APPENDIX A

Premises of the Specialty Summit: Professional Psychology Interorganizational Collaborative Summit on Specialization

Premise 1: Market Drivers—Medicare and Medicaid policy contain assumptions that specialization, and credentialing or other means of specialization vetting, exist (or should exist) within professional psychology. Public payers in several states also have commented to state associations and/or licensing boards that they presume professional psychologists routinely receive specialty training. Further, both public and private payers provide for the identification of a specialty as part of the application materials for health care providers, typically requesting identification of board certification within one or more specialties. Applied Behavior Analysis (ABA), as a specialized service, has become a case-in-point. Within Medicaid, Cigna, and TriCare, ABA is considered specialized within psychology and, at times, outside of psychology; and, ABA is a formally identified "focus" within the APA-recognized specialty of Behavioral and Cognitive Psychology. However, despite the increase in the demand for specialty credentialing among government and private insurers, the markets are not aware of, let alone educated on, professional psychology's recognition of specialties or credentialing of specialists by a specialty certification board. As another case-in-point, in at least one state, there is confusion over who could bill Health and Behavioral (H&B) Codes. For example, are the competencies of generically licensed practicing psychologists sufficient, or can only those board certified in Clinical Health Psychology deliver H&B services? Others who seek out psychological experts outside health service settings, such as judges, police chiefs and CEOs, will undoubtedly continue to look for specialty credentialing (e.g., forensic psychology, police and public safety psychology, and business and consulting psychology, respectively) as they consider the qualifications of those providing them with expert services. The marketplace has come to expect that specialists deliver specialized services, and psychology will not be exempted indefinitely from such expectations (and already is not exempt in some cases). If professional psychology does not collectively organize itself regarding specialties, specialization, and specialty certification, then certainly the confusion and assumptions of the marketplace itself will lead to the market's own organizational structures into which psychology will be placed. Professional psychology, it is argued here, must organize itself on specialties and credentialing of specialists or market forces will fill the void.

Premise 2: Quality Services (aka, the "Triple Aim") and the Affordable Care Act—The Triple Aim refers to simultaneously improving the health of the population, enhancing the experience and outcomes for the individual patient, and lowering the cost of care through improved efficiencies in the delivery of care. The models of both the Accountable Care Organization (ACO) and the Patient Centered Medical Home (PCMH) envision primary care as the locus for coordinated care. Provider credentialing and maintenance of competence, two factors relevant to the quality metric, will very likely become financially incentivized as ACOs, PCMHs, and whatever the private insurer models evolve to be, are forced to coordinate care and document quality. The presumption in healthcare reform is clear where providers are concerned: quality

providers decrease costs through improved treatment, reduced need for repeat treatment, and prevention at the primary and secondary levels—and the medical model relies, in part, on board certification in specialties as evidence of that quality. Users of psychological services outside of healthcare settings (e.g., corporations, public safety agencies, courts, schools) can also be expected to seek out psychologists who have demonstrated specialized competence in order to optimize confidence and minimize liability.

Premise 3:   Integration into Healthcare as Health Service Providers—As a necessity of survival for practicing psychologists, the transition from siloed practices with isolated services to integration into the broader health care system is key. To integrate, it will be necessary to model the health service psychology profession after medicine, partly due to the leadership role of medicine/primary care envisioned in the ACA. The AMA, for example, in a 2015 issue of the *Journal of the American Medical Association*, addressed the need for medicine's self-regulation of specialization, noting in particular only the American Board of Medical Specialties (ABMS) as the organization of credentialing boards (http://jama.jamanetwork.com/article.aspx?articleid=2290649). Psychology's general professional practice (analogous to a medical primary care practice area) already specializes, as medicine will or has come to expect; however, the specialization process within psychology is neither yet fully integrated within the stages of a psychologist's professional developmental nor across organizations. This reality can be seen in the lack of standardized structure within specialty education and training across levels (e.g., internship, post-doctoral). As well, licensing boards have not yet collectively endorsed a board certification process or other means to vet specialists (compared to the acceptance of the American Board of Medical Specialties in medicine).

Premise 4:   Consumer Protection—Consumers in today's health care market are reasonably sophisticated about the meaning of board certification as evidence of competency in a specialized area. Consumers know that Family Physicians/Pediatricians are **specialists delivering primary care, while Oncologists and Cardiologists, are non-primary care specialists who treat cancer or heart disease, respectively. With respect to psychology, consumers will increasingly demand that primary care psychologists, and non-primary care psychologists, equally provide evidence of competencies within their respective specialties.** This premise is true in both healthcare and non-healthcare settings. For example, courts will increasingly need to rely on those psychologists that show they are accountable to specialty-based processes; and the public on the whole will increase its demands that public safety personnel have been vetted by those with the specialized competencies to most effectively identify candidates least likely to pose a risk to public safety. For psychologists, board certification will eventually become that evidence of specialization, along with Maintenance of Certification (MOC) programs to document ongoing specialized competencies. ABPP has already established a MOC protocol, with individual specialties within ABPP having begun the piloting of the MOC processes as of early 2015. Consumers and third-party payers express the expectation that licensing boards be able to regulate the practice of psychologists *even within a specialty area* despite licensing being at the generic level. Thus, licensing boards will face increased pressure to either vet claims of specialized

competencies, or endorse credentialing, such as board certification, as evidence of specialty competencies. While licensing boards will eventually need to adopt a Maintenance of Certification and Licensure (MOCAL) process for general psychology practice competencies, advance competencies within specialties extends beyond the MOCAL process.

