Commentary: Healthcare Reform and Psychology’s Workforce: Preparing for the Future of Pediatric Psychology*

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Upcoming changes to the healthcare delivery system, detailed in the Patient Protection and Affordable Care Act (ACA; Public Law No: 111–148, March 23, 2010), focus on the growing expectation that interprofessional organizations (institutional practices such as accountable care organizations (ACOs) and patient center healthcare homes) will become the nexus of the delivery of efficient, cost effective, and quality healthcare services (Orszag & Emanuel, 2010; Rozensky, 2011). If the legislation survives the legal battles currently being waged, the healthcare delivery system will look very different by the end of this decade (Clay, 2011). The healthcare workforce of the future must be prepared to enhance quality of patient care utilizing defined, interprofessional competencies as they practice within an increasingly evidence-based, team-based, integrated care system—from prevention to primary to tertiary care—and for patients and families across the lifespan (Institute of Medicine, 2001; Wilson, Rozensky, & Weiss, 2010).

This article describes several challenges and opportunities facing professional psychology given the upcoming demands of the ACA and evolving healthcare system. We argue that preparation for increased institutional practice is required and that several philosophical and practical changes will be necessary as our profession adapts to this new healthcare system. The interprofessional strengths of pediatric psychology are discussed in particular and specific opportunities and recommendations are offered to enhance the future of pediatric psychology in (the new) healthcare.

Some Questions Professional Psychology Might Answer to Prepare to Successfully Participate in Upcoming Changes to the Healthcare System

We will focus on four broad areas of concern: (a) curriculum enhancements toward interprofessionalism; (b) professional accountability; (c) workforce needs and development; and (d) autonomy, self-definition and identity. These areas are based on 15 action steps needed to build the future of professional psychology (Rozensky, 2011). Some of these steps require substantial financial commitment by organized psychology (expansion of workforce analysis capabilities), some necessitate self-regulatory changes within the field (universal program accreditation and specialization by individual providers), and several reflect philosophical challenges to how we define who we are and what we do. Each of these areas anticipates demands for both affordable care and enhanced accountability in the developing healthcare system.

Curriculum Enhancement Toward Interprofessionalism

Developing an integrated, interprofessional and accountable healthcare system is at the core of the ACA. Healthcare reform is based on expanding and strengthening the primary care system through interprofessional healthcare teams. The ACA describes two organizational structures in the evolving healthcare system, the ACO and the Patient Centered Medical Home (PCMH). Rittenhouse, Shortell, & Fisher (2009), see the ACO concept as focused on aligning financial incentives and accountability across the care continuum with successful ACOs requiring a strong interprofessional, primary care base. The ACO, designed to improve care and reduce
costs, must provide services to at least 5,000 beneficiaries per “organization” using a structured group practice of physicians and other healthcare professionals (CMS, 2010). In order to assure a coherent delivery system, it is likely that ACOs will be built upon an extended hospital professional staff model, in concert with hospitals themselves, to assure continuity of care and meet the mandate of the ACO concept (Fisher, Staiger, Bynum, & Gottlieb, 2007). How is pediatric psychology positioned to participate in these changes?

The PCMH emphasizes the establishment of strong primary care services as the foundation for community centered delivery system reforms, with the successful PCMH having a comprehensive delivery system beyond its primary care core (Rittenhouse et al., 2009). The PCMH is considered by many (Nutting et al., 2011) to be a major improvement to the practice of primary care given its focus on access, coordination and comprehensive care, and the sustained personal relationship between patient and provider(s)—with patients actively engaged in a healthcare partnership. This model requires risk-sharing financial incentives in the form of global payments to the local healthcare system that are then passed on to individual providers (Nutting et al., 2011) as the basis of financial accountability. They will require clear evidence of properly prepared providers and routinely monitored, positive outcomes to meet the expectations for integrated, efficient and effective healthcare. How is professional psychology anticipating these changes?

Importantly, healthcare reform emphasizes the integration of mental and physical healthcare services. In patient-centered health homes, interprofessional teams work together to provide integrated care to patients. The ACA emphasizes the importance of interprofessional care and its impact on quality and cost savings. Interprofessionalism then involves development of competencies across disciplines and the application of those shared competencies in an integrated, team-based healthcare system. Furthermore, the ACA recognizes provision of interprofessional, integrated disease prevention, health promotion services, and treatment of chronic diseases. As such, the ACA will bring ample opportunities for psychologists to become part of interprofessional teams (Clay, 2011).

