Chair’s Column

Victor Molinari, Ph.D., ABPP
School of Aging Studies, College of Behavioral and Community Sciences, University of South Florida

These are exciting times for CoPGTP. I want to apprise our member programs of some of the initiatives CoPGTP is spearheading. One, the ABGERO is now financially autonomous and no longer draws from the CoPGTP coffers. ABGERO receives $5,000 each year from ABPP, in addition to a percentage of the new candidates’ fees to help defray travel and hotel costs for conducting oral exams. ABGERO is training more

Integrated Care: Becoming the Standard of Care

Antonette M. Zeiss, Ph.D.
Retired, Department of Veterans Affairs

In 1983, I became Director of the Interdisciplinary Team Training in Geriatrics program at the VA Palo Alto Healthcare System, one of 12 such centers in VA sites across the country. We trained associated health providers, in alliance with medical training, in older adult integrated care settings that operated as effective interdisciplinary teams. The most typical sites were in geriatric

Editors’ Note: Special Issue on Integrated Care

Providing optimal care for older adults requires that service providers integrate care with all spheres of the client’s life. In this Fall issue of the CoPGTP Newsletter we highlight theory and practice about how psychologists are working to integrate their provision of mental health care with medical care. Toni Zeiss leads with an overview of the history of interdisciplinary care and training over the past 30 years. Michele Karel & colleagues describe one approach to service and training in interdisciplinary care in Home Based Primary Care, and Alison Minkin & Jamie Mathews describe another example of integrating primary care and mental health care and its relevance to work with older adults.

Continuing our promotion of the development of geropsychology as a field of expertise, in this issue we implement a new column which will showcase those geropsychologists who have become board certified in geropsychology. –JY
Psychology Training in Veterans Health Administration (VHA) Home Based Primary Care (HBPC) Programs

Michele J. Karel, PhD, ABPP  
Psychogeriatrics Coordinator, Mental Health Services, VA Central Office  
Michelle Mlinac, PsyD, ABPP and Margaret Murphy, PsyD, ABPP  
VA Boston Health Care System  
B. Heath Gordon, PhD  
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Rachel Rodriguez, PhD, ABPP  
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The VHA HBPC program provides comprehensive, interdisciplinary, primary care in the homes of Veterans with complex medical, social, and behavioral conditions. HBPC is designed to serve Veterans with complex and chronic illness, providing primary care, palliative care, rehabilitation, disease management, and coordination of care services. Starting in 2007, mental health (MH) providers – usually a psychologist, sometimes a psychiatrist – have been integrated into each of 130 or so HBPC programs nationally.

HBPC mental health providers work closely with the HBPC interdisciplinary team (including nurses, physicians, social workers, pharmacists, dieticians, and rehabilitation therapists) to facilitate coordinated evaluation and treatment of mental and behavioral health concerns. The model for HBPC mental health integration is based on core evidence-based components of care: interdisciplinary, patient-centered, and collaborative care for all Veterans enrolled in HBPC; care management and stepped care approaches to determine the appropriate intensity of mental health services needed; and evidence-based psychological and psychopharmacological

Geropsychology and Primary Care: A Natural Fit!

Alison Minkin, Ph.D.  
Zablocki VA Medical Center  
Jamie Mathews, Psy.D.  
Edward Hines, Jr. VA Hospital

As geropsychologists and geropsychology trainees, we are well aware that the mental health (MH) needs of older adults are often under-recognized and underserved. Primary Care Mental Health Integration (PCMH) is a natural fit for geropsychology, as it promotes increased access to care while providing critical collaboration with interdisciplinary health care teams. Two frequently used models for integrating primary care (PC) and MH are Collaborative, Co-Located Care (CCC) and Care Management (CM). The CCC model involves a licensed MH provider who is co-located in the PC clinic and serves as a member of the PC team. MH services, including assessment and psychotherapy, are provided on-site and warm hand-offs between providers and the CCC clinician are encouraged (Pomerantz et al., 2010). In the CM model, a clinician provides ongoing assessment and monitoring of a specific condition (e.g., depression), usually offering psychoeducation and basic supportive interventions over the phone (Zeiss & Karlin, 2008). Both models emphasize collaboration with the PC team, and many sites incorporate a blended model of both CCC and CM.

