

APA GUIDELINES for Education and Training Competencies for Doctoral- Level Psychology Practice in Primary Care Settings

**TASK FORCE ON EDUCATION AND TRAINING COMPETENCIES
FOR PSYCHOLOGY PRACTICE IN PRIMARY CARE**

**APPROVED BY APA COUNCIL OF REPRESENTATIVES
AUGUST 2026**



**AMERICAN
PSYCHOLOGICAL
ASSOCIATION**



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Executive Summary

The purpose of the *APA Guidelines for Education and Training Competencies for Doctoral-Level Psychology Practice in Primary Care Settings* is to delineate recommended competencies to help educators and training programs prepare graduate students, interns, and post-doctoral fellows to provide psychological services in primary care. This document is an update to the *Competencies for Psychology Practice in Primary Care* (APA, 2015) developed to address the evolving landscape of practice in primary care settings. In addition to informing policy makers, health professionals, and the public about the recommended competencies for psychologists working in primary care, the goal was to produce competencies that could be used in graduate psychology education and training programs. The *Competencies for Psychology Practice in Primary Care* (APA, 2015) were approved by the APA Council of Representatives in 2015, and they have been used by training directors to inform curriculum and training program development and to assess trainees. This document is meant to complement other APA education and training guidelines. Consistent with the provisions of the APA policy on *Developing and Evaluating Standards and Guidelines Related to Education and Training in Psychology* (Section I C [1]; APA, 2004), enacted by the APA Council of Representatives, these guidelines are intended to be aspirational.

This document describes 20 competencies in the six domains or clusters below.

1. Science
 - a. Scientific mindedness and evidence-based practices
 - b. Biopsychosocial foundations
 - c. Population science and epidemiology
 - d. Research and program evaluation
 - e. Technology, informatics, and data-informed care
2. Systems
 - a. Leadership and administration
 - b. Interdisciplinary systems
 - c. Advocacy
3. Professionalism
 - a. Professional values and attitudes
 - b. Individual and cultural diversity
 - c. Ethics in PC settings
 - d. Reflective practice/self-assessment/self-care
4. Relationships
 - a. Interprofessionalism
 - b. Building and sustaining relationships in PC
5. Application
 - a. Practice management
 - b. Assessment
 - c. Intervention
 - d. Clinical consultation
6. Education
 - a. Teaching
 - b. Supervision

Within each competency, essential core competencies and examples of possible behavioral anchors or indicators of the competencies are provided.

Definitions of key terms used in the document can be found in Appendix A. Key documents that informed the revision of these competencies can be found in Appendix B.

Introduction

Background

Primary care (PC) functions as the cornerstone of sustainable health systems globally and continues to be the de facto behavioral health system across the lifespan in the United States and across the world (Kessler & Stafford, 2008; Vigo et al., 2025; Westfall et al., 2022; World Health Organization [WHO], 2022). PC also continues to be the primary place for the delivery of chronic and non-communicable disease management, with the number of people presenting with chronic diseases increasing (Savoy, et al. 2017). As such, the continued growth of behavioral health integration in primary care is needed, with a specific focus on behavioral health integration and team-based care as outlined in the updated primary care definition from the National Academy of Medicine (National Academies, 2021). Behavioral health integration in primary care has been linked to improvements with the Quintuple Aim (Itchhaporia, 2021), in other words, patient satisfaction (Hodgkinson et al., 2017; Ogbeide, et al., 2018), clinician satisfaction (Angantyr et al., 2015; Zubatsky et al., 2018), patient outcomes (Bogucki et al., 2021; Robinson et al., 2020; Wilfong et al., 2021), reduced costs (Landoll et al., 2019; Mancini et al., 2023; Reppeto et al., 2021), and improved health equity and access to care (Flynn et al., 2020; Margolis et al., 2022; Shahidullah et al., 2023). The World Health Organization (WHO, 2022) has emphasized that integrating behavioral health into general health services is essential to achieving the global targets outlined in both the WHO *Comprehensive Mental Health Action Plan (2013–2030)* and the WHO sustainable development goals for mental health (WHO, 2018, 2021).

This document is an update on the outcome of a 2012 American Psychological Association (APA) presidential initiative to articulate the competencies needed for the practice of PC psychology. PC embraces a team-based care and biopsychosocial approach to health and wellness (National Academies, 2021) and recognizes the emerging research on complexity science and how this impacts current PC practice, the complexity of PC teams (e.g., PC clinicians, nurses, social workers, dietitians, pharmacists, community health workers), and the complexities of the populations served (Fiscella & McDaniel, 2018; Katerndahl et al., 2010; Katerndahl et al., 2015). Ongoing changes in current health policy and financing models within the United States and globally will require all disciplines, including psychology, to reexamine their core competencies to include specific skill sets needed to address the provision of services such as telehealth and the ethical use of artificial intelligence in PC (Beheshti et al., 2022; Sarkar & Bates, 2024).

This updated document describes the skills needed to practice in the rapidly changing PC setting. These competencies are recommendations for trainees beginning in PC and for those who transition from specialty mental health settings, as these settings differ vastly in goals for care, intervention design and delivery, and overall practice management (Brown et al., 2021). This update starts with background information on the competency movement in professional psychology and describes the history of PC psychology competencies. Then we turn to the process in revising these competencies, present the competencies themselves in six clusters, and discuss the use of these clusters. Throughout, we use sample behavior anchors to illustrate the use of the PC psychology competencies in clinical practice.

This document is meant to complement other APA education and training guidelines, including, but not limited to the *APA Ethical Principles of Psychologists and Code of Conduct (2017)*, *APA Standards of Accreditation for Programs in Health Service Psychology (APA, 2018)*, *APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change (APA, 2021a)*, *APA Guidelines for Psychological Practice With Military Service Members, Veterans, and Their Families (APA, 2021b)*, *APA Resolution on APA, Psychology, and Human Rights (APA, 2021c)*, *APA Standards of Accreditation for Health Service Psychology: Master's Programs (APA, 2021d)*, *APA Guidelines for the Practice of Telepsychology (APA, 2024a)*, *APA Guidelines for Psychological Practice with Older Adults (APA, 2024b)*, *APA Guidelines for Clinical Supervision in Health Service Psychology (APA, 2025a)*, and the *APA Guidelines for Psychological Practice in Health Care Delivery Systems (APA, 2025b)*.