Wilson et al. (2010) describe the history and current development of Federal policy recommendations supporting “the integration of interprofessional education (IPE) into health professions education as a means of assuring a more collaborative health care workforce” (p. 210). Frenk et al. (2010) discuss how IPE results in “an enlightened new professionalism that can lead to better services and consequent improvements in the health of patients and populations” (p. 1954). Interprofessionality, as a response to ongoing fragmented healthcare practices, “is defined as the development of a cohesive practice between professionals from different disciplines” (D’Amour & Oandsan, 2005, p. 9). This includes development and application of shared interprofessional competencies during education, training (Schuetz, Mann, and Evertt, 2010) and clinical practice in an integrated, team-based healthcare system (Interprofessional Education Collaborative, 2011). Psychology’s rich history of, and current institutionally based clinical practice, form a strong foundation for successful involvement in the healthcare delivery system of tomorrow, but psychologists must continue to prepare to be part of healthcare’s evolving clinical team structure and financial systems (Rozensky, 2011). The evolution of curriculum for professional psychology is described by Clay (2011) as critical to preparing psychology for the new healthcare system’s interprofessionalism.

In a manner similar to the review of medical education done by Flexner at the beginning of the 20th Century (Cooke, Irby, Sullivan, & Ludmerer, 2006), professional psychology would do well to review and revise its graduate curriculum to assure that our next generation not only has the broad and general training to be prepared clinically and scientifically for an evidence-based healthcare system, but that the requisite interprofessional competencies are part and parcel of psychology’s basic education and training for those planning to work as health service providers. That will position psychologists for success in the accountable care, integrated care, interprofessional healthcare system that is the core of the ACA. What can pediatric psychology do to move toward this goal?

**Professional Accountability**

Promoting and ensuring accountable care is at the core of the ACA. In the new healthcare system, accountability will be manifested in numerous ways.

**Evidence and Financial Accountability**

A fundamental tenant of ACOs and PCMHs is that they are designed to improve care and reduce costs. As noted earlier, to be effective this “model will require support and risk-sharing incentives in the form of global payments” (p. 444) to the institutional practice (PCMH) for all services provided (Nutting et al., 2011). A premium will be placed on demonstrating that healthcare delivered to patients is not only effective, but also cost effective. The ACA also includes provisions for assessing “patient-centered outcomes research,” thus emphasizes the importance of considering effectiveness not only from the perspective of
the provider, but also the patient. As the healthcare system evolves toward enhanced accountability, it will be critical for psychologists to describe clearly how our services are evidence-based with strong, positive clinical outcomes that actually contribute to cost savings expected within the new healthcare system (Chiles, Lambert, & Hatch, 1999; Tovian, 2004).

Accreditation
Rozenzky (2011) reported on a brief survey of healthcare members of the Association of Specialized and Professional Accreditors that found that psychology may well be the only doctoral level health profession that allows some individuals from nonaccredited education and training programs to sit for licensing. How might that be viewed in a more highly accountable healthcare system where legally organized provider groups must assure the quality of each provider in its group practice? If ACOs will be built upon the foundations of hospital medical/professional staff structures—with their detailed credentialing and privileging requirements—it may be expected that psychology’s practitioners only come from accredited education programs as the very foundation of quality and “accountable” care (Rozenzky, 2011). Will our field rise to that level of expectation of accredited education programs in order to assure policy makers that we value assurance of quality from training through service provision and thus be included in the new accountable care system with no questions?

Specialization
Accountable healthcare institutions may well expect that documentation of provider specialization also will be a basic expectation for all licensed providers. Board Certification, for example, is expected of all physicians in hospital settings in order to be on the professional staff, and, if ACOs will be based upon hospital–professional staff structures, then credentialing, to “be on staff” of the healthcare (institutional) setting of tomorrow, will be based on board certification of its high level providers (Rozenzky, 2006) as either general practitioners (a general practice specialty) or as providers within recognized specialties. This is consistent with contemporary organized medicine’s viewpoint that specialization is a means for assuring quality of care in the increasingly specialized world of healthcare (Brennan et al., 2004). How will professional psychology be prepared for this credentialing expectation?