The evidence for integrated geriatric MH care continues to grow. Research consistently indicates that older adults prefer to receive MH treatment in their PC clinics (e.g., Brody, Khaliq, and Thompson, 1997). Integrated care has demonstrated superior outcomes when compared to both usual care and “enhanced referral” to specialty MH care in geriatric patients with depression, substance misuse, and anxiety (e.g., Alexopoulos, et al., 2005; Bartels, et al., 2004).
ABGERO Update
Victor Molinari, Ph.D., ABPP

According to my latest calculations, 52 people have received the ABGERO. A little over half of these specialists are senior geropsychologists (n=28), perhaps four are mid-career, and 20 are relatively early career. Almost half of the ABGERO specialists (n=25) work in the VA system, reflecting the tremendous role the VA has played in recruiting competent well-trained psychologists to work with older Veterans (and providing financial incentives to get the ABPP, but alas operationalized at local discretion). Other work settings of ABGERO specialists vary, with perhaps 12 in academia, 10 in private practice, three in hospital administration, and one working in an outpatient clinic specializing in the mental health of older adults. We have approximately five people in various phases of the application process. Worthy to note are seven students in the Early Entry Option stage who receive a significant break in the fees by banking their credentials early with ABPP. I should note that approximately 50% of all those who are becoming ABPP specialists are choosing this Early Entry Option, suggesting that receiving specialty credentials is ‘catching on’ at the earliest educational levels in psychology as students and academics understand its potential future value for marketing, and perhaps even ultimately licensing and reimbursement purposes (a long way down the road for the latter two). The officers of ABGERO who make up the Executive Committee are Victor Molinari (President), Shane Bush (Secretary), and Sue Whitbourne (Treasurer). In future editions of the CoPGTP newsletter, I plan to ask ABGERO specialists to discuss the pros and cons of the application procedures and their thoughts about being an ABGERO specialist. Please contact me if you have any questions regarding board certification in geropsychology.

Join other CoPGTP members at the annual CoPGTP meeting in Orlando, Florida

Thursday, November 19 at 7pm
Il Mulino, a restaurant in the GSA conference hotel
http://www.swandolphinrestaurants.com/ilmulino/
$50 per person

The CoPGTP Board welcomes representatives from programs who can provide us feedback regarding how best to serve its members.

Please RSVP by October 25 to Jonathan Gooblar: jgooblar@wustl.edu
oral examiners in order to develop regional examining teams to reduce travel expenses and use more ABPP money for training and other worthwhile purposes.

Two, Dr. Hinrichsen is heading the initiative to identify a core ‘fundamental knowledge’ base for training of post-licensure non-specialist psychologists who can gain ‘exposure’ (a term borrowed from our geropsychology training grid) in geropsychology by undergoing 15 hours of training. The big question (which may soon be posed to varied geropsychology stakeholder groups) is what content should be included in this training. We will be using the Pikes’ Peak Training model and the wisdom of geropsychologists to guide these choices. In the long term, we hope to build upon this core foundation to delineate requirements for exposure, emphasis, and major areas of interests at different levels of training (graduate, internship, fellowship and post-licensure) to create a training guide for those interested in working with older adults at all stages of professional development.

Three, the survey of graduates of graduate and post-doctoral programs in geropsychology which was funded by CoPGTP and directed by Brain Carpenter, Jenny Moye, and Michele Karel, has yielded interesting findings regarding training in clinical work, research, teaching, and supervision. Two manuscripts have been submitted for publication, with one ‘in press’ in the journal ‘Training and Education in Professional Psychology’ and the other ‘in revision’ in ‘Gerontology and Geriatrics Education.’ I plan to solicit an article for the next newsletter detailing the overall results of this project.

Four, as the CoPGTP representative and elected Chair of the Geropsychology Synarchy (and thereby the Geropsychology Synarchy representative to the Council of Specialties), I have been privy to interesting dialogue regarding how specialties are defined and what may be future developments in the specialization areas. Specialty nomenclature and designation has been a source of frustration to many psychologists who practice in areas that are not officially identified as specialties but who believe their areas deserve such status. APA’s Commission for the Recognition of Specialties in Professional Psychology (CRSPP) implements procedures to determine whether areas of practice have enough practitioners and enough of a unique evidence base behind their practice and training models to be awarded specialty status. The Council of Specialties (CoS), a group informally affiliated with APA, is a specialty advocate organization comprised of the varied specialties that ‘lobby’ for the overall needs of specialties. The American Board of Professional Psychology (ABPP) credentials specialists from the different specialties. To add to the confusion, all of these groups have different memberships (but luckily geropsychology is a full-fledged member of all three). There is a conference being planned to help these specialty organizations develop a better and more unified understanding of the need for specialties, both for the sake of psychologists and the public at large. I will keep you posted on developments in all these areas.

