 10.1007/s11121-009-0123-3.
- Weissman M, Verdeli H, Gameroff M, Bledsoe S, Betts K, Mufson L, Wickramaratne P. National survey of psychotherapy training in psychiatry, psychology, and social work. *Archives of General Psychiatry*. 2006; 63:925–934. doi:10.1001/archpsyc.63.8.925. [PubMed: 16894069]