Workforce Needs and Development
The field of workforce analysis looks at projections of worker “supply” versus forecasts for service “demands” that are then integrated with “…assumptions…based on trends or possible trends observed in the social, technical, economic, and political sectors of society” (Rozenzsky, Grus, Belar, Nelson, & Kohut, 2007, p. 240; The National Center for Health Workforce Analysis, http://bhpr.hrsa.gov/healthworkforce/). The resulting data from workforce analysis is essential in developing a vision and plan for growth in a field such that the profession can meet the projected needs of the population.

However, in order to establish an accurate, data-based picture of its workforce, organized psychology must allocate funds equivalent to those spent by other healthcare disciplines on workforce analysis activities (e.g., Dill & Salsberg, 2008). Analysis must look at not only who and how many are doing what today, but what are the workforce demands (services needs) for tomorrow (gap analysis). As the American Academy of Neurology (Butcher, 2011) has said about its own specialty-centric workforce studies, “policy makers and payers are increasingly focusing on the quality and cost of care” (p. 11) and they note that their research can illustrate demand, cost savings, and quality.

Psychology must have similar information in order to build a data-based strategic vision for psychology’s future and for use in advocating for our role in healthcare with policy makers, third-party payors, and local provider groups. Such information will allow us to make stronger arguments for funding for education and training and reimbursement for services. Moreover, we cannot rely solely on the workforce studies done by others. For example, the United States Bureau of Labor Statistic includes bachelors and masters prepared individuals in its psychology workforce data (http://www.bls.gov/oco/ocos056.htm). Psychology must control the definition of psychology in the workforce to assure an accurate representation of our provider group and our high level of services.

Establishing our Role
Many of the details of how the new healthcare system will function are being defined via Federal rules development. Advocacy for our work and services will be crucial as those details come into practice. Psychologists must participate in the actual process of redesigning healthcare delivery and hammering out regulations or risk being left out (Clay, 2011). The new healthcare system will, in all likelihood, have fewer and tighter resources due to financial restraints and higher accountability expectations. There may well be heightened competition for those resources. Given the integrated, interprofessional focus of the new healthcare system, there also are likely to be turf wars over who controls budgets and ultimately who administers, assigns and supervises professionals in these systems. Psychology will
need to be in a position to advocate nationally and locally for those resources and autonomy as a profession. Maintaining autonomy, even while serving as key, team-oriented members of the evolving, interprofessional healthcare workforce, will assure that psychology can advocate for the services it brings to our patients (Rozensky, 2004; 2011).

**Recommendations for Pediatric Psychology**

We have described some of the key changes to the new healthcare delivery system as detailed in the ACA. In summary, the overall field of healthcare will be focused increasingly on interprofessionalism. IPE, training and services are recognized specifically in the ACA as essential to that goal. ACOs and PCMHs will be the institutional practice venues of the future. Interprofessional practice competencies will be essential for all providers in this system. Accountability will be a defining feature of the new system to ensure the delivery of efficient and effective services. The new healthcare system is still “under construction”. As such, how do we assure that pediatric psychology is part of that future? We offer the following recommendations with the hope that they may help position pediatric psychology to take advantage of the opportunities offered by the ACA and the evolving healthcare system.

**Work Force Analysis**

In 1997, Robert Hannemann, then President of the American Academy of Pediatrics, said that each and every pediatric patient should be seen by a pediatric psychologist. A great aphorism, but, how’s that going a decade and a half later? The American Board of Pediatrics (ABP, 2011) recently published a compendium of 10 years of their published workforce analysis studies, including general pediatrics and by subspecialty, to illustrate supply, demand, and policy implications for their field and the healthcare needs of children. Unfortunately, the ABP workforce studies make no reference to psychologists even though they do present published studies about nurse and physician assistant workforce in pediatrics. Here, then is an opportunity to bring together our leaders in pediatric psychology with leadership in pediatric medicine to study the impact of the pediatric psychology workforce on patient care outcomes, quality, costs, and provider and patient satisfaction. Pediatric psychology, like its colleagues in pediatric medicine, should carry out its own workforce studies as well as join forces with the American Psychological Association to build this workforce analysis capacity as a keystone of psychology’s strategic planning.