Scope

These education and training guidelines are primarily meant to serve as an aspirational guide for preparing psychologists to work in PC settings. The guidelines define the recommended competencies that students may develop across the continuum of professional preparation. They are intended to support faculty and supervisors in designing and delivering developmentally appropriate learning experiences across a range of settings, including in classrooms, practicum training, internship, postdoctoral training, and continuing education programs. The guidelines are flexible and encourage the use of varied teaching strategies to foster competency development over time and across diverse training environments.

Other psychology professionals (e.g., those with an associate, bachelor's, or master's degree in psychology) also have valuable roles to play on PC teams, although the scope of their appropriate practice depends on a variety of contextual factors. The set of competencies delineated in this document is pri-

marily designed to prepare psychologists for the role they play in PC, but those who educate and train other psychology professionals may also find it helpful to draw from these recommendations to create tailored learning opportunities.

While these education and training guidelines were developed within the regulatory and financial context of the United States, they are globally informed and locally adaptable, recognizing the importance of situating this work within a broader global context (Kearney et al., 2020). Models of integrated care, primary care practice, innovations in community health and task-sharing, and interdisciplinary collaboration from other countries offer valuable insights that can inform and enrich U.S. approaches. These guidelines are not intended to create a standard of practice, particularly for psychologists already trained and practicing in the field. Nor are they intended to limit the ability of psychologists to practice within their scope of licensure under state law, or to limit coverage reimbursement or credentialing by third party payors for psychological services within that scope of licensure.

Process

The evolution of these competencies reflects a decade of progress in the APA and the broader global movement toward competency-based education. The original version of these competencies was developed by the Inter-Organizational Work Group on Competencies for Primary Care Psychology Practice, which was convened as an APA Presidential Initiative in 2012. This work group aimed to address the need for the articulation of agreed upon competencies for primary care psychology. In 2015, the APA Council of Representatives formally approved the *Competencies for Psychology Practice in Primary Care*.

In accordance with APA Association Rule 30-8.3, all guideline documents must be reviewed within 10 years of their original approval. In 2025, following a decade of rapid transformation in global health delivery, the APA Board of Educational Affairs (BEA) convened a revisions work group to update the competencies. This group included members of the original work group as well as individuals with expertise across key domains. Appendix C provides a full list of members.

Before work on the revision commenced, members of the original work group and other stakeholders were invited to respond to a survey and to share their perceived importance of the guidelines and indicate how they used the guidelines. These survey results were shared with the revision work group in their initial meeting for their consideration.

The revisions work group held several meetings to review the original competency clusters, components, and behavioral anchors. They articulated key documents that should inform the revisions (see Appendix B), identified areas in need of revision, and engaged in ongoing virtual collaboration between meetings to advance their work. As with all APA guidelines,

to ensure broad input and review, the proposed revisions were circulated for public comment. Feedback from stakeholders was incorporated into the final version.

Implementation and Maintenance of Standards and Guidelines

BEA serves as the APA entity responsible for oversight of the implementation and dissemination of these revised guidelines, which will occur through:

- publication of the document as a downloadable PDF on the APA website and in the [APA Council Policy Manual](#);
- distribution of the document to the leaders and members of psychology education and training councils; and
- distribution of the document to relevant audiences including psychology faculty, department chairs, and training directors through APA member and Division listservs

This is a living document. APA will periodically review and revise this document to reflect developments in the discipline and in the education and training process. Formal reviews will occur at least every 10 years, as required by APA Association Rule 30-8.3. However, BEA welcomes comments and suggestions at any time. Feedback may be sent to: edmail@apa.org.

Recommended Competencies, Core Components, and Examples of Possible Behavioral Anchors/Indicators for Education and Training in Psychology Practice in Primary Care (PC)

Cluster 1. Science		
Competencies	Core component(s)	Sample behavioral anchors
1A. Scientific mindedness and evidence-based practices	1A.1 Values and applies a scientific foundation in daily PC practice	Understands and values scientific approaches and applies research methods to enhance patient care in PC while contributing to the evidence base Cites and applies relevant literature to guide patient care Uses quality improvement data to inform practice decisions
1B. Biopsychosocial foundations	1B.1 Knowledge of the biological components of health and wellness	Employs knowledge of human anatomy, physiology, and pathophysiology Describes how common PC conditions interact with psychological and behavioral concerns (e.g., recognizing the co-occurrence of depression with diabetes and the impact of blood sugar levels on cognition and mood) Demonstrates familiarity with common medications used for medical and behavioral health conditions in PC (e.g., diabetes, hypertension, depression) and recognizes their typical effects and side effects on mood and cognition
	1B.2 Knowledge of the cognitive components of health and wellness	Demonstrates knowledge of the bidirectional impacts of cognitive functioning with other biopsychosocial factors and how these interactions impact health and wellness outcomes Articulates an understanding of health belief models and attitudes regarding help-seeking that influence health behaviors Demonstrates knowledge of cognitive factors that influence reactions to medical diagnoses and processing of health information
	1B.3 Knowledge of the affective components of health and wellness	Demonstrates knowledge of the bidirectional relations of affective factors (e.g., depression, anxiety) with other biopsychosocial factors and how these interactions impact health and wellness outcomes Demonstrates knowledge of affective factors that influence reactions to diagnoses, injury, disability, and processing of health information Recognizes that medical problems can present as mood disorders (i.e., psychiatric symptom mimics)