Geropsychology Training in 2014-15

Andrew L. Heck, Psy.D., ABPP Piedmont Geriatric Hospital
Jonathan Gooblar, M.A. Washington University in St. Louis

Over the past year, CoPGTP has continued to promote training initiatives to expand and strengthen Geropsychology across settings. Most notably, Geropsychology was formally recognized as an American Board of Professional Psychology (ABPP) specialty area of practice last Fall. This milestone comes at a time of great demand for practitioners who have achieved competency in working with older adults. ABGERO has certified over 50 geropsychologists, and continues to

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receive increasing numbers of applications monthly. Highlights of Geropsychology activity this year include:

- **Defining basic competencies:** The demand for practitioners who are knowledgeable about working with older adults has never been greater. While board certification provides an excellent opportunity for Geropsychology specialists to gain recognition for core competencies, many more general practitioners are interested in gaining fundamental knowledge and skills relating to serving older adults. In response to this need, CoPGTP has formed a workgroup to define basic knowledge and skills for working with older adults across a variety of settings that includes representatives from the APA Committee on Aging and Divisions 12/II (Society for Clinical Geropsychology) and 20 (Aging and Development), as well as Psychologists in Long Term Care (PLTC). The workgroup is also cataloging existing resources and developing a plan to disseminate basic competencies to practitioners and educators.

- **White House Conference on Aging:** The White House Conference on Aging (CoA), held every 10 years, brought together experts and advocates to discuss the state of caregiving, financial planning, healthy aging, elder justice, technology, and other issues this Summer. Members of CoPGTP contributed comments to the conference in several of these areas. More information about the conference is available at http://www.whitehouseconferenceonaging.com

- **Innovative training award:** CoPGTP board members enthusiastically recognized Ferkauf Graduate School of Psychology’s Older Adult Program (FOAP) with the 2014 Innovative Training Award. FOAP offers Geropsychology concentration and minor programs for their graduate students, including coursework, practica, research, and supervision in order to train the next generation of Geropsychology practitioners. More information is available at http://www.yu.edu/ferkauf/clinical-psychology/older-adult/.

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**Post-Licensure Update**

**Gregory A. Hinrichsen, Ph.D., ABPP**  
Department of Geriatrics and Palliative medicine, Icahn School of Medicine at Mount Sinai

**Workgroup: Core Knowledge and Attitudes for Psychologists who Work with Older Adults**

As reported in the Spring newsletter, a CoPGTP workgroup was formed to explore what basic knowledge and skills may be needed for psychologists interested in work with older adults. CoPGTP reached out to other relevant geropsychology groups and invited them to take part in this effort. In June we had a call with representatives from the APA’s Committee on Aging, Society of Clinical Geropsychology, Division 20/Adult Development and Aging, as well as Psychologists in Long-term Care. There was general agreement that a survey of geropsychology practitioners would yield a sense of what they felt was knowledge critical to getting started in work with older adults. In July, the CoPGTP workgroup discussed next steps. A conclusion was that we are not trying to identify “core competencies” but rather “foundational” or “core” knowledge and attitudes for psychologists who are beginning or want to begin work with older adults. Concretely, the question is, what fundamental knowledge and attitudes should be taught in the equivalent of a two day, approximately 14 unit continuing education workshop? Victor Molinari and I agreed to draft a survey, and we hope to have one completed in the coming months for review. CoPGTP member input is welcome.
primary care clinics and geriatric long-term care units, with sites also operating in medical specialty areas in some of the centers (including VA Palo Alto). At the time, this was a radical model, frequently challenged by health care traditionalists, and not always of interest to psychology trainees. One of the most amazing and rewarding aspects of my career has been to see how this model has become the standard of care not only for older adults in primary care but also for adults of all ages in many settings.

The principles that guide integrated care have not changed, including that mental health is an essential component of overall health. Physical problems can be risk factors for mental health problems, and vice versa. Treating the whole person and the family allows health care to address these interactions and serve interconnected needs. Integration of mental health in the primary care setting is an especially natural fit. 1. Patients initially bring their mental health concerns to primary care. 2. Primary care is a point of frequent contact for older adults. 3. Screening for mental health problems takes place in primary care. And, 4. having mental health services available in primary care reduces the likelihood of a patient failing to follow through on a referral for specialty mental health care. Integrated care promotes early identification and management of mental health issues, supports coordination of care across conditions, facilitates engagement of the patient, increases convenience of care for the older adult, and reduces the stigma of receiving mental health care. Integrated care embodies for the patient the concept that mental health is an integral component of overall health.