Premise 5: Balance of Health Service Psychology, Non-Health Service Professional Psychology Specialties, and Scope of Practice Concerns—Within professional psychology, the Affordable Care Act has driven the acceleration of attention to and adoption of specialties, specialization and specialty board certification. However, specialties within professional psychology exist outside of what is now known as health service psychology. For example, School Psychology, Forensic Psychology, Police and Public Safety Psychology, and Industrial/Organizational Psychology each have additional areas of practice outside of traditional healthcare settings. Furthermore, professional psychologists will not all specialize beyond clinical, counseling and/or school psychology practices, which are often conducted in independent and/or general practice settings. There is a need to balance the drivers of specialization (regardless of health service or non-health service settings) against the larger general issues of scope of practice for professional psychologists. The need for the Summit includes, as a goal, how to balance these potentially different forces, to integrate non-health-related specialties into the solutions to any problems or issues identified, and to balance the drivers from healthcare reform with other non-healthcare market and consumer concerns while finding ways to address scope-of-practice issues.

Proposed Goals and Objectives of the Interorganizational Summit on Specialty

1. Review of Key Concepts and Roles

    a. **Concepts**—Specialty, Specialization, Specialists, Board Certification, Regulatory Requirements for Continuing Education/Maintenance of Competency and Licensure, and Subspecialties Within Specialties

    b. **Roles of Primarily Specialty Organizations**—Council of Specialties in Professional Psychology, American Board of Professional Psychology, Commission for the Recognition of Specialties and Proficiencies in Professional Psychology

    c. **Roles of Organizations with Key Interests in Specialties**—APA Education Directorate, APAPO, APAGS, CAPP, ASPPB, APPIC, CoA, APA Board of Directors,

2. Identification of the Current State of Organizational Policies, Positions, and Procedures Regarding Specialties, Specialization, Specialists, and Board Certification in Professional Psychology

    a. Specific Identification of Implications of Specialty for i) Maintenance of Competency and Licensure (MOCAL) and ii) Maintenance of Certification (MOC)

3. Identification of Inconsistencies in Policies, Positions, and Procedures Among Organizations Either Directly or Indirectly Involved in Specialties, Specialization, Specialists, and Board Certification

    a. Delineation of Inconsistencies That Promote Unique or Complementary Agenda Across Organizations

    b. Delineation of Inconsistencies That Cause Inefficiencies to Shared Organizational Goals

    c. Articulation of Inconsistencies as Problem Statements to Facilitate Identification of Resolutions or Solutions

4. Identification of Proposed Resolutions or Solutions to Inconsistencies

5. Key Scope of Practice Concerns and Possible Solutions

    a. Health Care System's, Payer Systems' and Regulators' Views of General Practice Psychology as Specialty Care vs. Psychology's View of General vs. Specialty Professional Psychological Practice

b. Resolution of Health Service Professional Psychology as a Primary Care Practice Area vs. a Specialty Care Practice Area within Healthcare and Payer Systems

c. Intended and Unintended Consequences of Specialties in Professional Psychology on General Practice and Licensure

6. <u>Discussion of Need for Ongoing Interorganizational Collaboration</u>

7. <u>Consideration of Financial Support if Ongoing Collaboration is Endorsed</u>

Proposed Outcomes of the Interorganizational Summit on Specialty

Issues and Problem Identification

The Summit will identify current and anticipated issues/problems associated with specialties, specialization, and specialty credentialing in professional psychology. The Summit will also explore how inconsistencies in organizational policies, positions and procedures may promote benefits to professional psychology, as well as how some inconsistencies may create inefficiencies in the shared goals of the organizations. In particular, the context of these issues will include: 1) non-health service issues related to protection of the public and internal professional self-monitoring regarding i) public safety, ii) adjudicatory bodies, and iii) corporations and organizations; 2) health service issues related to i) healthcare reform, ii) integrated medicine, iii) accountable care organizations, iv) medical homes, and v) health service psychology.

It is envisioned that issues will likely include: 1) scope of practice, 2) education and training in specialties, 3) public representation of a) specializations by psychologists and b) programs purporting to educate and train within specialties, and 4) demonstration/maintenance of specialty competencies.

Problems will be defined as those issues that create inefficiencies and impediments to the ongoing promotion of the value of specialties, specialization, and specialty board certification, and may include 1) inconsistencies in the definitions of specialty, specialization, and specialty credentialing across organizations, 2) gaps in the processes of specialty recognition across organizations, 3) gaps between medicine's specialty processes and those of psychology, 4) inconsistent messaging to consumer audiences about specialty issues among organizations, 5) inconsistencies in messaging to students and trainees regarding specialization and credentialing, 6) gaps between professional organizations' specialty policies and standards and those found across regulatory jurisdictions, 7) health service psychology as a primary care practice area vs. the healthcare system's categorization as a specialty practice, and 8) the lack of a unified voice on key issues within specialty across key organizations.