Opipari-Arrigan, Stark, and Drotar (2006) present information on the workplace settings and faculty appointments for members of the Society of Pediatric Psychology (SPP) that serves as an initial step in this direction. They found 63% of pediatric psychologists reported working in hospital settings as their primary setting, 22% in private practice, and the remaining in various academic, mental health, or school environments. They also noted that hospital-based psychologists “…were held accountable for generating over half (52%) of their salary” (p. 636) using research dollars and that 80% were providing direct patient care services to cover costs. For those with academic appointments, 49% were in departments of pediatrics, 26% in psychiatry, and only 14% in independent psychology departments.

These data can serve as a model to help better understand the actual base rates of where pediatric psychologists work and can be helpful in beginning to understand the needed supply of psychologists within specific practice areas. This approach to self-study might help to mitigate what has been the concerning number of trainees unable to find accredited doctoral internship training sites (e.g., Rodolfo, Bell, Bieschke, Davis, & Peterson, 2007) by helping to more accurately plan and advocate for their future. How large was the pediatric psychology workforce in the late 1990s; how many have we added since; and how many new pediatric psychologists will we need to augment the workforce to reach the goal of comprehensive, integrated child and adolescent healthcare as envisioned by the new ACA and reflected in Hannemann’s positive challenge well over a decade ago (1997)?

**Update Task Force Recommendations on Training in Pediatric Psychology**

It is critical that the next generation of pediatric psychologists be trained clinically and scientifically for an evidence-based, integrated and interprofessional healthcare delivery system. A decade ago a SPP task force report (Spirito et al., 2003) provided recommendations on the types of training experiences considered most important for the development of competency in pediatric psychology. We recommend that the SPP convene a task force to update these recommendations including a list of key clinical and scientific competencies that will be necessary for pediatric psychologists to master to successfully function in the new integrated healthcare system. Recommendations could include the specifics of...
interprofessional competencies, team-based competencies, and the expansion of knowledge-based and applied competencies. For example, the ability to assess developmental, biopsychosocial and family factors affecting adherence to medical and psychological care and the ability to provide brief targeted therapy for issues commonly seen in primary care settings. Our colleagues in clinical health psychology have developed a list of competencies that could serve as a guide as we work to establish a set of competencies for the training of future pediatric psychologists (France et al., 2008). These recommendations can help assure that students are competent in the integration of mental health, behavioral health, and healthcare psychology including exposure to a range of practice environments that will facilitate their choosing future scientific and/or clinical work environments within the new healthcare system.

**Greater Demonstration of Cost Offset, Clinical Significance, and Patient Satisfaction**

As the healthcare system evolves toward enhanced accountability, can we describe clearly how our services are evidence based with strong, positive clinical outcomes that actually contribute to cost savings expected/required within the new healthcare system (Chiles et al., 1999; Tovian, 2004)? Our history is mixed in this area. On one hand, SPP has made good strides with its emphasis on empirically supported treatments (e.g., Janicke & Finney, 1999; Jelalian & Saelens, 1999; McGrath, Mellon, & Murphy, 2000). However, despite the importance of conducting research on interventions in pediatric psychology, relatively few intervention papers have been published historically in *Journal of Pediatric Psychology* (JPP) (Brown, 2007; Kazak, 2002; Tercyak, 2006) and that trend has continued over the last 5 years (Drotar, Personal Communication, 2011). It will be critical for the field to continue to add to the research base demonstrating the efficacy and effectiveness of our interventions. However, while documenting the evidence base for our interventions will be necessary to succeeding in the new healthcare system, standard methods of reporting statistically significant improvement in health, behavior, and psychosocial outcomes will not be sufficient. With the increased emphasis on accountability in the ACA, policy makers and payers will be increasing focused on quality and cost of care. Despite some commendable early research in this area (Finney, Riley, & Cataldo, 1991; Rodrigue et al., 1995; Sobel, Roberts, Rayfield, Barnard, & Rapoff, 2001) pediatric psychologists have published little data demonstrating that our services lead to enhanced patient satisfactions and cost offsets. Such research, and data, will be essential as pediatric psychologists advocate for the inclusion of, and reimbursement for, their services in the integrated healthcare arena and to ultimately ensure the viability of the field in the future.

