VA New York Harbor Healthcare System-Brooklyn Campus
Postdoctoral Residency in Geropsychology
2024-2025 Training Year

Updated December 2023

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Fully Accredited by the American Psychological Association
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Please note that the application deadline for our program is December 1, 2023, 11:59PM ET
See page 15 for Program Admissions, Support and Initial Placement Data

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I. Introduction

Thank you for your interest in the Geropsychology Postdoctoral Residency program at the VA NY Harbor Healthcare System (VA NYHHS) Brooklyn campus. Training in geropsychology has become vital as the general US population ages. By 2030 one in five Americans will be 65 or older which will be the fastest growing segment of the population (US Census Bureau, 2020). The 65-and-older population grew by over a third (34.2% or 13,787,044) during the past decade, and by 3.2% (1,688,924) from just 2018 to 2019.

The American Psychological Association's Blueprint for Change: Achieving Integrated Health Care for an Aging Population (2007) highlighted the overall necessity of supporting and developing an interdisciplinary health care system in which psychologists would play a vital role in assessment, intervention and consultation across a broad range of settings in which older adults are served. In 2010, Geropsychology received specialty status by APA and in 2013 Geropsychology was recognized as a specialty by the American Board of Professional Psychology (ABPP). Our training program received full accreditation by APA's Commission on Accreditation in the Geropsychology specialty in 2015 and has continued to adapt over time to the developments and identified training needs of our future generation of geropsychologists as this specialty has grown and expanded. The program has an APA re-accreditation site visit scheduled for March 2024.

Our training program provides a broad range of clinical and didactic experiences with a wide range of older Veterans across a variety of treatment settings. Residents are able to work with supervisory training staff who have specialty training and experience in geropsychology, health psychology and neuropsychology. The program maintains a strong emphasis on geriatric neuropsychology and integrating cognitive assessment and intervention across many clinical settings. Many of our graduates continue their careers as geropsychologists within the VA as well as in settings outside of VA.

II. VA New York Harbor System Overview

a. General Hospital Setting

The VA New York Harbor Healthcare System (VANYHHS) Brooklyn main medical campus is located in Bay Ridge, Brooklyn, a diverse and bustling neighborhood in New York City. The Brooklyn VA also includes a campus in St. Alban's, Queens and a Community-Based Outpatient Clinic (CBOC) in Staten Island. Each campus has a parking lot and many do drive cars to the facility. In addition, the Brooklyn campus is accessible by a variety of MTA bus and subway lines and the St. Alban's campus is accessible by the Long Island Railroad (from Atlantic Avenue station in Brooklyn or Penn Station in Manhattan).

The VANYHHS Brooklyn Campus is a full-service medical center and is affiliated with the State University of NY - Downstate Medical Center. The medical center is fully accredited by Joint Commission and is a full-service teaching hospital providing comprehensive coverage of all medical, surgical and dental specialties. In addition to Psychology practicum, pre-doctoral internship and postdoctoral residencies,

the medical center maintains residencies in all medical specialties and subspecialties. Many additional training programs are offered in nursing and other allied healthcare professions which allows for a rich interaction between psychology postdoctoral residents and other allied health trainees. Another advantage of working in our urban medical center is being part of a racially and culturally diverse staff (Black/AA 30%; Asian 14%; White 28%; Veteran 15%).

b. Mental Health Service/Psychology Section

Psychology is a section within the overall Mental Health Service which is comprised of psychiatrists, psychologists, social workers, and peer specialists under the overall leadership of the Associate Chief of Staff for Mental Health. The psychology service is headed by a section Chief of Psychology at each of the Manhattan and the Brooklyn campuses. There are 30 psychologists on staff across the sites included in the Brooklyn psychology service who provide consultation, mental and behavioral health services, and neuropsychological and psychological assessment throughout a variety of clinics, residential programs and inpatient services.

c. Clinical Training Opportunities with Older Adults

As an urban Medical Center, there is a patient population of male and female Veterans, their spouses and occasionally children who are from a diverse mix of cultural and religious backgrounds and who represent all ages and socio-economic groups. A large percentage of these are Veterans over the age of 65. In fiscal year 2023, the VA NYH Brooklyn campus treated over 27,000 patients, with over 13,000 being 65 years of age and older. The CLC has 142 beds including a specialized palliative care unit and a dementia unit. Our veteran population is racially diverse as well (40% White/Caucasian, 39% Black/African American; 4% Asian). The diversity and breadth of our older adult patient population renders our VA a prime training location for those specializing in working with older adults.