Policy

It is hoped that the Summit will identify key policy considerations that can solve or lead to the resolution of some or all of the problems that the Summit identifies. Targeted policies may be within organizations, across the profession of psychology, or within other organizational systems (e.g., healthcare systems, healthcare payer systems, organizational consumers of professional psychological services [e.g., courts, police departments, corporations, educational systems]). Those policy considerations may take the form of conceptual refinement steps or recommendations for policy action. These considerations will likely generate

additional work for the Summit organizations individually and, in the future, collectively in a Summit 2.0.

Dissemination

It is anticipated that the Summit will disseminate its work in several forms:

1. Journal articles in key journals such as *Professional Psychology: Research and Practice*, *Training and Education in Professional Practice*, specialty-specific journals, or the AP addressing issues relevant to the mission of each journal
2. Professional press articles such as the *Monitor* to detail the news of the Summit being held and its outcomes
3. Presentations at national and state organizations such as American Psychological Association of Graduate Students; the Graduate Student magazine; American Psychological Association (APA); APA Division annual meetings; APA's Committee on Early Career Psychologists, specialty organizations; State, Territorial, and Provincial Associations (STPAs), State Licensing Boards (directly from CoSPP); and other organizations (e.g., Association for Behavioral and Cognitive Therapies, Association for Behavior Analysis International, American Counseling Association, National Association of Social Workers, American Medical Association, Association of State and Provincial Psychology Boards, International Association of Chiefs of Police, Association of Family and Conciliatory Courts, American Bar Association)
4. A proceedings document, published either within a scholarly journal or freestanding by a national publisher (e.g., APA, Guilford, Wiley).
5. Press releases to key non-psychological organizational outlets (e.g., the American Bar Association, International Association of Chiefs of Police), news media, and social media outlets.
6. A key talking points document that will change over time based on outcomes of ongoing work stemming from the Summit.

Next Steps

The Summit will develop a "next steps" plan, targeting work not completed within the Summit itself. The plan will address 1) the issues/problems yet to be addressed and/or resolved, 2) the structure of completing necessary work (e.g., formation of an organization within or external to one or more of the Summit participants), and 3) proposals on how these next steps will be accomplished.

APPENDIX B

Principle Factors Identified as an Outcome of the Interorganizational Summit on Specialty, Specialization, and Board Certification

Principle Factors:

Motivators:

1. Improve the well-being of the pubic and articulate how specialty and board certification fits within population health management
2. Protect the public from risks to their well-being
3. Empower the profession's relevance and vitality
4. Create a workforce to promote better outcomes to our consumers and the public and board certification improves the likelihood of that outcome
5. Value proposition of psychology as evidence based
6. Board certification is consistent with the goal of life-long learning
7. Creation and maintenance of specialties advances the relevance and vitality of the field

Root Causes:

1. Historical precedence
2. Inertia and system resistance to modification and change
3. Unintentional lack of communication leading to purposeful barriers to communication
4. Fear of ….(criticism, loss of identity, loss of rights/license, prescriptiveness means losing independence)
5. Problem with team playing vs. losing identity if we are on the team

Aspirational Solutions:

1. Consensus around the parameters with flexibility
2. Endorse having board certification as a natural step in health service psychology
3. Coordinated messaging and shared ideas with an adoption of a common specialty/specialization/certification language, including the adoption of the Taxonomy across all organizations for which it is relevant
4. Enhancing how board certification contributes to the value of the profession on the whole
5. Undergrad curriculum for pre-psych and modification within licensing board's requirements if it changes the graduate program breadth and length, and integrate information on licensing and board certification into the curriculum
6. Create a unified set of competencies that is adopted across organizations
7. Data on value of the ABPP re: Patient Experience and Outcomes

8. Articulate how board certification creates the basis of holding one's self out as a specialist to the public
9. Creation of a clearly articulated "retrofit" method for Board Certification that is made available to in-service psychologists.
10. Better define the sequence of training, and the necessity of a generalist foundation before the introduction of specialty training.
11. Consider tying Board Certification exams to EPPP-2, should it be adopted, by considering the proposed EPPP-2 as measuring the Foundational Competencies, and potentially relying on it to inform the ABPP examination of those Foundational Competencies in the Board Certification exam; while ABPP continue to exam the Functional Competencies within the Board Certification exam.
12. Taking the EPPP to be taken prior to completion of the coursework for the PsyD/PhD/EdD, and mapping this easing of demands to matriculation toward Board Certification.
13. Consistency across organizations in the definition and recognition of specialties and specialists.
14. All specialties shall be members of CoS.
15. TEPP or another journal becomes the mouthpiece journal for specialty-related issues, and fosters dissemination of items like the Taxonomy documents from each specialty.
16. Streamlining the process among the organizations from the application to the specialty board certification with each organization performing each relevant step rather than several doing the same things.
17. Organizations involved in training and education adopt a unified language for specialties and the taxonomy
18. Education and Training programs will inform their students about specialty and the method of obtaining board certification.