Cluster 1. Science

	1B.4 Knowledge of behavioral and developmental aspects of health and wellness	Demonstrates knowledge of the bidirectional relations of behavioral and developmental factors with other biopsychosocial factors and how these interactions impact health and wellness outcomes Describes effect of age and developmental context on health across the lifespan Demonstrates knowledge of health behaviors (e.g., physical activity, sleep, nutrition, substance use) and their impact on health and wellness across developmental stages Understands behavioral risk factors and how coping styles influence health outcomes, treatment adherence, and recovery in PC
	1B.5 Knowledge of the role and effect of families and social support on health	Demonstrates knowledge of the bidirectional relations of families with other biopsychosocial factors and how these interactions impact health and wellness outcomes Recognizes the effect of acute and chronic illness on physical and behavioral health of caregivers, siblings, and other family members Demonstrates knowledge of the impact of caregiver stress on individual and family health outcomes and recognizes how caregiver burden interacts with patient care, family dynamics, and social determinants of health Demonstrates knowledge of the role of social support in promoting health, preventing illness, and improving treatment outcomes. Recognizes how social networks and relationships influence coping, resilience, adherence, and recovery across the lifespan Utilizes knowledge about the effect of the family and other members of the support system to support treatment adherence
	1B.6 Knowledge of the effect of social determinants of health and historical context on health and wellness	Demonstrates knowledge of the bidirectional relations of social and environmental factors with other biopsychosocial factors and how these interactions impact health and wellness outcomes (e.g., gender-related health issues, historical and collective trauma of a population) Describes association between socioeconomic status and health outcomes and access to care Recognizes the relationships between sociocultural factors (i.e., culture and cultural identity) on health management in PC settings
1C. Population science and epidemiology	1C.1 Knowledge of prevalence and trends for PC-relevant conditions	Employs knowledge of population-based approaches to health promotion Demonstrates knowledge of health policy and health services research Demonstrates knowledge of research methods for quality improvement initiatives to enhance patient safety, patient satisfaction, and health outcomes
	1C.2 Application of population health science to prevention and screening.	Uses clinical algorithms in PC (e.g., clinical pathway for chronic pain in PC) Applies population health principles to guide prevention and screening in PC, using stepped-care approaches that both match interventions to patient complexity and support patient self-management

Cluster 1. Science

1D. Research and program evaluation	1D.1 Ability to conduct research in PC settings	Searches the literature to identify the usual course of medical treatments and variations in care relevant to research conducted in PC settings Demonstrates an understanding of quantitative and qualitative analytic procedures and of mixing these methods for evaluating outcomes in PC settings (e.g., biostatistics) Demonstrates the ability to generate and execute research designs that maintain internal validity but enhance external validity (e.g., effectiveness trials, pragmatic trials, and other alternatives to randomized controlled trials)
	1D.2 Ability to select valid, brief, and actionable measures for conducting research and evaluating applied clinical activity in PC settings	Demonstrates knowledge of patient outcome measures appropriate for research in PC settings Integrates outcome measures spanning multiple domains, including biomedical indicators (e.g., lab values), economic metrics (e.g., cost effectiveness, financial impact), and psychological outcomes, to provide a comprehensive evaluation of effectiveness. Creates reliable and valid screening, diagnostic, and monitoring instruments using health information systems
	1D.3 Ability to conduct research in an ethically responsible manner in PC settings	Demonstrates an understanding of the local and federal regulatory requirements for human subject research as they apply to research conducted in PC Demonstrates an awareness of technical/ethical/legal issues that arise when conducting research using the electronic health record (EHR)
	1D.4 Ability to conduct research within the context of an interdisciplinary team	Collaborates effectively on interdisciplinary research teams by contributing psychological science perspectives to study design, implementation, and analysis Consults with interdisciplinary team members to facilitate the integration of behavioral science principles into research questions, methods, and interpretation Recognizes and navigates differences in scientific methods, terminology, and priorities across disciplines to facilitate effective collaboration
	1D.5 Application of research skills for quality improvement, practice evaluation, interventions, and programs	Creates or implements baseline needs assessment within PC settings for both patients and clinicians Evaluates effectiveness of screening methods, prevention programs, and biopsychosocial interventions used in PC settings Engages in quality improvement practices and practice-based research associated with practice-based networks where collective results can be used to evaluate the effectiveness of PC efforts on health outcomes
	1D.6 Dissemination of research findings	Prepares and delivers research findings in formats accessible to different audiences (e.g., PC team, patients, administrators, policymakers) Develops brief, actionable summaries (e.g., infographics, one-page briefs, dashboard reports) tailored to clinical or administrative decision-making Disseminates research findings in peer-reviewed formats (e.g., journals, conference presentations) and contributes to practice-based research networks to expand the evidence base

Cluster 1. Science

1E. Technology, informatics, and data-informed care	1E.1 Knowledge of health informatics	Evaluates informatics approaches for their scientific validity, usability, and impact on behavioral health outcomes in PC Uses informatics to communicate effectively across the care team, manage knowledge, and support clinical decision-making Extracts and interprets EHR data to track individual patient progress and monitor population-level health outcomes
	1E.2 Application of technology in care delivery	Reviews and applies scientific evidence on the effectiveness of health information technologies (e.g., telemedicine, patient portals, mobile health apps, artificial intelligence decision-support tools) in PC while attending to ethical principles for application of such technologies Evaluates the impact of health information technology on patient safety, satisfaction, and quality of care, particularly in behavioral health Uses technology-driven reminders, registries, and outcome-tracking systems to support stepped-care approaches and follow-up
	1E.3 Application of data-informed practice	Uses patient- and population-level outcome data to adjust care plans and intervention strategies Applies dashboards and registry data to identify at-risk groups (e.g., high utilizers of the emergency room) and guide targeted prevention or stepped-care interventions Analyzes trends in PC data to identify disparities, gaps in care, or opportunities for program improvement

Cluster 2. Systems

Competencies	Core component(s)	Sample behavioral anchors
2A. Leadership/administration	2A.1 Understands the mission, structure, history, scope, payment model, patient population, leadership style, and position of psychology within the PC practice.	Recognizes appropriate chains of communication to initiate a change in local systems of care Understands current reporting lines for psychologists and the broader professional team within the organization Understands billing practices for PC within the health system Articulates the economic value of integrated PC services by linking them to cost savings, improved clinician efficiency, reduced unnecessary utilization, and quality metrics that support the practice's mission and financial sustainability
	2A.2 Along with other practice leaders, facilitates integration across multiple domains (clinical, operational, administrative, and financial)	Works effectively with organizational leaders to promote the availability of resources for an effective behavioral health integration in PC Creates business plans that track costs and quality associated with PC Develops standards of care for psychology services within PC settings