All of the residents' training takes place at the Brooklyn Campus of VA NYHHS. The Brooklyn Campus is a highly complex, three division, academically affiliated facility. It consists of the Medical Center in Bay Ridge, Brooklyn; the Primary and Extended Care Center including the Community Living Center (CLC) at St. Albans, Queens; and a Veterans Healthcare Community Based Outpatient Clinic (CBOC) in Staten Island. Residents' training takes place at the Medical Center in Bay Ridge and at the St. Alban's campus in various clinic areas including geriatric primary care, hematology/oncology/palliative care, geriatric neuropsychology, long-term extended care/community living center (CLC), and home-based primary care (HBPC).

d. Facility Support

Residents share an office space together and also have an office in their rotation's clinical areas. Residents will be assigned their own VA laptop computer which can be used on-site and remotely when telework is approved. Cars are provided by the VA for travel in the Home-Based Primary Care program. The full-service newly designed Learning Resource Center is under construction and adds to the additional Learning Resource online availability: VA clinical databases - Learning Resources Center - LibGuides at VA NY Harbor Healthcare System. The Brooklyn facility has a large parking lot directly behind the building to accommodate those who commute by car. Residents can also use the fitness gym located on the 16th floor at lunch hours.

III. Residency Program Description

a. Program Mission/Philosophy

The VANYHHS – Brooklyn Campus Postdoctoral Residency in Geropsychology is APA-accredited and offers a **Major Area of Study in the Specialty of Geropsychology**. At least 80% of trainee time is dedicated towards clinical, didactic, practical training and program development in the specialty of working with older adults.

The program mission is to develop focused and in-depth postdoctoral preparation for advanced practice in professional geropsychology. The program philosophy is based on the Scholar-Practitioner Model and utilizes the Pikes Peak Model for Training in Professional Geropsychology (Pike's Peak Geropsychology Knowledge and Skills Assessment Tool [copgtp.org]) as a guide for developing an individualized training plan to develop the advanced competencies defined by the program. . The program mission is consistent with the VA emphasis on high quality, integrated health care for Veterans, their families and caregivers.

b. Specific Qualifications for Applicants/Residents

The postdoctoral residency program seeks applicants with prior training and/or strong interest in geropsychology, health psychology, neuropsychology and with interprofessional collaboration across clinical settings. A background in neuropsychological assessment is recommended as this is heavily focused on in all training rotations; however strong interest in developing competencies in this area is also prioritized over experience. Additionally, prior training and/or interest in evidence-based psychotherapy practices and shorter-term interventions in medical settings is required. Most importantly, a strong interest in and commitment to working with Veterans, older adults and their families/caregivers, and people with medical illness across various settings is necessary.

Residents must also have a driver's license to be able to participate in the home-based primary care (HBPC) rotation.

Interviewing: The health and safety of our psychology trainees, along with the competent care of our nation's Veterans, is of utmost importance to us. Additionally, we are committed to recruiting and retaining a diverse group of applicants and do not want the financial or other challenges associated with travelling to our medical center for interviews to disadvantage anyone. In-person interviews may also be made available, alongside remote interviewing options. Should the choice between in-person and remote interview be available, applicants should feel comfortable choosing the interview modality of their preference. Interview modality will have no impact on ranking and selection of residents. Our interview process is an opportunity for our training staff to learn fully about our applicants as well as an opportunity for us to convey what it is like to train with our training program/staff and to work in our particular medical center with the interdisciplinary teams we collaborate with. We strive to provide a full and engaging interview process with either modality.

Vaccinations/Testing of Health Professions Trainees (HPTs):
Consistent with national VHA policy, all trainees onboarded/hired on or after November 22, 2021 must be fully vaccinated for COVID-19 (or have an approved exception) before beginning employment and/or training rotations with VA.

Health Professions Trainees (HPTs) are appointed as temporary employees of the Department of Veterans Affairs. As such, HPTs are subject to laws, policies, and guidelines posted for VA staff members. There are infrequent times in which this guidance can change during a training year which may create new requirements or responsibilities for HPTs. If employment requirements change during the course of a training year, HPTs will be notified of the change and impact as soon as possible and options provided. Our program will continue to provide high quality training in professional psychology while simultaneously keeping our trainees' health and wellness at the forefront. Please feel free to reach out should you have any questions.