In order for teams to work, team members must manage disagreement, so they can coordinate their efforts and integrate the care experience. To help teams with these processes, I have used the Harvard Negotiation Project materials (e.g., Fisher, Ury, & Patton, 1981) in team training. This approach respects the offerings of all individuals and professions on a team, and encourages team members to approach disagreement as an opportunity to learn from each other and to find and pursue shared goals, rather than become adversarial. I urge psychologists to read the Harvard Negotiation Project materials and to develop personal competencies in this approach.

APA has steadily increased efforts to support integrated care for many years. In 1998, the Education Directorate prepared a report for SAMHSA - Interprofessional Health Care Services In Primary Care Settings: Implications for the Education and Training Of Psychologists. I served on that work group, along with Susan McDaniel, who is now APA President-Elect, and Cynthia Belar, who later became the head of the Practice directorate. As a next step, Sharon Brehm, in her Presidential year, established an initiative to develop knowledge of and policy regarding integrated care for older adults. I served as Co-Chair of that Presidential Initiative, with Toni Antonucci, working toward our 2007 product - Blueprint For Change: Achieving Integrated Health Care For An Aging Population (available on the APA website). The Blueprint provides guidance for psychologists to be effective in contributing to, joining, and creating integrated care teams; it describes a basic model for providing integrated care; lays out skills that psychologists bring to integrated care; and discusses how the basic model of integrated care can be applied in a variety of health care settings.

Since these early efforts, integrated interprofessional care has surged into a remarkable position as a dominant model. The World Health Organization (2010), the Institute of Medicine (2010), the Pikes Peak Model (Knight et al., 2009), and numerous other projects have expanded psychologists’ understanding of integrated, interprofessional care and psychology’s role in it. Excitingly, the last two APA Presidents (Nadine Kaslow and Barry Anton) and the President-Elect, Susan McDaniel, have all focused on integrated care efforts for their
assessment and intervention when indicated.

Home Based Primary Care can be a rich and rewarding context in which to provide, and receive, mental health training for Psychology Fellows, Interns, and practicum students. This training context allows for collaboration with interdisciplinary teams, provides exposure to innovative care practices, and gives trainees a glimpse into the home life of Veterans. The environmental and social context of the home environment informs integrated assessment and care planning. Training in HBPC provides an excellent opportunity for psychology trainees to develop skills in geropsychology, behavioral medicine, and palliative care. Common training opportunities in HBPC include: capacity evaluations regarding medical decision-making, independent living, and/or financial management; cognitive/dementia evaluations; individual, couples and family therapy; caregiver interventions; crisis intervention; risk assessment and management; elder abuse/neglect evaluation and reporting; team consultation and training; managing team conflict and facilitating team performance; and quality improvement/program evaluation projects.

Psychology training in HBPC demands special supervision, ethical, boundary, and team considerations.

- Psychology interns and postdoctoral fellows must demonstrate that they have developed relevant knowledge and skills before they are able to make home visits on their own. Of note, each local VA Medical Center has guidance regarding trainee participation in home visits. A supervising psychologist, if not accompanying the trainee, must be readily available at an identified phone number during the home visits.

- Psychology practicum students are not to conduct home visits independently, while they may accompany supervisors or other

- Trainees must receive orientation and training related to handling emergency situations and related HBPC policies and procedures prior to making a home visit.

- The home care environment is fertile ground for ethical and clinical dilemmas, and thus must be addressed as part of psychology training in this setting. Trainees are challenged to “think on their feet” in managing many challenging situations, including:
  - Maintaining privacy and confidentiality: family members or other visitors frequently come and go, or inquire about the patient’s well-being.
  - Managing professional boundaries: the home care environment challenges typical professional boundaries. Patients/families often offer food and drink, ask for help to clear the snow off the path or fix a broken light (or, the professional may feel compelled to help even if not asked). These situations are further complicated if team members do not respond consistently across visits.
  - Safety: staff safety is a paramount concern, with risk of weapons (Veterans are informed that weapons must be locked and put away), aggressive pets, unhygienic environments, or high crime neighborhoods. Trainees must learn to trust their intuition and exit a situation that feels threatening.

- When the trainee and supervisor are making joint home visits, supervision often occurs in the car! In this context, supervision tends to be more collaborative and allows for immediate clinical planning and case discussion after a visit.