Cluster 2. Systems

	2A.3 Contributes to planning and implementing organizational change to optimize service delivery for behavioral health integration in PC	Understands systems redesign and approaches to productivity enhancement to reduce inefficiencies (e.g., Plan-Do-Study-Act [PDSA]) Uses evidence-based measures and implementation processes to enhance adherence to elements of integration Examines space and technology utilization and makes recommendations accordingly, with particular attention to impact upon interprofessional team functioning
	2A.4 Demonstrates and promotes effective communication in a range of leadership roles	Promotes effective communication and collaborative decision-making in health care teams, including facilitating each team member communicating their perspective Leads or participates in staff meetings, clinical meetings, and organizational meetings Recognizes and reinforces effective performance and actionable feedback for areas of growth to team members and employees
	2A.5. Understands and applies employment policies for psychologists and behavioral health professionals within health care organizations	Contributes to the development and implementation of professional standards for psychologists and other behavioral health clinicians within PC settings Collaborates with practice leadership to implement a comprehensive 360-degree evaluation process for performance evaluations of all clinicians and staff Demonstrates familiarity with hospital/medical setting bylaws, credentialing, privileging, and staffing responsibilities
	2A.6 Supports training programs in PC psychology and interprofessional education at local, regional, national, and global levels	Advocates for institutional investment in an accredited psychology program with a PC focus supported by formal business plans Oversees efforts to develop PC psychology continuing education programs for psychologists and other health care professionals
2B. Interdisciplinary systems	2B.1 Appreciates that PC takes place in the larger “health care neighborhood,” within the community and social context	Provides community-informed care by engaging and forming partnerships with schools, health care systems, and community agencies that support specific populations (e.g., LGBTQ+ organizations and HIV outreach groups; Community Action Agencies and Latino, Black, or other culturally specific agencies with health care access goals) Promotes interprofessional education led by an interprofessional team, emphasizing scope of practice, teamwork, communication, respect, and mutual support Collaborates with other team members on the development of team-based protocols for health issues
2C. Advocacy	2C.1 Demonstrates knowledge of state and federal health care policy and its influence on health and wellness and PC services	Describes how Centers for Medicare and Medicaid Services policies impact health insurance reimbursement for screening and integrated behavioral health services in PC Identifies opportunities to advocate for better integration of behavioral health services in PC at the local, state, federal, and global levels Engages in human rights advocacy through actions aimed at promoting equitable care in PC settings Demonstrates an understanding of other social determinants of health such as exposure to trauma, violence, or food and housing insecurity, all of which often affect access to care

Cluster 2. Systems

	2C.2 Recognizes and addresses the health care needs of the community, including differences in cultural beliefs, and works to address how health care for all is prioritized in care delivery, state funding, and resource allocation	Develops evidence-based resources for the community regarding vaccines for children and adults (e.g., measles, flu, COVID) Works with families, school, and early intervention systems to address the population's rates of childhood obesity Develops advocacy skills for various government levels for resources to address the needs of the PC patient population
	2C.3 Recognizes that advocacy to improve population health may involve interacting with a number of systems	Demonstrates understanding that transitions of care (e.g., inpatient to nursing home or patient's home, pediatric to adult care) are influenced by funding, facility capacity, caregiver availability and capacity, and patient capacity Recognizes the unique and competing interests of different stakeholders in the health care system (e.g., patients, clinicians, payers, employers, and government) Understands that policy has a significant impact on factors such as food insecurity/access to healthy food that contribute to chronic disease, as well as individual health behaviors that contribute to chronic disease
	2C.4 Informs policy relevant to PC psychology at local, state, federal, and global levels	Serves on advisory boards of community, state, or professional associations Uses data and clinical/patient stories to show impact of integrated PC psychology on chronic disease prevention and management in order to advocate for funding to improve patient access to these services Provides technical assistance on legislation impacting the practice of integrated PC
	2C.5 Advocates within the psychology profession for increased research, training, and practice in PC	Works with the appropriate psychology training councils to increase graduate level education and practicum opportunities in PC Works with the local, state, national, and global psychological associations on a coordinated effort to train psychologists and integrate psychology into PC practices

Cluster 3. Professionalism

Competencies	Core component(s)	Sample behavioral anchors
3A. Professional values and attitudes	3A.1 Consolidates professional identity as a PC psychologist	Conveys to others the roles/skill sets that the PC psychologist brings to the setting Participates in professional organizations regarding the development and advancement of PC psychology Shares education and training background and conveys role to patients
	3A.2 Values the culture of PC settings and conveys an attitude of flexibility	Adapts to PC environment, including frequent interruptions, fast pace of clinic, unpredictable access to space, and diverse patient presentations Able and willing to participate in the care of the full range of patients served by the PC team across the lifespan Uses language consistent with a PC setting (e.g., appointment vs. session; patient vs. client) and culture

Cluster 3. Professionalism

3B. Individual and cultural diversity	3B.1 Monitors and applies knowledge of self and others with a cultural humility lens in PC settings	Demonstrates cultural responsiveness to a variety of factors that influence health care (e.g., developmental, cultural, and domains of cultural identity) as well as the intersections of these variables Keeps updated on the latest literature related to best practices with diverse populations in PC and adapts practice based on the latest findings Reflects on own cultural identity and its impact on treatment of patients and the PC team
3C. Ethics in PC settings	3C.1 Identifies and addresses the distinctive ethical issues encountered in PC practice, informed by the APA Ethical Principles of Psychologists and Code of Conduct (APA, 2017)	Demonstrates commitment to ethical principles with particular attention to multiple relationship matters, confidentiality, informed consent, boundary issues, team functioning, and business practices Demonstrates understanding of the common ethical dilemmas in PC and how to address these dilemmas Demonstrates sensitivity and knowledge of ethical codes of other disciplines present in PC
	3C.2 Demonstrates knowledge about the legal issues associated with health care practice	Effectively addresses scope of practice concerns for psychologists in PC Identifies and seeks to address problems encountered in team functioning (e.g., diffusion of responsibilities) Articulates state and federal laws and regulations related to documentation and billing (e.g., Centers for Medicare and Medicaid Services) and care delivery and can identify and consult with counsel when necessary Within pediatric primary care settings, appropriately navigates legal and ethical issues related to parent, guardian, minor, and proxy access to health records, consistent with applicable law, court orders, organizational policy, and professional guidance.
	3C.3 Articulates aspects of health care system policies that regulate the delivery of services in U.S. health care systems	Demonstrates familiarity with hospital/medical setting bylaws, credentialing, privileges, and staffing responsibilities Demonstrates knowledge about standards set forth by national accrediting bodies
3D. Reflective practice/self-assessment/self-care	3D.1 Supports importance of reflective practice in PC settings	Develops skills of self-awareness Identifies clinical situations in which intra- and interdisciplinary supervision and consultation are indicated Seeks and is receptive to feedback on performance
	3D.2 Understands importance of self-assessment in PC settings	Evaluates own competencies and determines need for continuing education on an ongoing basis Keeps abreast of emerging literature in PC to apply in practice Responds to common interpersonal challenges experienced by PC team members in a reflective manner