Potential for Drug Testing
Please click the below link to see the **VA Drug-Free Workplace Program Guide for Veterans Health Administration (VHA) Health Professions Trainees (HPTs)**

https://tinyurl.com/yf7kk2oa

c. Program Aim and Competencies

Consistent with the Pikes Peak Model of Training in Professional Geropsychology, the program aims to prepare residents to be ethical and culturally sensitive future leaders in Geropsychology, with the ability to work independently in clinical practice with older adults in a range of professional roles and over multiple health service settings using evidence-based practices.

Program Competencies
In order to meet our program aim, the focus of training is on developing advanced competence in professional psychology practice and in the specialty of professional Geropsychology. We embrace a

competence-based training model that incorporates attainment of advanced competencies in both core postdoctoral level competencies and Geropsychology specific competencies. The following competencies are assessed at mid-year and end-of-year:

- Integration of Science and Practice
- Ethical and Legal Standards
- Individual and Cultural Diversity Issues
- Communication and Interpersonal Skills
- Assessment
- Intervention
- Consultation and Interprofessional/Interdisciplinary Systems
- Professional Values, Attitudes, and Behaviors
- Supervision and Teaching
- Advocacy

All residents are required to demonstrate competencies in these areas to complete the program.

d. Evaluations/Minimal Levels of Achievement

Residents receive formal competency-based evaluations at the mid-year (6-month) and end-of-year (12 month) period. The evaluation is completed by all supervising psychologists who are involved with the trainee for that period of time. (See appendix b for Postdoc Evaluation Form). Competency domains (and behavioral anchors) include those for profession-wide competencies as well as geropsychology-specific competencies.

Minimal levels of achievement in order to maintain good standing in the program and to complete the program are as follows: ratings of 4 or above on all competency global scores on the mid-year evaluations and 5 or above on final evaluations for all competency global scores at the end-of-year.

Postdoctoral residents also complete feedback (formally written and orally) to the training committee about supervisors, rotations, didactics and all aspects of the program. Residents are given the form Due Process, Remediation, and Grievance Procedures (see appendix c) during the orientation week so that they understand the rights and responsibilities of both trainees and supervisors and are aware of the processes for resolving concerns that could arise during the training year.

e. Rotations and Clinic Assignments

(Please also see below section entitled: Response and Adaptations to Training Program due to COVID-19; page 12)

Rotations and assignments have been established with the training needs and aims of the residency program in mind. Residents participate in both major and minor rotations in order to be exposed to the

range of older adult presentations from community-dwelling older adults to more frail and ill patients at the end of life across a range of treatment settings. In addition, each resident is allocated time in their training plan to choose a project specific to their interests in Geropsychology. This can be a quality improvement project, the development of new programming in a clinical area, or other options such as membership on a committee with the development of an individualized goal. Residents receive support from supervisors in developing this idea and setting appropriate goals throughout the training year.

Incoming Geropsychology residents complete the aspirational *Pikes Peak Geropsychology Knowledge and Skills Assessment Tool, version 1.4 (2013)* (see appendix a) to assess their level of competency in geropsychology practice at the beginning of the year in order to develop an individualized training plan (see appendix d; Postdoc Training Plan) with the training committee. This self-assessment is used again at the mid-year and end-of-year in order to continue to modify the training plan as needed.

Adaptations to residents' training assignments can be considered and adjusted as needed based on the unique training needs and interests of residents as well as related to any future guidelines or situations based on global health situations (e.g. COVID-19 considerations).

1. Major Rotations

Oncology/Palliative Care/Serious Medical Illness: The VA NY HHS CoA-accredited (Commission on Cancer) Cancer program provides high-quality and state-of-the art services to Veterans with a broad range of hematological/oncological diagnoses across the cancer care continuum. Psychology plays an important role on the interprofessional team and has contributed to many quality improvement projects to meet the requirements of the accredited cancer program. Oncology patients are seen in outpatient medical clinic, are treated in the chemotherapy suite and in radiation therapy and are followed by the oncology team when admitted onto the medical floors.