- One supervision model (B. H. Gordon) has trainees discussing chart review and a
Even more compelling is that integrated care appears to improve access to MH treatment for African-American and Latino older adults (Arean, et al., 2005; Ayalon et al., 2007).

An example of how PCMHI can be implemented into geriatric PC can be seen at a large Veterans Administration (VA) hospital in the Midwest. Approximately 955 of the over 48,000 Veterans served by this hospital are empaneled within the geriatric PC clinic (numbers current as of July 2015). This geriatric PC clinic serves Veterans who are typically 80 years or older and whose health care needs could benefit from more intensive PC services (e.g., longer visit duration and more frequent follow up visits) with a medical team who has training and experience in geriatrics. One PCMHI psychologist (approximately 32 hours per week) and one PCMHI psychiatrist (approximately four hours per week) are on the geriatric PC team. The psychologist functions as a CCC provider, and the psychiatrist provides case consultation and medication recommendations to the PC providers as needed. CM referrals, as appropriate, are also available and are overseen by other PCMHI nursing and psychiatry staff.

Reasons for referral to PCMHI staff in this clinic frequently involve presenting problems that are also seen within geropsychology, such as cognitive changes and dementia, caregiver stress, grief, and adjustment to cognitive and functional changes. Family involvement in treatment is common, and there is often ongoing communication and collaboration with multiple family members and caregivers. Significant barriers to transportation call for flexible and creative scheduling as well as an increased use of telephone-based support, particularly for caregivers.

The availability of PCMHI services within this geriatric PC clinic aims to improve access to care by reducing barriers and stigma associated with MH care, and it assists with enhanced collaboration of care. Further, given that older adults are the fastest growing segment of the population, a population-based, stepped care approach, as is utilized in PCMHI programming, can help address the growing treatment needs of this population. Some additional ideas for development include: clinical reminders for staff to routinely assess baseline cognitive status and home safety, enhanced training in geriatrics and diversity issues, shared medical appointments, caregiver support and patient education classes, and outreach and collaboration with other clinics and community agencies. Integrating MH services into geriatric PC is likely to be a crucial component to improving access and treatment outcomes for older adults. It is an exciting and expanding field, ripe with opportunities for geropsychologists!

Presidential initiatives. Integrated care is indeed becoming the standard of care in the US and other countries. It is a deeply rewarding way to provide care, with documented benefits for patients, their families, and for health care providers. I hope all of you have a chance to work in such settings during your careers, as I treasure my experiences promoting this approach to care.

References
Internship Report
Heather Smith, Ph.D., ABPP
Milwaukee VA Medical Center

Interdisciplinary Staff Training

As outlined in the Pikes Peak Model of Geropsychology Training (Knight, et al., 2009), interdisciplinary staff consultation is a core foundational competency of geropsychology practice. One important aspect of consultation is the ability to provide education to interdisciplinary staff regarding psychological factors affecting older adult patients. The opportunity to observe, develop, and deliver staff education on topics such as dementia, delirium, behavioral management, and decision-making capacity assessment, among others, is a cornerstone of the geropsychology training offered at the Milwaukee VA Medical Center (VAMC) as well as other VAMC facilities across the country. This essential internship and postdoctoral fellowship training experience is available in such integrated care settings as long-term care, adult day care, inpatient and geriatric rehabilitation, acute medicine, intensive care, primary care, and home based primary care (HBPC).

Geropsychology trainees participate in interdisciplinary staff education provided in-person or online and including both didactic and experiential instruction. Educational approaches are modeled by staff geropsychologists, and outcome measurement of education sessions is emphasized as essential to guiding future efforts and assessing efficacy of the training provided. For example, geropsychologist Alison Minkin, Ph.D. led the investigation of the effectiveness of training HBPC nursing staff in motivational interviewing (MI), with a goal of increasing patient medication adherence. Results indicated

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Post Doctoral Report
James (Chip) Long, Ph.D., ABPP
Central Arkansas VA Medical Center, Little Rock

APPA CAS Set to Begin Second Year

Last year, over 150 postdoctoral training programs and more than 800 applicants utilized APPA CAS (APPIC Psychology Postdoctoral Application Central Application System). Dr. Wayne Siegel, Online Coordinator for APPA, stated this was a higher participation rate than what was expected for the first year of the program.