Cluster 3. Professionalism

	3D.3 Understands importance of PC team member engagement in self-care practices	Actively promotes self-care/wellness consultation opportunities for other PC team members (e.g., employee assistance programs) Models self-care to other team members Leads the promotion of healthy functioning teams that promote psychological safety and self-care
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Cluster 4. Relationships

Competencies	Core component(s)	Sample behavioral anchors
4A. Inter-professionalism	4A.1 Values a coordinated interprofessional team approach to care	Demonstrates understanding that effective patient care relies on a team of professionals, not a single clinician Recognizes the importance of multilevel working relationships within the PC team Views self as an active and essential member of the patient care team
	4A.2 Appreciates the unique contributions that all members of the health care team bring to PC team	Communicates the multiple capacities that a PC psychologist can serve on the team Recognizes when and how to use other team members' specific disciplinary expertise
	4A.3 Builds cooperative partnerships that promote healthy interprofessional team functioning characterized by mutual respect and shared values	Promotes collegial and mutually respectful relationships with colleagues from different disciplines Promotes and participates in team meetings (e.g. case conferences, team huddles, morning meetings)
	4A.4 Attends to team dynamics and offers support to enhance collaboration and effectiveness	Helps foster awareness of different communication and interaction styles within the team Uses psychological knowledge and skills to address challenges in team behavior and functioning Identifies team interactions that facilitate or impede team-based care
	4A.5 Demonstrates awareness, sensitivity, and skills in working professionally with diverse individuals	Communicates effectively with patients in a manner that is sensitive to power differentials that may be present in PC Maintains awareness of power dynamics among professionals within the team and works to foster balanced, respectful interactions among team members (e.g. inviting contributions from less frequently consulted team members)

Cluster 4. Relationships		
4B. Building and sustaining relationships in PC	4B.1 Understands the importance of communicating clearly, concisely, and respectfully in a manner that is understandable and meaningful to various audiences (e.g., clinicians, patients, staff)	Uses language that aligns with the communication preferences, educational background, and cultural context of patients and clinicians, including the use of medical interpreters or other supports when needed Uses multimodal supports to enhance a patient and family's understanding of a recent diagnosis Works with patients and families from diverse cultural and immigrant backgrounds to explain treatment plans in a manner consistent with their cultural values and educational background
	4B.2 Negotiates resolution of conflict between clinicians, staff, patients, and systems	Facilitates team process when there are professional disagreements by focusing on shared goals to attempt to resolve differences Mentors other professionals in effective conflict resolution strategies grounded in psychological principles Maintains awareness of power dynamics and works to foster balanced, respectful interactions between team members and between patients and clinicians
	4B.3 Maintains and models appropriate boundaries for patients, families, clinicians, and teams	Advises patients and their families about availability and limits, of PC behavioral health services after hours and informs patients of alternative resources that are available to them (e.g., on-call service, crisis hotlines, Emergency Department) Communicates with the team how to access PC behavioral health services when the PC psychologist/team is not available Clearly communicates professional limits in therapeutic and team contexts (e.g., clarifying availability, scope of involvement)

Cluster 5. Application		
Competencies	Core component(s)	Sample behavioral anchors
5A. Practice management	5A.1 Addresses stakeholder needs within the chosen behavioral health integration in PC model, considering available resources such as space and team composition.	Distributes care in a manner best suited for the patient and the population (e.g., tracks percent of time spent consulting with other clinicians, in targeted assessments/interventions, family systems-based interventions, and detailed assessments/interventions) Implements and schedules clinical services in a manner that fits effectively with a PC model of service delivery (e.g., provides preventative services when patients present for well visits, plans for intervals [e.g., 4-6 weeks] between appointments when warranted) Considers socio-cultural factors of the community and strives towards health equity

Cluster 5. Application

	5A.2 Applies principles of population-based care along a continuum from prevention and wellness, to subclinical problems, to acute and chronic clinical needs	Delivers assessment and intervention across the continuum of health and illness, including acute care, prevention, health promotion, and risk reduction for physical, behavioral, and substance use-related health concerns. Follows evidence-based and evidence-informed models of assessment and intervention across consultations (e.g., uses 5As Model: Assess, Advise, Agree, Assist, Arrange framework) Develops and implements workflows to promote population-based care, including clinician education, service delivery strategies, and awareness of community referral networks
	5A.3 Provides a range of services (e.g., targeted interventions, consultations, in-depth assessment) that meet the needs of patients and clinicians, consistent with the needs and realities of PC.	Uses appointment time efficiently (e.g., in a 30-minute appointment identifies problem, degree of functional impairment) Recognizes the fast-paced nature of PC and incorporates other PC team members as patient needs arise during the appointment Provides a range of targeted assessment/intervention services to meet patient and practice needs that match the context of PC
	5A.4 Can work effectively as a member of an interprofessional team (e.g., can co-interview, co-assess, and co-intervene with other PC and team members)	Collaboratively creates treatment plans with members of the PC care team Co-facilitates targeted assessment effectively with other health care professionals Co-leads medical group visits with PC clinicians and team members
	5A.5 Understands how payment for services may influence the type of services provided	Informs patients of the potential for fee for services and where to seek answers for billing related questions Is knowledgeable about varying payment models/codes and uses them as applicable (e.g., Health and Behavior Assessment and Intervention codes, Psychiatric Collaborative Care Model codes)
	5A.6 Communicates information that addresses a patient's needs, improves PC practice, and allows for research (when institutional review board approved) without revealing unnecessary confidential information	Writes clear, concise EHR notes focused on referral problem, frequency, duration (acute or long-term), functional impairment, and specific recommendations Recognizes the limitations of free-text health care patient notes, and uses templates/structured notes within the EHR when applicable