The interdisciplinary Palliative care team, comprised of an attending physician, oncology and palliative care social worker, nurse practitioner, reiki provider, and music/recreation therapy interns, chaplaincy fellows, psychology interns and residents, and medical students, residents, and fellows supports Veterans early and throughout the course of serious illness to help Veterans and their families to best achieve goals of care and quality of life consistent with the patient and families values. The palliative care team consults with the primary medical teams and assesses and follows patients in both outpatient and inpatient medical settings.

Residents participate in the following in conjunction with the oncology service and the palliative care service:

- medical rounds with the palliative care team;
- weekly interprofessional palliative care didactics;
- support of medical treatment and provide information, assistance and when needed;
- brief neuropsychological assessment and succinct, timely feedback to the team;
- capacity evaluation;

- interprofessional collaboration;
- health and behavior assessment and interventions;
- health and behavior assessment, interventions and psychotherapy for Veterans and their caregivers across inpatient, outpatient, and treatment settings to address the psychological, social, relational, and psychical changes associated with serious or life-limiting illness and end-of-life;
- psychotherapy/psychoeducation groups (cancer support groups, groups for specific diagnoses, meaning-centered psychotherapy groups);
- program development and outcome evaluation;
- goals of care discussions.

In addition, in collaboration with Renal Medicine, fellows are also referred Veteran's on dialysis with co-morbid psychosocial distress, cognitive and/or psychiatric concerns, providing chairside assessment and intervention in the dialysis unit and opportunities for collaboration and consultation with the Veterans Renal treatment team. Opportunities may also be available to conduct comprehensive Mental Health Evaluations for Candidacy for Kidney Transplant, as well as Mental Health Evaluations for Spinal Cord Stimulator Implantation.

Primary Care Geriatric Clinic: Residents will be involved in a comprehensive Geriatric Primary Care Clinic (GeriPACT) Geriatric Patient Aligned Care Team GeriPACT - Geriatrics and Extended Care (va.gov) that attends to the biopsychosocial needs of older adult Veterans and considers contextual and social determinants of health and wellbeing. The postdoctoral resident will gain skills and experience in working within a fully integrated interdisciplinary team including the attending physician, medical students, social work, nursing, psychiatry, and pharmacy. Integrative and collaborative care is further supported through weekly team meetings of the staff, which includes case discussion as well as informal education through a journal club series. Residents may also provide services for geriatric patients who are connected to other primary care teams (PACT) in support of the overall primary care mental health integration (PCMHI).

Residents learn about and participate in providing the following activities:

- Same-day cognitive and emotional/behavioral health screening;
- Curbside consultation with other medical team members;
- Individual therapy and caregiver interventions within a time-limited and "problem-focused" manner:
    - Examples: Problem-Solving Therapy, Cognitive Behavioral Therapy (as well as integration of mindfulness-based approaches), Acceptance and Commitment Therapy, Motivational Interviewing; REACH-OUT caregiver interventions;
- Integration of "Whole Health" approach treatment that provides Veterans with patient-centered, personalized, and proactive health care;
- Focused neuropsychological assessment and feedback with a focus on common concerns within geriatric neuropsychology (e.g., dementia vs. mood disorder) and learning about the clinical

utility of neuropsychology when working with the oldest of old and geriatric neuropsychology broadly;
- Identify and integrate cultural and diversity factors into assessment and intervention services;
- Quality improvement projects, program development and outcome evaluation;

2. Minor Rotations

Home-Based Primary Care: Home-based primary care (HBPC) HBPC offers a PACT model for Veterans with significant support needs surrounding serious medical and mental health diagnoses that prevent them from engaging regularly in medically necessary outpatient primary care. Members of the HBPC team include a palliative care physician, the program manager, medical support assistance, nurse practitioner, RN, social work, nutrition, physical therapy, and psychology, which serves as a consultant to the HBPC team. Residents learn to provide psychosocial, psychiatric, and brief neuropsychological assessment as well as psychotherapy and behavioral treatment for older adults with serious medical illness and their families/caregivers, in the home setting. The home context allows Residents to expand and challenge their understanding of traditional psychotherapeutic frames and to enhance their ability to assess and integrate the psychosocial factors, particularly the family systems and social and structural determinants of health, into their assessment and case conceptualization, to strengthen their skills in interdisciplinary consultation and collaboration, and to develop increasing flexibility in adapting and delivering evidence-based interventions. Given the increasing diversity of our older adult veterans in terms of race, identity, generation, socioeconomic status, and so on, Residents will have the opportunity to build greater confidence and competence in providing culturally appropriate care. Cases can vary widely, and Residents may have the opportunity to offer psychotherapy for the treatment of depressive and anxiety-related disorders, substance use, phase-of-life, developmental, and adjustment issues secondary to medical illness and disability, as well as opportunities to provide caregiver support, including treatments such as REACH VA.