Seven Motivators for Interorganizational Collaboration from Chicago Summit Meeting

Motivators for Participating Organizations to Collaborate on Resolution of Difference in Specialty Definitions:

The need/willingness/desire to:

1. Improve the health or welfare of the public through the articulation of the role of specialties and Board Certification in population health management or organizational functioning.
2. Protect the public from risks of harm from incompetent practice.
3. Agree that the creation and maintenance of specialties advance the relevance and vitality of professional psychology.
4. Empower professional psychology to maintain relevancy and to promote growth through specialization and Board Certification.
5. Create a professional psychological workforce that
   a. Improves outcomes for consumers
   b. Improves outcomes for the general population
   c. Provides evidence that the establishment of specialties, specialization, and Board Certification improves the likelihood of 5.a and 5.b.
6. Articulate an agreed-upon value proposition that specialty, specialization, and Board Certification are evidence-based.
7. Create a policy that specialization and Board Certification are integral steps in accomplishing psychologists' goal of life-long learning.

Discussion:

Do these motivators create sufficient rationale for the organizations to seek consensus on definitions of, policies about, and processes affecting specialty, specialization, and Board Certification?

Task:

1. Identify motivators that support the efforts of organizations to reach consensus on issues where disagreement exists on specialties, specialization, and Board Certification.
2. Craft a consensus statement, to be endorsed by each organization, that articulates agreement for ongoing collaboration regarding unified or complementary positions regarding specialty, specialization, and Board Certification.

Causes for Lack of Coordination among Organizations on Specialty, Specialization, and Board Certification

Delineation of Agreed Upon Causes:

1. **Historical Precedents**: As professional psychology evolved, various specialty-related organizations (e.g., CRSPPP, ASPPB, COA, ABPP) have informally or formally created and used specialty-related concepts, processes, and definitions that reflect their respective understanding of the idea of specialty. Often, the understanding reflects the specific professional psychology organization's mission and is not shared throughout professional psychology, creating confusion and inconsistent practice within professional psychology. For example, while the CoS recognizes sleep psychology as an area of specialization the ABPP does not; CRSPP uses the term "proficiencies" where others do not; and ABPP recognizes "subspecialties" and others do not. Indeed, over the past two decades, APA's COA recognizes three professional psychology doctoral training program specialties (clinical, counseling and school psychology), though it has used other terms to describe specialty programs. As specialty-related professional psychology organizations progressed in their understanding of specialty, they developed their own definitions, systems of specialty education and training, and mechanisms for specialty competency recognition. Additionally, while other professions, most notably medicine, have external forces that create a need for profession-wide internal consistency regarding specialty, specialization and specialty board certification, as yet psychology has no such analogous external forces. For example, in most states, hospitals require physicians to be specialty board certified to obtain privileges as do third party payers. It is in the interest of professional psychology to adopt shared, common and unified understandings and practices of specialty, specialization and specialty board certification. Each professional psychology organization will need to participate in a reevaluation of their current practice and to manifest a willingness to adopt cross-organizational understanding of these terms and the sequence by which individuals progress through education, training, licensure, specialization, and, ultimately, specialty board certification. A shared, well-planned, organized and meaningful model that articulates the progression from entry into psychology education through specialty board certification is valuable to psychology students, licensed psychologists, professional psychology, and to the public, which expects psychologists to practice competently within their specialty.

2. **Organizational Inertia**: Organizational inertia refers to the tendency for organizations to create policies, definitions, and processes in response to current needs, then to maintain those things in spite of changing exigencies. As specialties, specialization, and specialty credentialing evolved, existing organizations adapted relatively independently when necessary and new organizations emerged. For example, CRSPPP created a mechanism to recognize credentialing organizations for the purpose of listing credentials in

the APA membership directory, but those actions ended up being somewhat inconsistent with the CoS position that a single credentialing organization (ABPP), that certifies specialists, is in the best interest of the profession of psychology. The result has been confusion over the role of CRSPPP's recognition vis a vis CoS's position. To further complicate matters, the list of CRSPP and CoS specialties differs from those recognized by ABPP. Unfortunately, the tendency to modify any one organization's positions in these regards faces systemic resistance as does any modification to systemic structures, members and roles.

3. **Communication Barrier**s: As professional psychology organizations conducted their specialty and board certification endeavors, many of them operated with an unintentional lack of communication with their companion professional psychology organizations, who themselves were conducting similar business. Sometimes this lack of communication was the result of not knowing about other organizations' efforts, other times it was an insufficient understanding of the need to communicate with them. Sometimes, this resulted in a sense of organizational independence and a belief that there was no need to communicate across organizations. Often, the arguments are heard as "We do this and they do that. Why do we need to communicate about this to them?" Forces internal and external to professional psychology have impacted psychology specialization, specialties, and board certification bringing its lack of communication and coordination to the forefront and drawing attention to its fractured understanding of these topics to the outside world. Indeed, this lack of communication has fostered confusion regarding the types of specialties, specialization processes, and identification of specialists, not only in the public eye, but in the perceptions of licensed psychologists. Of great concern, doctoral students may be left uncertain regarding the most appropriate specialty trajectories, if any, across their graduate, internship, post-doctoral, and post-licensure experiences without sufficient guidance from the organizations in which they, their mentors, and their training programs are part.

4. **Fears of Formalization**: For any organization, adoption of formalized policies and definitions can lead to uncertainty and fears. For example, one organization may not have formalized policy stating that specialties are required, leading that organization to express concerns about other organizations adopting a definition of specialty, recognizing various specialties, or stating the need for board certification to practice in a particular specialty. . Other concerns include fears that policies which formally recognize specialties may lead to the loss of a generalist model of professional psychology, fear of adverse licensure actions for someone who is practices a specialty lacks board certification, and the fear that adopting specific requirements for specialty practice undermines the independence of general professional psychology. These concerns can lead to a reduction in collaboration and resolution of differences in the varied organizations, and can undermine opportunities to improve professional psychology's unity, shared understandings, and stature as a healthcare profession.