Cluster 5. Application

	5A.7 Adequately assesses the evidence for and appropriately uses the most up to date technology and methods to guide clinical service delivery	Encourages patients and families to use the patient portal of the EHR Provides telehealth services when indicated Stays up to date with organizational guidelines for artificial intelligence (AI) software embedded within EHRs (e.g., ambient AI software) consistent with applicable law, organizational policy, informed consent or notice requirements, confidentiality obligations, and documentation standards
5B. Assessment	5B.1 Selects and implements screening methods using evidence-based assessment measures appropriate for PC to identify patients at risk or in need of specialized services	Assists PC team in selecting measures to include in routine appointments that can identify common presenting problems (e.g., depression, anxiety, substance use disorders, sleep difficulties, disruptive behavior) and can be effectively administered in a PC setting (e.g., brief, easy to score) Utilizes data from multiple sources (e.g., U.S. Preventive Services Task Force, American Academy of Family Physicians, community/population) when selecting screening measures to implement in routine visits Utilizes results of screenings to facilitate patient connection to appropriate level of services (e.g., prevention, brief intervention, comprehensive evaluation)
	5B.2 Encourages the use, administration, and interpretation of psychological assessments for PC settings in a manner that maintains test integrity	Understands strengths and limitations of screening tools designed for specialty mental health (SMH) services when adapted for PC Appropriately uses evidence-based assessments for PC and the most up to date databases (e.g., Cochrane, DynaMed, Essential Evidence Plus, Epocrates, Lexi-Comp, Turning Research into Practice (TRIP), UpToDate, Agency for Health Research and Quality Atlas on Outcome Measures in Integrated PC) Employs appropriate standards and pathways when embedding screening tools within the EHR for patients to complete prior to the appointment (e.g., clinic protocol is in place if the patient selects question 9 [suicidality question] on the PHQ-9 and does not show for the appointment)
	5B.3 Uses assessment questions and measures geared toward current functioning, while simultaneously incorporating psychological, behavioral, and physical components of health and well-being	Assesses how the patient's physical condition (e.g., Body Mass Index, HbA1c, out of range lab values), thoughts, emotions, behaviors, habits, interpersonal relationships, and environment influence the identified problem and functioning Uses assessment strategies that can be tied to a behavioral change plan Uses a variety of assessment measures appropriate for PC
	5B.4 Incorporates multiple data points (e.g., referral question, screening results, assessment data) to rapidly assess patient's needs and develop collaborative treatment plan	Uses referral information, focused interviewing skills, and behavioral observations to efficiently identify the problem, degree of functional impairment, and symptoms for patients. Uses targeted screening tools to determine areas in need of attention during current visit Engages in shared decision-making practices to support clinical decision-making on when to refer patients to SMH or other community-based resources (e.g., outpatient psychiatry department, partial/full hospitalization program, crisis stabilization, addiction medicine)

Cluster 5. Application

	5B.5 Assesses pertinent behavioral risk factors	Screens for suicide risk and conducts an evidence-based suicide assessment on patients as guided by the latest clinical practice guidelines and research Identifies the health risks for pediatric patients with asthma residing with someone who smokes cigarettes Uses reliable and developmentally appropriate methods to assess substance use across the lifespan
	5B.6 Involves input of family members and social supports in the assessment process as indicated	Is aware of release-of-information protocols and obtains appropriate consent and documentation to involve others in patient's care Obtains information from caregivers/guardians in the treatment process Actively solicits information from outside sources as needed (e.g., interviews a teacher to obtain data to assist in the assessment of a child with a disruptive behavior problem)
	5B.7 Evaluates and uses intrapersonal, family, and community strengths, resilience, and wellness to inform understanding of patient's needs and to promote health	Uses interview and assessment measures that include evaluation of psychosocial variables (e.g., behavioral patterns, health beliefs, family, social support, cultural values) Effectively questions patient about support system, spiritual resources, and links to community resources Employs information gained from evaluation in development of a health care plan
	5B.8 Monitors patients longitudinally using standardized measures, as indicated, to identify changes in presenting problems and effectiveness of recommended interventions	Works collaboratively with PC team to perform ongoing assessment of fluctuations in presenting problem and of emerging problems Conducts follow-up assessment to evaluate effectiveness of recommended interventions
	5B.9 Provides clear, developmentally and clinically appropriate feedback to patients and, when appropriate, caregivers/family members regarding assessment findings, diagnostic impressions, and recommendations for care, with attention to feasibility, accessibility, and other considerations	Provides patients clear psychoeducation on new behavioral health diagnoses, including treatment options and recommendations Works with the care team to provide consistent and clear feedback to patients with new diabetes diagnosis on lifestyle changes and interventions.