Saint Albans CLC (including Palliative Care/Hospice Unit) Community Living Centers - Home (sharepoint.com) Community Living Centers (VA Nursing Homes) - Geriatrics and Extended Care: Residents will work on state-of-the-art palliative care unit in CLC as well as other long-term care units, providing assessment and intervention with patients and families around serious illness and end of life issues. Residents will participate weekly in interdisciplinary team meetings. Residents will gain additional neuropsychology training in the CLC doing bedside assessment, and capacity evaluations. Residents can also be involved in ongoing initiatives to improve the management of behavioral issues that impact Veterans and staff on the units (Staff Training in Assisted Living Residences-VA (**STAR-VA**), CLCs Ongoing National Center for Enhancing Resources and Training (**CONCERT** Home - CONCERT: CLCs' Ongoing National Center for Enhancing Resources & Training (sharepoint.com) as well as additional educational initiatives for supporting staff working with older adults with complex needs associated with cognitive impairment and multiple comorbid medical issues within the CLC.

3. Additional Training Assignments

Residents participate in the following additional training activities throughout the year:

Geriatric Neuropsychology Clinic: Residents complete neuropsychological assessment on older adults who are referred for evaluation of cognitive/emotional disorders. Consults are received from many different disciplines and clinics. Neuropsychology clinic follow-up interventions are provided following evaluation for many Veterans and families. Inpatient/bedside assessments are also managed through the neuropsychology clinic.

Geriatric Mental Health Psychotherapy: Residents develop an EBP (e.g. CBT, MI, MCP, ACT, PST) outpatient caseload of older adults and their family members in need of mental health services via direct observation and demonstration by staff and audio tape supervision.

Quality Improvement/Program Development/Special Project: Residents work with supervisors to develop and participate in a special project that could include quality improvement, program development, or other role that contributes to the resident's particular interests/goals and furthers the goals of the training program. Residents are also supported in completing professional papers and presentations. Another option is participation in a project related to diversity, equity and inclusion. We understand that residents enter our program with varying levels of experience and competence in this area and our training staff is committed to working with trainees to develop a plan to advance their training and competence in this area. Leading a project on the hospital's Alliance for Healthcare Equity, Accountability, and Diversity (AHEAD) is one example of an opportunity available to residents.

Healthy Sleep Group and Cognitive Behavioral Therapy for Insomnia (CBT-I): Residents will have the opportunity to cope facilitate the healthy sleep group, a well-attended bimonthly psychoeducational group for Veterans with sleep complaints, and to carry at least two CBT-I cases throughout the year, with the possibility for more, should residents' interest and schedule permit.

Supervision of Interns/Externs and Teaching: In order to develop advanced postdoctoral competencies, residents supervise a psychology extern or intern throughout the course of the year. Residents learn to provide competency-based supervision in weekly supervision sessions, as well as by modeling and accompanying their supervisees in a number of different clinical experiences. Residents also participate in various teaching activities throughout the year (e.g. present at MH Grand Rounds, provide a monthly Geropsychology seminar to psychology interns, present to interprofessional geriatric team).

f. Workload

Residents have a graduated patient workload that follows their initial adjustment, past experiences and comfort level with the area of specialty in their rotations, building to 25-30 hours of direct patient care. Workload may also be adjusted throughout the year based on other demands and interests that the resident may express.

g. Supervision

Each resident will have at least 2 supervisors across major and minor rotations. When residents are on-site and seeing Veterans in person, at least one supervisor will also be available on-site. Supervisors are also available in-person or by telephone or video for immediate crises or issues that arise. Residents are provided with a minimum of two hours of individual supervision with psychology staff who are on the training committee. Psychology supervisory staff will co-lead, role-model and demonstrate intervention, assessment and consultation techniques with older adult patients in all assigned areas of service delivery. In addition, psychology staff maintains an open-door policy and residents can request additional supervision/consultation and/or brief clinical discussions at any time. Interprofessional huddles occur often in order to coordinate treatment and discuss developments with patients in clinical work areas.