5. **Organizational Turf Concerns**: While different organizations have different language, criteria, and guidelines regarding specialization, specialties, and specialty board certification, some organizations have expressed concerns that collaborating with other organizations may risk their autonomy, identity, and, control over their mission. For example, APA (and CRSPPP specifically) now has guidelines on the terms to use for specialty coverage at each of four (4) stages of education and training. However, adoption of these guidelines by COA, APPIC, or CCTC has been slow or non-existent, in part because of each of their concerns regarding how such adoption may affect their ability to carry out the prescribed goals of their organization. Whereas identifying more specialties may be appropriate for CRSPPP, for example, it may not be feasible within the ABPP's organizational structure to recognize every CRSPPP recognized specialty.

Discussion:

Are these causes well defined? Do they represent reality? Will the articulation of these causes foster engagement by the constituent organizations or will they create unnecessary, unwanted and avoidable defensiveness by one or more constituent groups? Finally, will each organization accept these causes and use them for motivation to change the status quo?

Tasks:

1. Adoption of a statement of causes (or modified causes)

2. Creation of a common statement of purpose to drive the future work of accomplishing proposed goals.

Proposed Work for the Organizations at the Interorganizational Summit on Specialty, Specialization, and Board Certification

Delineation of Agreed Upon Proposed Goals from Chicago Summit:

<u>Education and Training Goals</u>

1. Curriculum: Creation of a model curriculum including pre-psychology ("pre-psych") undergraduate education, akin to "pre-med," "pre-law," with educational recommendations that continue through the completion and culminates in the doctoral degree in professional psychology, designed specifically for practice in health service or general applied psychology. Such a curriculum will address core foundational and functional competencies in psychology while also allowing for specialty graduate offerings reflecting graduate competencies in specialties that are advanced in different programs. Such a curriculum would be defined using models such as Teaching, Learning, and Assessing an a Developmentally Coherent Curriculum (APA, 2008), which uses concepts such as knowledge, skills and attitudes to structure the content to be covered in coursework and training within a developmental model (basic, developing, and advanced).
    a. Modification of the APA and ASPPB Model Licensing Act regarding expected (required?) graduate training content, taking into account the acquisition of knowledge and competency coverage during undergraduate "pre-psych" curriculum.
    b. Assurance that information about licensing and board certification requirements are included in the undergraduate "pre-psych" curriculum.
2. Sequence of Training: Define generalist psychology education and training standards that articulate both health service and general applied psychology.
    a. Articulate education and training guidelines for specialty education and training , including acknowledgement that development of specialty competencies occurs only after completion of an accredited broad and general education and training program. This articulation should include incorporation of the APA CRSPPP Specilaty Education and Training Taxonomy model that defines specialty content coverage at various levels across the stages of advanced education and training.
3. Integration of Specialty into Curriculum: Create standards for doctoral programs, internships and post-doctoral residencies that address coverage of psychological specialties, specialization education and training, obtaining board certification, including when and how to begin specialization.

4. Competencies: Adoption of uniform foundational and functional competencies for each specialty across levels of training that are yoked to the credentialing of specialists. Foundational competencies would include those broad and general competencies expected of all professional psychologists (e.g., universal and cross-cutting competencies), while functional competencies would include those specific competencies expected of specialists in any given specialty (e.g., specialty specific).

Goals regarding Parameters of Specialty, Specialization, and Board Certification

1. Flexibility: Ensure that definitions and licensure policies on specialty, specialization, and board certification include sufficient flexibility such that specialization in one specialty does not preclude competency-based practice in other specialties. Also ensure that there are flexible paths to specialization within each specialty based on whether the individual decides to specialize as a graduate student, intern, fellow, or post-licensed psychologist.
2. Messaging: Develop coordinated content across organizations that is consistent about the language and concepts of specialty, specialization, and board certification:
    a. Adopt the language of APA CRSPPP Education and training Guidelines: *A Taxonomy for Education and Training in Professional Psychology Health Service Specialties* (Taxonomy)
    b. Adopt a consistent specialty list across regulatory and professional associations to promote consistency in public understanding.
    c. Publish scholarly articles authored by members of diverse organizations on outcomes of the Summits and other issues regarding specialty in both flagship journals and other media outlets to communicate consistent and coherhentcoherent inter-organizational positions.
3. Specialty Definition: Adopt uniform definitions of specialty, specialization, and specialist across all organizations, including:
    a. Consistent recognition of individual specialties across organizations (e.g., across CRSPPP; CoS; ABPPP).
    b. A single organization with which specialty boards affiliate for the purpose of examining and board certifying psychologists.
    c. Acceptable uses of modifiers to "psychologist" that may imply specialization (e.g., Dr. so&so Ph.D., ABPP).
4. Organizational Roles: Commit to roles of each organization regarding specialty, specialization, and board certification:
    a. Delineate unique functions and shared functions across organizations.
    b. Define criteria for specialty organizational membership on, or affiliation with, broad specialty organizations (e.g., COS, ABPP),

which defines only one pathway rather than multiple options for membership, relying on collaboration with other relevant organizations (e.g., CRSPPP, COA).