Cluster 5. Application

5C. Intervention	5C.1 Focuses patient recommendations and interventions on functional outcomes and symptom reduction in a targeted manner	Uses evidence-based interventions to improve functioning in areas such as meeting family, school, and work responsibilities; improving quality of social interactions; decreasing disruptive behaviors; improving sleep; decreasing pain; reducing anxiety; improving mood; and improving exercise and nutrition Aligns recommendations with patient's values, goals, and desired outcomes
	5C.2 Offers interventions that encourage patient agency and self-management from a trauma-informed lens and result in proper use of health care resources	Meets routinely with a patient with multiple morbidities to decrease frequency of urgent care visits Employs methods such as "teach-back" to assure patient understanding of health care instructions Uses motivational interviewing to encourage a patient to attend diabetes education programs and to engage in proactive health behaviors Emphasizes choice and self-agency during warm handoffs and ensures communication that is empowering the patient to select their own intervention path after reviewing all options
	5C.3 Effectively uses current evidence-based interventions appropriate for PC to treat physical health (i.e., health behavior change) and behavioral health-related issues	Implements targeted, evidence-based interventions appropriate for PC settings Focuses on patient self-management, symptom reduction, and functional improvement with Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, and solution-focused interventions such as deep breathing, cue-controlled relaxation, cognitive disputation, sleep hygiene, stimulus control, increased exercise, problem solving, assertive communication, and disease management
	5C.4 Offers and solicits evidence-based interventions that can be reinforced and monitored by all PC team members	Shares and solicits information about behavioral interventions in a manner that encourages endorsement and support by the PC team Effectively engages family members/social supports in the intervention
	5C.5 Uses biopsychosocial model to provide effective patient education and communication	Describes to the patient the relevant factors (e.g., physical, behavioral, cognitive, environmental, social) that can affect symptoms with consideration of their health literacy level and in the context of their culture and values Uses an understanding of the patient's context, culture, and personal history to provide relevant education and shared decision making Provides empirical evidence whenever possible to the patient about how the interventions offered will lead to functional improvement
	5C.6 Targets evidence-based interventions to improve chronic care management	Uses behavioral intervention strategies to improve a patient's chronic disease self-management Collaborates with PC team to provide one-on-one visits, groups/classes, and enhanced medical visits, focused on chronic pain, prenatal care, diabetes, etc. Ties treatments offered to chronic condition-specific registries

Cluster 5. Application

	5C.7 Offers interventions that are inclusive of the family/social system	Elicits involvement of supportive others in meeting treatment goals (e.g., involves spouse in nutritional planning for patient with diabetes) Provides psychoeducation to family caregivers as appropriate (e.g., has family visits for patients with neurocognitive disorders) Involves immediate and extended family members/social supports in creating behavioral changes, supporting healthier behaviors, and improving adherence
	5C.8 Bridges appropriately between behavioral health services offered in PC and SMH as well as community resources	Refers patient to SMH services when the intensity of service needed is beyond the scope of PC Develops efficient ongoing communication strategies between PC team members and the referral source to ensure ongoing collaboration Uses community resources as applicable (e.g., local schools, psychoeducational groups, support groups, parenting programs, and cultural and spiritual resource centers)
5D. Clinical consultation	5D.1 Assists in the development of standardized and reliable processes for consultative services for PC psychology	Assists the PC team regarding when and how to incorporate a PC psychology clinician into the process of care Uses empirical literature to develop parameters for when consultations should be triggered (e.g., diagnosis of a chronic pain triggers an evaluation for pain management, initial Type 2 DM diagnosis)
	5D.2 Clarifies, focuses on, and responds to consultation question raised, in an efficient manner	Conducts a thorough health records review of the referred patient Includes other PC team members in response to consultation question Communicates specifically regarding initial consultation question to other PC team members
	5D.3 Helps PC team conceptualize complex patients in a manner that enhances patient care	Collaborates with other PC team members to facilitate effective and efficient interactions between the entire health care team, patients, and their support systems Is readily available to PC team to discuss ways to interact effectively with patients with challenging interpersonal styles Provides knowledge about behavioral and psychological matters to other team members
	5D.4 Tailors recommendations to work pace and environment of PC	Gives PC clinician actionable recommendations that are brief, concrete, and evidence-based Documents brief, actionable recommendations to the PC clinician and team within the note in the EHR
	5D.5 Communicates with PC team effectively	Communicates effectively using multiple modalities, including spoken, written, digital media, and other accessible formats Conveys and receives both urgent and routine clinical information to PC team members, using appropriate infrastructure/clinic procedures (e.g., face-to-face, EHR instant messaging, chart notes) Utilizes support staff efficiently and effectively to communicate patient information

Cluster 5. Application

	5D.6 Work as effective member of PC team, ensuring integrity of the consultation process (e.g., when algorithms trigger automatic consults, when EHR updates/technology changes occur)	Effectively explains the rationale for the consultation that has been automatically triggered to the patient Completes feedback loop with PC clinicians following consultation Is flexible and responsive to system changes and individual needs and update processes accordingly
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Cluster 6. Education

Competencies	Core component(s)	Sample behavioral anchors
6A. Teaching	6A.1 Understands and is able to apply teaching strategies about PC psychology	Develops a portfolio of educational strategies to demonstrate and teach PC psychology competencies with a strong focus on behavioral demonstration of and feedback on each competency Modifies teaching strategies based on learner's needs (e.g., discipline-specific training, level of familiarity with behavioral health concerns, developmental level, skill level of clinician) Provides training, clinical supervision, and precepting models for psychology trainees in PC psychology with approaches appropriate for the PC context
	6A.2 Knowledge of strategies to evaluate effectiveness of teaching methods and procedures in PC psychology	Obtains summative and formative feedback on trainees Discusses the strengths and weakness of different trainee assessment methods Implements individualized educational plan for clinical supervisor to improve effectiveness of teaching identified from trainee feedback
	6A.3 Understands importance of and facilitates teaching of psychology trainees by other health care professionals	Implements opportunities for psychology trainees to observe and participate in clinical activities with other health care professionals Encourages teaching activities for psychology trainees by physicians, advanced practice clinicians (e.g., nurse practitioners, physician assistants), and other health care professionals Provides training and supervision to other behavioral health clinicians, medical students, medical residents, and other PC team members working within PC settings
	6A.4 Educates and trains PC psychologists regarding health promotion, disease prevention, and management of acute and chronic disease across the lifespan	Develops materials for PC health care team to address patient concerns about disease prevention (e.g., vaccine hesitancy) or treatments Demonstrates the ability to educate and train PC psychologists in health promotion, disease prevention, and chronic disease management across the lifespan by integrating evidence from both U.S. and international literature Actively incorporates global perspectives and culturally responsive practices to enhance relevance and effectiveness in PC settings