h. Seminars

VA Multi-Site Geropsychology Postdoctoral Seminar (weekly): This seminar covers a sequence of topics ranging from the development of geropsychology as a specialty practice, normal aging and development, assessment of older adults, specific interventions and treatments, and a broad range of other topics specific to geropsychology practice (e.g. supervision, diversity/multicultural issues, and professional and career development). This seminar was developed to provide a forum for geropsychology postdoctoral residents to form their own community and to be exposed to the growing community of geropsychology supervisors across the VA. Opportunities for further connection to the geropsychology postdoctoral community are provided through this seminar group.

Evidence-based Psychotherapy (EBP) (weekly): This seminar covers EBP (ACT-D, CBT-I, CBT-D, MI, CBT-CP, and MCP) didactics and training, as well as case presentation and supervision. Shorter-term evidence-based psychotherapies adapted for use in primary-care mental health models are also covered. This seminar is held over video platform with postdoctoral residents at our Manhattan VA campus with the goal of providing other opportunities for our residents to connect and form relationships with their training colleagues.

Supervision Seminar: This monthly seminar is didactic and focuses on competency-based supervision model. It is held over video with Manhattan VA postdoctoral residents and allows for discussion of supervision experiences that residents are having in their supervision practice. Throughout the year, multicultural competence in supervision is interwoven through all didactics and discussion.

VA Geropsychology Webinars: VA webinars and in-person conferences and learning opportunities relevant to current resident cases or training needs are assigned on a regular basis. The VA Geropsychology Community of Practice is continuing to grow with a large number of seminars, presentations and ability to connect to the larger VA geropsychology community. Geropsychology postdoctoral residents are always supported in becoming involved in leadership roles on various geropsychology committees, etc. throughout the VA.

Other Seminar Offerings (availability each year is dependent on staffing and individual postdoc's schedules):

Neuropsychology Seminar: This seminar covers didactics in many topics related to neuropsychological assessment as well as neurological disorders associated with aging. Case material is reviewed and discussed in the group format.

Multicultural and Diversity Issues: This seminar is didactic and has an interactive component including case material to address multicultural and diversity issues specifically related to working with older adults.

Ethics Seminar: Residents will become knowledgeable about primary ethical and professional issues in geropsychology. Residents will learn to anticipate, avoid, and resolve ethical challenges.

Interdisciplinary Geriatric Team Journal Club: Residents can participate in a journal club with the geriatric primary care team. Participants include medical students, residents and fellows, attending physician, psychiatrist, pharmacist, social worker, psychology residents and supervisors. The journal club has been enthusiastically attended by all and has fostered an increasing interest in psychology/neuropsychology by medical students, residents and fellows.

Interdisciplinary Palliative Care Didactics: Residents participate in weekly brown bag, practice-based seminars lead by members of the palliative care team, focused on improving knowledge of the different contributions of the disciplines to palliative care, important interdisciplinary issues in palliative care, and key cross-disciplinary competences, and are expected to present themselves while on this rotation.

i. Response and Adaptations to Training Program Due to COVID-19 Pandemic

The COVID-19 pandemic required modifications and adaptations to our already established training program's policies and practices beginning in 2020. We worked to balance training and service delivery needs with personal and public health and safety. Our adaptations were made with ongoing consultation with the Office of Academic Affiliations (OAA), APA Commission on Accreditation (CoA) and other organizations who guide and monitor programs and trainee preparation to work in health service psychology. In the future, our training program will continue to adapt as needed if and when these issues become primary again.

In response to the COVID-19 pandemic, mental health staff were approved to telework 2 days/week if their clinical responsibilities accommodated that schedule. This work schedule has continued and will likely be permanent. The particular training rotations and clinical responsibilities of the resident will determine if/when a resident may telework. All staff and trainees are available to provide a percentage of their clinical work to patients over telehealth, including Veteran Video Connect (VVC) and telephone (minimally) which is a necessary competency for professional psychologists into the

future. Supervision for sessions held in-person will always be provided by a supervisor who is also on-site for that clinical visit. Any face-to-face contact will be done with appropriate PPE and considerations towards the trainees' individual circumstances, comfort level and safety.