Dr. Siegel described the initial run of the APPA CAS as a “major leap forward” in establishing a centralized location for application materials, as well as standardizing some of the steps involved in the application process. The original effort was not without its fair share of growing pains, however. Dr. Siegel stated he expects a smoother process this year, as APPIC and Liaison International (application management services) have worked diligently to address several of the concerns identified during the initial run. For example, changes were made to improve the APPA CAS system’s structure to make it compatible with a larger number of web browsers. It is believed this will improve the process by which application materials are uploaded to the site. In addition, applicants will no longer need to submit transcripts from their undergraduate degrees, and additional adjustments were made to how applications are finalized to make it less confusing and more streamlined for all parties involved.

APPA CAS remains free for APPIC member programs and there will be no fees for non-APPIC member programs for a limited time. Postdoctoral programs new to the service will need to register with Liaison International to be listed as a

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that the MI training increased medication adherence among Veterans enrolled in HBPC at follow-up 1 month and 6 months after the education (Minkin, et al., 2014).

Recently, previous fellow Weston Donaldson, Ph.D., developed an online training to enhance the cultural competency of Community Living Center (CLC) interdisciplinary staff in working with older LGBT Veterans. Participants completed pre- and post-education measures assessing LGBT knowledge, attitudes, and skills. Preliminary results indicate an increase in staff members’ LGBT-related knowledge and self-perceived skill in caring for transgender Veterans.

In summary, interdisciplinary staff education is an important aspect of the consultation offered by geropsychologists in integrated care settings. Opportunities for training in the delivery of such educational interventions are essential at the internship and fellowship levels.

If you have clinical, research, or other aspects to your internship training program that you would like to highlight in future newsletters, please contact me at Heather.Smith7@va.gov.

References:


Postdoctoral Report, Continued from page 9

scientific article related to the case (e.g., regarding one of the patient’s diagnoses) on the drive to a patient’s home, and processing of the visit and case conceptualization on the drive back.

- The Pikes Peak assessment tool helps to define training needs and evaluate trainee progress in HBPC rotations.

In the years to come, home-based health and mental health care services are expected to grow, and will continue to offer rich training opportunities for geropsychologists-in-training.

For further reading:
Student Spotlights
This section introduces CoPGTP members to current students and future geropsychology colleagues, promoting student involvement in CoPGTP and the field of geropsychology in general!

Victoria Liou-Johnson, MS, is a fourth year PhD student in clinical psychology with an emphasis in neuropsychology at the Pacific Graduate School of Psychology at Palo Alto University. Her interests focus on older adults. Victoria is currently mentored by Sherry A. Beaudreau, PhD, ABPP, at the Palo Alto VA, where she collaborates on geropsychology research on emotion, neurocognition, and behavioral medicine. Previously, she completed a Master of Science in Clinical Psychology with a certificate in Gerontology and worked in community mental health. Victoria’s interests are in neuropsychological assessment and interventions for older adults with dementias and/or lifelong learning disorders. In addition, she is interested in improving access to neuropsychological services for Native Americans. Victoria became interested in working with older adults as an adolescent, after summers volunteering with her grandmother at skilled nursing facilities. Victoria has obtained a wide range of clinical training from highly respected mentors. In addition to working with Dr. Beaudreau, she trained in neuropsychological assessment at Kaiser Hospital with Rex Bierley, PhD, and continues at Kaiser providing psychotherapy to older adults and assessment in the Adult ADHD Clinic with Susan Plate, PsyD. Victoria is a full-time neuropsychological extern at UCSF’s Memory and Aging Center with Joel H. Kramer, PsyD, as well as UCSF’s Epilepsy Clinic with Deborah Cahn-Weiner, PhD. Victoria’s research includes attitudes of medical students on geriatric medicine, treatment satisfaction among older Veterans in a sexual dysfunction clinic, interventions for cognitive decline, and correlates of cognitive function in community-residing older individuals. Her long-term career goal is to become board-certified in geropsychology and neuropsychology. She aspires to work as a clinician and researcher in a VA or university hospital setting with older patients suffering from memory disorders.