What steps can be taken in this regard? First, there should be an increased focus on research documenting the cost-offset associated with successful treatment of the problems commonly seen in primary care or other integrated healthcare settings. For example, demonstrating how the successful management of chronic pain can offset the costs of healthcare utilization and functional limitations would be useful. Illustrating how adherence promotion can offset the costs of nonadherence to medical treatment on costs, morbidity, and quality of life would provide similar useful information. This will be particularly important within the context of translation research examining interventions delivered in real-life practice or community-based settings. Second, to assist in this effort, practitioners and researchers alike should attempt to gather cost and cost-offset data in their treatment studies whenever possible. Third, students should receive training in how to conduct cost-offset and cost-effectiveness research and be encouraged to include cost-offset data in their dissertation research when applicable. Routine education in program evaluation for some students would help build this capacity into the future of the field. Fourth, to draw further attention to this issue, it may be beneficial for the JPP to consider publishing a special issue on cost-offset research thus encouraging studies across diseases and treatment venues. Fifth, researchers should consider not only reporting statistical significance, but also the clinical significance of the outcomes associated with their interventions. This would provide students with a clinical context to consider the science they have just read and provide advocates with vignettes useful in helping policymakers contextualize good science to the day-to-day lives of their constituents. Finally, along with clinical significance, researchers need to report more comprehensive patient satisfaction data. This should include not only traditional measures of this construct such as treatment acceptability, but also patient assessment of outcomes relative to their hopes and expectations for treatment. Here too our data can then be used with policymakers to illustrate how evidence-based services are good politics for their constituents.

**Developing a Database of Evidence-Based Treatments in Pediatric Psychology**

In the previous recommendation, we noted the paucity of published treatment outcome research in our field. To be fair, this observation is in reference to publications in *JPP*. The publication rate of interventions studies in JPP is not a perfect measure of our productivity in this area, as this may
partially be a function of researchers choosing to publish their treatment outcome research in medical or illness-specific journals. It would seem beneficial for pediatric psychologists to develop a compendium of the state of the evidence base for the interventions in our repertoire. While incredibly beneficial, the last full issue in the series of articles on empirically supported treatment in pediatric psychology was published over 10 years ago. Thus, we recommend that SPP should consider supporting an effort (possibly develop a task force) to update the library/documentation of evidence-based treatments in Pediatric Psychology. Something similar to a Cochrane Collaborative (http://www.cochrane.org/about-us/evidence-based-health-care) that would assemble the best in evidence-based practices thus providing for our students the best examples of science and practice, for those at the frontline a compendium of best practices, and for those who choose to advocate for the field and the children served both nationally and locally. This type of information would be a nice compliment to the workforce analysis as we prepare to market our services. Clearly, this speaks to Kazdin’s (2008) admonition that “the unifying goals of clinical research and practice are to increase our understanding of therapy and to improve patient care” (p. 151) and this speaks directly to the goals of the ACA.

**Expand Pediatric Psychology’s Role in Integrating Behavioral and Physical Healthcare in Primary Care Settings**

Brown and Roberts (2000) and Rae (2004) have encouraged pediatric psychologist to expand their work in primary care and the field has a history of successes in that venue (e.g., Clay & Stern, 2005; Finney et al., 1991; McDaniel, Belar, Schroeder, Hargrove, & Freeman, 2002; Schroeder, 1996), as well as a strong institutionally-based (hospital) clinical practice presence (Opipari-Arrigan et al., 2006). Does this strong foundation assure successful involvement in the healthcare delivery system of tomorrow? Not necessarily. Given the emphasis of the new healthcare system on integrative care and primary care patient center medical homes, pediatric psychology would do well to be even more proactive in expanding its role in integrating behavioral and physical healthcare in primary care settings. For example, Schroeder (1996) has described several models to carry this out; how integrated are pediatric psychologists in day-to-day primary care a decade and a half later? Pediatric psychologists can work to increase collaborations in service delivery and more importantly, in conducting research to document the effectiveness (both clinically and costs) of brief targeted interventions in primary care settings. To this end, training of the next generation of pediatric psychologists should include a focus on developing the competencies needed to function successfully in primary care settings. A strong training emphasis on the briefly targeted assessment and therapy, especially for conditions commonly seen in primary care settings such as abdominal pain, toileting and feeding issues, management of oppositional and disruptive behavior, and sleep problems seem warranted. Training in this area will be further enhanced by developing primary care practicum placements that will allow observation and hands-on clinical experiences.