5. Redundancy Across Organizations: Reduce redundancies and inconsistencies regarding specialty recognition:
    a. Create agreement on a single application model (for example, application for recognition of a specialty such as the CRSPPP application versus ABPP Affiliation application or one single, shared, universal application) to minimize redundancy and duplication of effort.
    b. Determine ways that foundational competencies are measured through EPPP exams and elimination of re-examination of same competencies at board certification examination. The EPPP2 format that includes testing of competencies is a step in the correct direction.
    c. Develop a universal credentials bank or mechanisms for data sharing to streamline reviews among relevant organizations.

Goals for Professional Issues and Board Certification

1. Value of Board Certification: Collaborate on research or evaluations regarding the association between Board Certification, patient/client experience and treatment/service outcomes.
2. Board Certification and Risk Management: Study and publish comparisons of adverse licensing or ethics actions between board certified specialists and those without board certification.
3. Professional Psychology: Create policies and definitions that encompass both health service and general applied psychology as foundations upon which further specialization and/or board certification are based.
4. Scope of Practice: Delineate a model of psychology practice that embodies the need for generalist practitioners and specialists.
5. Self-Assessment: Adopt models for professional psychologists to self-assess their competencies (e.g., ABPP MOC, MOCAL, the Ontario Self-Assessment Model) across levels of training.
6. Flexibility: Create flexible alternate routes to specialization in addition to formal postdoctoral training for psychologists who have not previously completed training in that specialty area.
7. Payment and Contracting: Work with CMS and other payers to recognize areas of specialty practice with appropriately higher levels of payment and contracting preferences for specialists in those areas. Support pay increases for professionals who achieve specialty status while employed in some healthcare settings as is done in some VA medical centers.

Discussion: Are these overarching categories adequate to describe the general areas under which organizations can collaborate to find solutions that are agreeable to them? Does the list of proposed actions, positions and policies represent sufficiently the work all organizations can agree upon?

Tasks:

1. Reach agreement on a list of proposed goals to take back to our organizations.
2. Create components for a statement of support for the proposed goals to encourage each organization to adopt the proposed goals.
3. Identify which organizations would have interests in each proposed goal.
4. Create a work plan to obtain sign-off on interorganizational agreement to the proposed goals.

APPENDIX C

Revised Seven Motivators for Interorganizational Collaboration from Chicago Summit Meeting

Motivators for Participating Organizations to Collaborate on Resolution of Difference in Specialty Definitions:

   The need/willingness/desire to:

   1. Improve the health or welfare of the public through the articulation of the role of specialties and Board Certification in population health management or organizational functioning.
   2. Protect the public from risks of harm from incompetent practice.
   3. Agree that the creation and maintenance of specialties advance the relevance and vitality of professional psychology.
   4. Empower professional psychology to maintain relevancy and to promote growth through specialization and Board Certification.
   5. Create a professional psychological workforce that
        a. Improves outcomes for consumers
        b. Improves outcomes for the general population
        c. Provides evidence that the establishment of specialties, specialization, and Board Certification improves the likelihood of 5.a and 5.b.
   6. Articulate an agreed-upon value proposition that specialty, specialization, and Board Certification are evidence-based.
   7. Create a policy that specialization and Board Certification are integral steps in accomplishing psychologists' goal of life-long learning.

Discussion:

Do these motivators create sufficient rationale for the organizations to seek consensus on definitions of, policies about, and processes affecting specialty, specialization, and Board Certification?

Task:

   1. Identify motivators that support the efforts of organizations to reach consensus on issues where disagreement exists on specialties, specialization, and Board Certification.
   2. Craft a consensus statement, to be endorsed by each organization, that articulates agreement for ongoing collaboration regarding unified or complementary positions regarding specialty, specialization, and Board Certification.

Revised Causes for Lack of Coordination among Organizations on Specialty, Specialization, and Board Certification

Delineation of Agreed Upon Causes:

1. **Historical Precedents**: As professional psychology evolved, various specialty-related organizations (e.g., CRSPPP, ASPPB, COA, ABPP) have informally or formally created and used specialty-related concepts, processes, and definitions that reflect their respective understanding of the idea of specialty. Often, the understanding reflects the specific professional psychology organization's mission and is not shared throughout professional psychology, creating confusion and inconsistent practice within professional psychology. For example, while the CoS recognizes sleep psychology as an area of specialization the ABPP does not; CRSPP uses the term "proficiencies" where others do not; and ABPP recognizes "subspecialties" and others do not. Indeed, over the past two decades, APA's COA recognizes three professional psychology doctoral training program specialties (clinical, counseling and school psychology), though it has used other terms to describe specialty programs. As specialty-related professional psychology organizations progressed in their understanding of specialty, they developed their own definitions, systems of specialty education and training, and mechanisms for specialty competency recognition. Additionally, while other professions, most notably medicine, have external forces that create a need for profession-wide internal consistency regarding specialty, specialization and specialty board certification, as yet psychology has no such analogous external forces. For example, in most states, hospitals require physicians to be specialty board certified to obtain privileges as do third party payers. It is in the interest of professional psychology to adopt shared, common and unified understandings and practices of specialty, specialization and specialty board certification. Each professional psychology organization will need to participate in a reevaluation of their current practice and to manifest a willingness to adopt cross-organizational understanding of these terms and the sequence by which individuals progress through education, training, licensure, specialization, and, ultimately, specialty board certification. A shared, well-planned, organized and meaningful model that articulates the progression from entry into psychology education through specialty board certification is valuable to psychology students, licensed psychologists, professional psychology, and to the public, which expects psychologists to practice competently within their specialty.