Amanda Runyan is a geropsychology post-doctoral fellow at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, MA. She completed her PhD in community-clinical psychology at Wichita State University in Wichita, KS under the mentorship of Dr. Louis Medvene, where she was afforded the opportunity to study and research aging both from a clinical as well as a systems-level perspective. Last year, Amanda completed an APA-accredited internship at Heritage Clinic in Pasadena, CA. There she trained under Dr. Janet Yang, providing field-based psychological services to older adults with a diverse range of presenting concerns. Currently, she is providing care to older Veterans and their families in the community living center, hospice/palliative care, home-based primary care, and outpatient units. Amanda’s interests also include nursing home residents’ role in person-centered care, Acceptance and Commitment Therapy with older adults, mindfulness, and how individuals can age successfully across SES and physical health spectrums. Both her research interests and clinical work have been strongly influenced by the belief that aging is a dynamic developmental process with opportunities and gains as well as challenges and loss. She is grateful to the experiences, supervisors, mentors, colleagues, and, of course clients, who have strengthened and affirmed her decision to focus on geropsychology. After completing fellowship and licensure, Amanda plans to pursue board certification in geropsychology and looks forward to continued work with older adults and meeting others with a similar dedication.
Nicole Torrence is a Geropsychology post-doctoral resident at the VA Puget Sound, American Lake Division. She earned her Ph.D. in Clinical Psychology with a curricular emphasis in Geropsychology from the University of Colorado, Colorado Springs. In 2014, she moved to Palo Alto to complete her predoctoral internship in Geropsychology at the Palo Alto VA. Nicole is passionate about culturally diverse older adults and learning from their wisdom and life experiences. She enjoys the challenge of working with older individuals with mental health and medical comorbidities. Nicole has special interests in interprofessional collaboration on behalf of older adults and their family in order to maximize and/or maintain health, welfare, independence, and quality of life. Nicole approaches psychotherapy from a patient-centered approach and utilizes a variety of evidence-based psychotherapeutic interventions. She has worked in multiple settings including, Geriatric Outpatient Community Mental Health and Neuropsychology, Inpatient Psychiatry, Geriatric Primary Care, Spinal Cord Injury, and Community Living Center (i.e. acute, long-term, hospice/palliative care, and dementia specialty care). As a scientist-practitioner, Nicole embraces the reciprocal nature of research and practice. She has collaborated on multiple research projects published in peer-reviewed journals. She has diverse research interests in the areas of aging, integrated care, neuropsychology, psychometric properties, and mindfulness. Nicole is committed to working with older adults and plans to pursue board certification in Geropsychology after her fellowship. Nicole hopes to fill a staff psychologist position where she can conduct direct patient care and contribute to Geropsychology training.

Morgan Eichorst: Although I’ve always had a connection with older adults, my geropsychology research and clinical interests were sparked as I sat in an Introduction to Gerontology course during my undergraduate years at Miami University. Just a century ago, it was common to die at home, rather than in a hospital or other facility, and to be cared for by familiar family and friends, rather than medical personnel. One hundred years, in the scheme of human evolution, is a fraction of a second. How has this seemingly enormous societal shift regarding end-of-life care changed it? And, more precisely, how has it changed us? My research passion is for questions like these—questions about how the dying process affects older adults, families, and those in health care. I think knowledge of our own mortality has the potential to spur us to live the most astounding lives, and I believe that by shrinking from this knowledge we risk cheating ourselves out of the immense sense of perspective they gift to us. My clinical passion is for individuals who face the dying process—in the midst of chronic illness or suddenly, personally or through a loved one, gracefully or full of anxiety. I feel strongly that changing the culture on death and dying starts by being willing to sit with someone in their last hours, and to talk about the mix of emotions death brings to us. It’s not comfortable; death is not beautiful; and we fear the unknown. Ultimately, though, I believe it is worth it—and I hope to spend my career underscoring this message through my research and clinical undertakings.
Membership Report
Elizabeth Mulligan, Ph.D., ABPP
VA Boston Healthcare System

The CoPGTP board recently revised our membership criteria, hoping to make it more inclusive. We added language to encourage programs developing geropsychology training to apply for membership as well as language to encourage initial/renewed membership for programs who have been actively engaged in training in the past but have lost funding. Our recruitment efforts are ongoing. Please contact the members-at-large if you have suggestions for potential new members or questions about the criteria for membership. The current membership criteria are:

**Members** in CoPGTP are training entities with at least one geropsychologist engaged actively in training (or having engaged actively in training). Members offer didactic and/or experiential training in geropsychology, which may occur in a range of settings. Members of the training council are programs rather than individuals. However, it is recognized that training programs in professional geropsychology may, and often do, consist of one geropsychologist supervising training in one or more settings. A “program” consisting of one individual may join as a full member of the council if the individual is a professional geropsychologist who provides didactic and/or experiential geropsychological training as a core part of their work that assists trainees in meeting one or more of the Pikes Peak competency areas. Alternatively, an individual may join as an associate member if these conditions are not met.

**Associate Members** in CoPGTP are training entities, including individual trainers, that show significant interest and current or past substantive involvement in geropsychology training even though the training entity does not meet criteria for full membership.