**Establish Greater Linkages and Collaborations With Public Health Colleagues**

Given the ACAs emphasis on prevention and health promotion, pediatric psychologists should redouble our efforts to establish linkages and collaborations with colleagues in public health. Public health and population-based research and practice have not traditionally been the focus of pediatric psychology. Despite efforts to the contrary, few articles submitted or published in the *JPP* have taken a public health or prevention focus (Brown, 2007; Kazak, 2000). While the *Journal* did publish a special issue on integrating public health and pediatric psychology in 2004, few submissions were received which led to a relatively shorten issue (Brown, 2007). Historically research conducted by pediatric psychologists has some important scope and methodological differences from that of our public health colleagues. However, rank and file pediatric psychology’s respective and complimentary areas of expertise in individual, family, community, and population-level interventions are ripe for collaboration with public health. Such transdisciplinary “meeting of the minds” can produce fresh and creative ways to address longstanding problems (Tercyak, 2006) in the public health. In a very thoughtful article outlining challenges and recommendations to develop effective solutions and interventions at the population level, Fuemmeler (2004) described how frameworks and models familiar to pediatric psychologists, such as theories of behavior change and development, could be feasibly integrated into public health frameworks and research to strengthen the salience of the preventive and health promotion interventions. Further, collaboration with health services researchers can facilitate the analysis of the cost-offset and cost-effectiveness associated with our interventions. There will be numerous opportunities for pediatric psychologists who develop expertise and collaborations in this direction in the evolving healthcare system.
**Advocacy**

Psychologists, including pediatric psychologists, must be at the table when team-based reimbursement structures are defined in legal statute, Medicare and Medicaid rules, insurance company policies, and within local contractual relations that will be structured by each newly established ACO or PCMH (Rozensky, 2011). Are we ready for this? Gathering more effectiveness and cost-offset data will be necessary, but not sufficient. We must actively advocate for our services. We must become strong salespersons of our profession with confidence in the excellent data based products we provide. We should continue to build strong relationships with our medical colleagues, medical foundations, and patient advocacy groups so they clearly know what pediatric psychological services are and how they benefit our mutual patients. We should not shy away from involvement in local, state, and national organizations that advocate for psychology’s role in public policy regarding healthcare reform. Many pediatric psychologists may not have experience serving in this role but do have the requisite knowledge to communicate to policymakers the importance of services to children and their families. It may be beneficial for Division 5+ to work in concert with APA to build a cadre of advocates who can learn how we can more effectively advocate for our services and to coordinate our efforts with APA and other divisions within APA. As noted early, we cannot rely on our physician colleagues to advocate for us. While many may be well intentioned, they will not have the motivation nor passion to advocate as strongly for us as we will for ourselves especially when limited budgets may determine services. The cause of children’s healthcare can make pediatric psychologists strong advocates on Capitol Hill. And, the next time National Public Radio carries a story that says, “The American Academy of Pediatrics says . . . “, hopefully the psychologist who did that research will get the credit. Credit that might well translate into training funds for our students and reimbursement for the services pediatric psychologists provide to their patients.

**Board Certification**

Given the expectation for documented specialization for all licensed providers in the evolving healthcare system, we strongly recommend that pediatric psychologists seek board certification (ABPP) in Clinical Child and Adolescent Psychology since that certification currently exists. This will put pediatric psychologists on equal footing with other high level licensed providers in organized, ACOs.

We suggest that pediatric psychology consider going a step further. Pediatric psychology has a long history of developing specialized clinical services for children and their families based on a strong scientific literature. However, pediatric psychology is yet to be identified officially by APA as a recognized specialty (there are currently 12 such recognized specialties including Clinical Child Psychology and Clinical Health Psychology). It may well be time for Pediatric Psychology to consider seeking that recognition based on the criteria utilized by the Commission for the Recognition of Proficiencies and Specialties in Professional Psychology, and, if recognized, then begin the establishment of the examination process for those individuals seeking board certification as a specialist (as carried out, for example, by the American Board of Professional Psychology). Pediatric Psychologists would then be recognized as “board certified” specialists like their pediatric medicine specialty colleagues, and as expected in organized, accountable, healthcare settings.