Cluster 6. Education

	6A.5 Participates in the education and training of multiple stakeholders in the larger health care system about PC psychology	Presents at community health care forums on health topics Provides training to PC team members on the role of psychologists in addressing biopsychosocial concerns Presents at hospital wide staff meetings such as grand rounds regarding PC psychology initiatives
6B. Supervision	6B.1 Understands the ethical, legal, and contextual issues of the supervisor role in PC	Encourages that PC psychology training standards meets all accreditation requirements for clinical supervision Assists trainees in balancing role flexibility and limits of clinical competence Incorporates telesupervision practices that meet training standards and accreditation requirements
	6B.2 Applies a range of methods to the supervision of psychology trainees	Creates opportunities for psychology trainees to receive supervision from colleagues from other disciplines Creates opportunities for trainees to educate, supervise, and train other health care professionals Stays up to date on the use of technology (e.g., telesupervision, artificial intelligence) to effectively enhance the supervision of trainees in PC settings when appropriate or necessary

Summary

Health care delivery in PC settings emphasizes high-quality primary care that focuses on the provision of whole person care from an interprofessional team (National Academies, 2021). Psychologists are an important part of the PC team, along with other behavioral health clinicians. Because of this, it is of the utmost importance that psychologists practicing in PC and those teaching the next generation of PC professionals understand the mission and purpose of different models of behavioral health integration in primary care (Reiter et al., 2018; Sunderji et al., 2020; Unützer et al., 2013).

These guidelines suggest that psychologists not only display competence in clinical service delivery in PC but also teach other PC team members about psychology's contribution to PC settings and understand the bidirectional nature of teaching in PC settings. Competence in designing research protocols; implementing, developing, and evaluating behavioral services within PC settings; and serving as administrators and leaders in the biopsychosocially focused health care system of tomorrow are also important components of psychological practice. Through the application of these guidelines, psychology has the opportunity to enhance the breadth and quality of psychological services delivered to diverse populations across the lifespan in PC settings, improving access to care and facilitating health equity for all. PC represents the most widely accessible point of entry into health systems globally. Continuing to meet patients, families, and communities where they want to receive their care is likely to increase the reach and impact of psychological services. To realize this goal, those providing graduate, internship, and postdoctoral education in PC psychology are encouraged to adopt these recommendations to prepare psychologists in training to meet the unique demands of PC practice.

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Definitions of Key Terms

Key Definitions

BEHAVIORAL ANCHOR

Observable, measurable examples of how essential components of a competency might be demonstrated. Behavioral anchors are examples, so they vary by the model of service delivery being used, the population being seen, and the system of care.

CARE MANAGEMENT

Specific type of service, often disease specific (e.g., depression, congestive heart failure) whereby a PC team member, usually a nurse or social worker, provides early assessment and intervention, care facilitation, and ongoing follow-up (Farrell et al., 2015).

COMPETENCE IN PRIMARY CARE PSYCHOLOGY

The knowledge, skill, and attitudes – and their integration – that allow an individual to perform tasks and roles as a PC psychologist, regardless of service delivery model (Kaslow, Dunn, & Smith, 2008).

COMPETENCIES

Distinctive elements necessary for competence, they correlate with performance and can be evaluated against agreed upon standards (McGaffee, Rasmussen, & Roldolfa, 2023).

CORE COMPONENTS

Critical components that delineate the knowledge/skills/attitudes that make up each of the competencies consistent with the structure of the benchmarks model (Hatcher et al., 2013).

HEALTH AND BEHAVIOR ASSESSMENT AND INTERVENTION (HBAI) CODES

Current Procedural Terminology (CPT) codes that psychologists use when billing for services that help patients cope with or manage physical health conditions (APA Services, 2022).

HEALTH CARE (OR MEDICAL) NEIGHBORHOOD

The health care neighborhood is defined as a patient-centered health home and the constellation of other clinicians and teams providing health care services to patients and families within it, along with community and social service organizations and state and local public health agencies to improve health outcomes and improve health equity (Iqbal et al., 2025).

INTEGRATED CARE

Tightly integrated on-site teamwork with a unified care plan to deliver patient-centered, whole person care. Often connotes organizational integration as well, perhaps involving social and other health care services (AHRQ, 2025).

INTEGRATED PRIMARY CARE

Also known as “integrated behavioral health” or “primary care behavioral health.” Integrates medical and behavioral health services in a collaborative manner within a primary care appointment. Because most patients in PC have a physical ailment affected by stress, problems maintaining healthy lifestyles, are managing a chronic disease, or impacted by a psychological disorder, it is clinically effective and cost-effective to make psychologists part of PC. Patients can feel that for any problem they bring, they have come to the right place. PC team members working together is an embodiment of the biopsychosocial approach to care (AHRQ, 2025).

NON-COMMUNICABLE DISEASES

A group of conditions that are not mainly caused by an acute infection, result in long-term health consequences, and often create a need for long-term treatment and care. Mental health conditions are often considered part of this category (Pan American Health Organization [PAHO], n.d.).

PATIENT-CENTERED CARE

The patient and family’s experience recognition, respect, and dignity throughout all aspects of the care process.

POPULATION-BASED CARE

A population health perspective encompasses the ability to assess the health needs of a specific population; implement and evaluate interventions to improve health of that population; and provide care for the individual patient in the context of the culture, health status, and health needs of the populations of which the patient is a member (Shahzad et al., 2019).

PRIMARY CARE BEHAVIORAL HEALTH

“A team-based approach to integrating behavioral health services into primary care settings, placing a Behavioral Health Consultant (BHC) as a core member of the primary care team” (p. 1). The BHC provides high-volume, generalist, and consultative care across the lifespan to manage a broad range of behavioral health and physical health conditions within the primary care population. This model aims to improve patient health outcomes, access to care, and the quality of care by

making behavioral health a routine part of primary care rather than a separate specialty service. (Reiter, et al., 2018).

PRIMARY CARE PSYCHOLOGY

The application of psychological knowledge and principles to common physical and behavioral health problems experienced by patients and families throughout the lifespan and presented in PC (Hughes-Reid, 2019; McDaniel & deGruy, 2014).

SOCIAL DETERMINANTS OF HEALTH

The conditions in which people are born, grow, live, work and age, and people's access to power, money, and resources (WHO, n.d.)

TASK-SHARING/TASK-SHIFTING

The shifting of tasks, typically from more to less highly trained individuals to make efficient use of these resources, allowing all providers to work at the top of their scope of practice.

APPENDIX B

Key Documents Used by the Work Group

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