**Geropsychologists** are psychologists with knowledge, skill, training, and experience related to the aging process who specialize in assessment and intervention with older persons. As an aspirational goal, the geropsychologist(s) affiliated with a professional geropsychology training program should themselves have been trained in a program that provides training in core elements of geropsychology at one or more of the following levels of training: graduate school, internship, and/or post-doctoral level. However, it is also understood that training in geropsychology can occur in many different ways and at different points in an individual’s career. Therefore, if a professional has obtained a combination of substantive independent learning experiences or has a history of sustained clinical practice in applied geropsychology setting(s), then this may also provide the basis for competent geropsychology practice and training. At the Membership Committee's discretion, a combination of substantive independent learning experiences and practice in applied geropsychology setting(s) may also provide the basis for competent geropsychology practice and training.

The CoPGTP board continues to make efforts to communicate with our members and solicit feedback via our annual dinner meeting and via distribution of the minutes from our monthly phone meetings on the listserv. Please make note of the following information about our upcoming annual dinner meeting:

**What:** CoPGTP Annual Dinner Meeting
**When:** Thursday, November 19 at 7pm at the GSA Annual Scientific Meeting
**Where:** Il Mulino, a restaurant in the conference hotel, the Swan and Dolphin
http://www.swandolphinrestaurants.com/ilmulino/
**Cost:** $50/person, with remaining cost subsidized by CoPGTP
**Agenda:** Formal agenda TBA, but expect an update on CoPGTP initiatives, formal distribution of awards, and time for fellowship with CoPGTP colleagues from near & far
**Registration:** Details to come closer to the meeting date. We hope to see all of you there!
Student Representative Report

Michelle Feng
USC / Boston Consortium, VA Boston Healthcare System

As one of the student representatives, I have taken on the project of redesigning the CoPGTP website, with the support of the website committee. In the past year, we collected feedback from trainees and CoPGTP members to help guide our redesign efforts. Together with a website designer, we are revamping the entire look and feel of the site with the objective of creating a smoother and more organized interface. On this new site, which we anticipate to go live by the end of the year, all outdated material will be removed and replaced with several helpful additions. For example, we have created an online application form for new applicants, which will make the membership application process seamless. We have also included direct links for members to pay dues online, as well as a form to contact the Council directly using an official CoPGTP email address. Furthermore, we are working to create a way for individual members to update their own training program information using a flexible format. We hope this will aid in keeping our website current and easy to use, with the goal of becoming the top resource for all who are interested in geropsychology training. Stay tuned!
Recent member publications


Karel, M., Sakai, E., & Molinari, V., Moye, J., & Carpenter, B. (Accepted for publication, 7/23/15) Training for geropsychology practice and supervision: Perspectives of geropsychology program graduates. Training and Education in Professional Psychology.

CoPGTP Board 2014

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Student Representatives:
Patricia Bamonti, Michelle Feng, Jon Gooblar, Stephanie Young

For prospective members

Membership in CoPGTP is open to programs in which at least one geropsychologist is currently or has recently been engaged in training. Members are required to offer didactic and/or experiential training. This training is offered in one or more settings that serve older adults. Importantly, members of the training council are training programs, which usually consist of more than one individual. That said, it is recognized that training programs in professional geropsychology may consist of only one geropsychologist. Associate (non-voting) membership is available also to individuals who are interested in, and are, or have been, involved in geropsychology training but do not meet the criteria for full membership. CoPGTP hosts an annual dinner and membership meeting at the APA or GSA conventions.

Benefits of membership include the following:

- Listserv venue for sharing training ideas, strategies, difficulties, and brainstorming solutions
- Sharing of opportunities for students and trainees
- Access to training competency documents and training models as they develop
- Relationship/consultation with other geropsychologists providing training
- Research grant opportunities offered each year
- An award for innovative training offered each year
- Invitation to an annual meeting with educational and networking opportunities, and
- Public acknowledgement of the entity as a recognized geropsychology training program.

You may download the application from our website (www.copgtp.org). Annual dues are $200 per calendar year for full membership; $100 per year for associate membership. If you have additional questions, please email any of the members-at-large listed on this page.

About CoPGTP

CoPGTP is an organization of programs providing training in geropsychology. It is committed to promoting excellence in training in professional geropsychology and to supporting the development of high quality programs at the graduate school, internship, postdoctoral fellowship, and post licensure levels. CoPGTP grew out of the June 2006 Geropsychology Training Conference which produced the Pikes Peak Model of Geropsychology Training.