**Affirm Psychology’s Identity and Build Internal Administrative Structures That Allow for Maximum Autonomy and Freedom**

First, pediatric psychologists must be proud to call themselves “psychologists.” While local settings might encourage the use of terms like “behavior specialist;” or calling oneself “a neuroscientist” might be perceived as somehow more prestigious, these terms only stand to undermine the future of pediatric psychology. A key interprofessional competency is helping our medical and nursing colleagues explain to a child and parent why the pediatric psychologist is being brought in on consultation and how that consultation will be helpful in assuring comprehensive care. Being called a pediatric psychologist is part of developing that competency.

Second, with the growth of the PATIENT Centered HealthCare/Medical Home and the introduction of ACOs as defined in the PATIENT Protection Act & Affordable Care Act, pediatric psychology clearly is practicing in a patient-centered system. We treat patients not clients. That is the language we must use to communicate with referral sources, our interprofessional colleagues, and policy makers who pay for patient care services (Rozensky, 2011). With respect to traditions in our field, we now must encourage our students to use the term patient, not client; a small, but important issue of identity as a healthcare provider in this new system (our pediatrician colleagues might be a bit confused if we refer to their recently referred seven year old patient with diabetes as a “client”).
Finally, while there are a number of administrative models in for the structure of local healthcare services, it is our impression that the field of Psychology will benefit most if psychologists maintain their administrative autonomy even while serving as key, team-oriented members of the evolving, interprofessional healthcare workforce. Psychologists should manage our own scope of practice, our own professional staff, our own budgets, and our own credentialing and privileges within any institutional practice setting (Rozensky, 2004). In other words, when possible, psychologists should manage their own departments or divisions, supervise and evaluate psychologists, psychologists advocate for psychologists, and if budget times are lean, psychologists can advocate for their own services without relying on others to argue for them (Rozensky, 2004). This will be critical because when resources are tight, the more psychology is in a position to manage its own resources, the less likely someone from another discipline will decide that our services are less needed than another.

Coordinate Efforts With APA

As we have hopefully demonstrated in this article, there are many things that pediatric psychology can do as it prepares to meet the challenges and opportunities of the future healthcare system. To facilitate this, Division should work closely with APA to coordinate efforts. The stress of the upcoming changes in healthcare will necessarily bring about some competing demands within our own field. Coordinating efforts with APA will assure that the various communities of interest and specialty groups across professional psychology work together for the common good of our patients, our students and our future as a science-based health profession. Most notably, conducting a pediatric psychology-oriented work force analysis could be completed in conjunction with APA to plan for our future as described earlier. Second, advocacy will be critical. However, many pediatric psychologists may not have experience advocating for our services with state and national policymakers or insurance organizations. It may be beneficial for Division 54 to work with APA to learn how we can more effectively advocate for our services and to coordinate our efforts for education funding, scientific funding, and patient care services. For example, as noted by Clay (2011), the APA Practice Organization has new initiatives that will guide psychologists through the process of getting involved as their states begin to redesign Medicaid programs. There are a variety of other issues that seem ripe for coordination with APA. For example, APA has established a Primary Care Training Care Task. How will Division 54 work with this task force or other similar work groups designed to sharpen the future of education and practice? If pediatric psychology continues to develop its own set of training guidelines and competencies, there is a natural interplay of these forces. As we noted earlier, either now or at some point in the near future, it may be the time to seek APA recognition of pediatric psychology as a specialty and develop a board certification process to claim pediatric psychology’s place along with other medical and psychological specialty groups. In addition, how can we better educate members of Division 54 on using Health and Behavior Codes more effectively to obtain reimbursement for services? How do we prepare our own advocates to work to change any state laws that do not allow reimbursement for pediatric psychologists using H&B codes? Finally, as noted earlier, professional psychology must have the same level of credentialing standards as all other disciplines on the healthcare team—this will be a major expectation if we want to be part of organized, accountable healthcare. Having all of our education and training programs accredited by APA will help define the basis of accountability and quality for our field. Division 54 has a vested interest in working with APA to advocate for this issue.

Conclusion

We have offered 10 broad sets of recommendations that Pediatric Psychology might consider addressing based on a brief review of the upcoming changes to the healthcare system. The Affordable Care Act, with its focus on accountability both financially and for quality outcomes of care, provides challenges for the entire field of healthcare. Pediatric psychology is positioned well to respond to those challenges as it considers how to react to the recommendations offered. We hope this article will spur discussion in this direction.

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