2. **Organizational Inertia**: Organizational inertia refers to the tendency for organizations to create policies, definitions, and processes in response to current needs, then to maintain those things in spite of changing exigencies. As specialties, specialization, and specialty credentialing evolved, existing organizations adapted relatively independently when

necessary and new organizations emerged. For example, CRSPPP created a mechanism to recognize credentialing organizations for the purpose of listing credentials in the APA membership directory, but those actions ended up being somewhat inconsistent with the CoS position that a single credentialing organization (ABPP), that certifies specialists, is in the best interest of the profession of psychology. The result has been confusion over the role of CRSPPP's recognition vis a vis CoS's position. To further complicate matters, the list of CRSPP and CoS specialties differs from those recognized by ABPP. Unfortunately, the tendency to modify any one organization's positions in these regards faces systemic resistance as does any modification to systemic structures, members and roles.

3. **Communication Barrier**s: As professional psychology organizations conducted their specialty and board certification endeavors, many of them operated with an unintentional lack of communication with their companion professional psychology organizations, who themselves were conducting similar business. Sometimes this lack of communication was the result of not knowing about other organizations' efforts, other times it was an insufficient understanding of the need to communicate with them. Sometimes, this resulted in a sense of organizational independence and a belief that there was no need to communicate across organizations. Often, the arguments are heard as "We do this and they do that. Why do we need to communicate about this to them?" Forces internal and external to professional psychology have impacted psychology specialization, specialties, and board certification bringing its lack of communication and coordination to the forefront and drawing attention to its fractured understanding of these topics to the outside world. Indeed, this lack of communication has fostered confusion regarding the types of specialties, specialization processes, and identification of specialists, not only in the public eye, but in the perceptions of licensed psychologists. Of great concern, doctoral students may be left uncertain regarding the most appropriate specialty trajectories, if any, across their graduate, internship, post-doctoral, and post-licensure experiences without sufficient guidance from the organizations in which they, their mentors, and their training programs are part.

4. **Fears of Formalization**: For any organization, adoption of formalized policies and definitions can lead to uncertainty and fears. For example, one organization may not have formalized policy stating that specialties are required, leading that organization to express concerns about other organizations adopting a definition of specialty, recognizing various specialties, or stating the need for board certification to practice in a particular specialty. . Other concerns include fears that policies which formally recognize specialties may lead to the loss of a generalist model of professional psychology, fear of adverse licensure actions for someone who is practices a specialty lacks board certification, and the fear that adopting specific requirements for specialty practice undermines the independence of general professional psychology. These concerns can

lead to a reduction in collaboration and resolution of differences in the varied organizations, and can undermine opportunities to improve professional psychology's unity, shared understandings, and stature as a healthcare profession.

5. **Organizational Turf Concerns**: While different organizations have different language, criteria, and guidelines regarding specialization, specialties, and specialty board certification, some organizations have expressed concerns that collaborating with other organizations may risk their autonomy, identity, and, control over their mission. For example, APA (and CRSPPP specifically) now has guidelines on the terms to use for specialty coverage at each of four (4) stages of education and training. However, adoption of these guidelines by COA, APPIC, or CCTC has been slow or non-existent, in part because of each of their concerns regarding how such adoption may affect their ability to carry out the prescribed goals of their organization. Whereas identifying more specialties may be appropriate for CRSPPP, for example, it may not be feasible within the ABPP's organizational structure to recognize every CRSPPP recognized specialty.

Discussion:

Are these causes well defined? Do they represent reality? Will the articulation of these causes foster engagement by the constituent organizations or will they create unnecessary, unwanted and avoidable defensiveness by one or more constituent groups? Finally, will each organization accept these causes and use them for motivation to change the status quo?

Tasks:

1. Adoption of a statement of causes (or modified causes)

2. Creation of a common statement of purpose to drive the future work of accomplishing proposed goals.

Revised Proposed Work for the Organizations at the Interorganizational Summit on Specialty, Specialization, and Board Certification

Delineation of Agreed Upon Proposed Goals from Chicago Summit:

<u>Education and Training Goals</u>

1. Curriculum: Creation of a model curriculum including pre-psychology ("pre-psych") undergraduate education, akin to "pre-med," "pre-law," with educational recommendations that continue through the completion and culminates in the doctoral degree in professional psychology, designed specifically for practice in health service or general applied psychology. Such a curriculum will address core foundational and functional competencies in psychology while also allowing for specialty graduate offerings reflecting graduate competencies in specialties that are advanced in different programs. Such a curriculum would be defined using models such as Teaching, Learning, and Assessing an a Developmentally Coherent Curriculum (APA, 2008), which uses concepts such as knowledge, skills and attitudes to structure the content to be covered in coursework and training within a developmental model (basic, developing, and advanced).
2. Modification of the APA and ASPPB Model Licensing Act regarding expected (required?) graduate training content, taking into account the acquisition of knowledge and competency coverage during undergraduate "pre-psych" curriculum.
3. Assurance that information about licensing and board certification requirements are included in the undergraduate "pre-psych" curriculum.
4. Sequence of Training: Define generalist psychology education and training standards that articulate both health service and general applied psychology.
5. Articulate education and training guidelines for specialty education and training , including acknowledgement that development of specialty competencies occurs only after completion of an accredited broad and general education and training program. This articulation should include incorporation of the APA CRSPPP Specialty Education and Training Taxonomy model that defines specialty content coverage at various levels across the stages of advanced education and training.
6. Integration of Specialty into Curriculum: Create standards for doctoral programs, internships and post-doctoral residencies that address coverage of psychological specialties, specialization education and training, obtaining board certification, including when and how to begin specialization.
7. Competencies: Adoption of uniform foundational and functional competencies for each specialty across levels of training that are yoked to the credentialing of specialists. Foundational competencies would include those broad and general competencies expected of all professional psychologists (e.g., universal and cross-cutting competencies), while functional

competencies would include those specific competencies expected of specialists in any given specialty (e.g., specialty specific).

Goals regarding Parameters of Specialty, Specialization, and Board Certification

1. Flexibility: Ensure that definitions and licensure policies on specialty, specialization, and board certification include sufficient flexibility such that specialization in one specialty does not preclude competency-based practice in other specialties. Also ensure that there are flexible paths to specialization within each specialty based on whether the individual decides to specialize as a graduate student, intern, fellow, or post-licensed psychologist.
2. Messaging: Develop coordinated content across organizations that is consistent about the language and concepts of specialty, specialization, and board certification:
    a. Adopt the language of APA CRSPPP Education and training Guidelines: *A Taxonomy for Education and Training in Professional Psychology Health Service Specialties* (Taxonomy)
    b. Adopt a consistent specialty list across regulatory and professional associations to promote consistency in public understanding.
    c. Publish scholarly articles authored by members of diverse organizations on outcomes of the Summits and other issues regarding specialty in both flagship journals and other media outlets to communicate consistent and coherent inter-organizational positions.
3. Specialty Definition: Adopt uniform definitions of specialty, specialization, and specialist across all organizations, including:
    a. Consistent recognition of individual specialties across organizations (e.g., across CRSPPP; CoS; ABPPP).
    b. A single organization with which specialty boards affiliate for the purpose of examining and board certifying psychologists.
    c. Acceptable uses of modifiers to "psychologist" that may imply specialization (e.g., Dr. XXXX, PhD, ABPP).
4. Organizational Roles: Commit to roles of each organization regarding specialty, specialization, and board certification:
    a. Delineate unique functions and shared functions across organizations.
    b. Define criteria for specialty organizational membership on, or affiliation with, broad specialty organizations (e.g., COS, ABPP), which defines only one pathway rather than multiple options for membership, relying on collaboration with other relevant organizations (e.g., CRSPPP, COA).
5. Redundancy Across Organizations: Reduce redundancies and inconsistencies regarding specialty recognition:
    a. Create agreement on a single application model (for example, application for recognition of a specialty such as the CRSPPP application versus ABPP Affiliation application or one single, shared,

universal application) to minimize redundancy and duplication of effort.

    b. Determine ways that foundational competencies are measured through EPPP exams and elimination of re-examination of same competencies at board certification examination. The EPPP2 format that includes testing of competencies is a step in the correct direction.

    c. Develop a universal credentials bank or mechanisms for data sharing to streamline reviews among relevant organizations.

<u>Goals for Professional Issues and Board Certification</u>

1. Value of Board Certification: Collaborate on research or evaluations regarding the association between Board Certification, patient/client experience and treatment/service outcomes.
2. Board Certification and Risk Management: Study and publish comparisons of adverse licensing or ethics actions between board certified specialists and those without board certification.
3. Professional Psychology: Create policies and definitions that encompass both health service and general applied psychology as foundations upon which further specialization and/or board certification are based.
4. Scope of Practice: Delineate a model of psychology practice that embodies the need for generalist practitioners and specialists.
5. Self-Assessment: Adopt models for professional psychologists to self-assess their competencies (e.g., ABPP MOC, MOCAL, the Ontario Self-Assessment Model) across levels of training.
6. Flexibility: Create flexible alternate routes to specialization in addition to formal postdoctoral training for psychologists who have not previously completed training in that specialty area.
7. Payment and Contracting: Work with CMS and other payers to recognize areas of specialty practice with appropriately higher levels of payment and contracting preferences for specialists in those areas. Support pay increases for professionals who achieve specialty status while employed in some healthcare settings as is done in some VA medical centers.

Discussion: Are these overarching categories adequate to describe the general areas under which organizations can collaborate to find solutions that are agreeable to them? Does the list of proposed actions, positions and policies represent sufficiently the work all organizations can agree upon?

Tasks:

1. Reach agreement on a list of proposed goals to take back to our organizations.
2. Create components for a statement of support for the proposed goals to encourage each organization to adopt the proposed goals.
3. Identify which organizations would have interests in each proposed goal.

5. Create a work plan to obtain sign-off on interorganizational agreement to the proposed goals.