IV. Commitment to Diversity

One of the benefits of our residency training program is the great diversity of the Veterans that we serve in New York City. The postdoctoral residency has always been committed to promoting awareness of and respect for multiculturalism and all aspects of diversity as well as to inculcate cultural humility and a lifelong commitment to self-evaluation and self-critique in order to be competent providers of mental and behavioral health care for older adults and their families. Residents have been encouraged and supported in evaluating and contributing to initiatives to continue to promote and grow a culture of acceptance and inclusivity throughout the medical center. We continue to expand our consideration of diversity and multiculturalism to include theoretical models in psychotherapy and assessment, delivery of care, research paradigms and all aspects of professional practice. As noted above in the section detailing seminars, residents participate in a variety of year-long seminars that interweave multicultural and diversity awareness to inform all levels of psychology practice as well as participate in other training opportunities to support our commitment to cultural humility in the practice of geropsychology.

As a psychology department, members of training committees, and as members of a larger hospital-based institution, we have taken active steps toward assessing our own biases and roles in contributing to racial inequities. We have made a commitment to continue our growth with continued self-reflection and action steps in our Psychology department's Multicultural Diversity Committee (MDC), on our training committees and in our psychology and mental health staff meetings. Additionally, our hospital's Alliance for Healthcare Equity, Accountability, and Diversity (AHEAD) includes many members of our psychology staff on this interprofessional committee and provides concrete services and support to staff and clinicians throughout the hospital around diversity issues and educates and provides support to the hospital administration around programming and best practices to support equity and diversity throughout the hospital.

Trainees (postdoc residents and interns) are encouraged to and have opportunities to be members on either of these committees and to participate in projects. In addition to year-long seminars and continued focus on maintaining a diversity and multicultural lens in assessment, intervention and research, postdoctoral residents will also participate in other training experiences (e.g. book clubs, department/hospital events to support diversity) with other trainees and staff.

We are committed to improving our recruitment and retention of diverse trainees and staff, fostering an inclusive, accepting and equitable environment for our Veterans, staff and trainees, and bringing a focus on multicultural/diversity competence throughout our clinical work and training and supervision of our future psychologists.

Efforts to recruit and support residents from diverse backgrounds are continually evaluated and prioritized with the goal of developing a pipeline to continue to diversify our psychology staff as psychology trainees often become employed in our service. With this in mind, resident applicants from diverse groups who are underrepresented in professional psychology are highly encouraged to apply.

V. Postdoctoral Residency Program Admissions, Support and Initial Placement Data
Date Program Tables are updated: October 4, 2023

Postdoctoral Residency Admissions, Support, and Initial Placement Data

Program Disclosures	
Does the program or institution require students, trainees, and/or staff (faculty) to comply with specific policies or practices related to the institution's affiliation or purpose? Such policies or practices may include, but are not limited to, admissions, hiring, retention policies, and/or requirements for completion that express mission and values?	No
If yes, provide website link (or content from brochure) where this specific information is presented:	NA
Postdoctoral Program Admissions	
Briefly describe in narrative form important information to assist potential applicants in assessing their likely fit with your program. This description must be consistent with the program's policies on resident selection and intern and academic preparation requirements:	
The postdoctoral residency program seeks applicants with some prior training in geropsychology, health psychology and in medical settings with interprofessional teams. It is expected to have some training experience in neuropsychological assessment as this is heavily focused on in all training rotations. Additionally, prior training and interest in shorter-term evidence-based treatments (e.g. cognitive-behavioral) that are useful in the medical setting is required. Most importantly, a strong interest in and commitment to working with older adults across various settings is necessary.	
Describe any other required minimum criteria used to screen applicants: None	
Applicants must meet the following prerequisites to be considered for our postdoctoral training program: 1. Completion of doctoral degree, including defense of dissertation, from a clinical or counseling psychology doctoral programs accredited by the American Psychological Association (APA) or	

the Canadian Psychological Association (CPA) before the start date of the residency. 2. Completion of an APA-accredited psychology internship program 3. U.S. citizenship. 4. Matched postdoctoral residents are subject to fingerprinting, background checks, and a urine drug screen. 5. Male applicants born after 12/31/1959 must have registered for the draft by age 26. *** Failure to meet these qualifications could nullify an offer to an applicant.	
Financial and Other Benefit Support for Upcoming Training Year*	
Annual Stipend/Salary for Full-time Residents	$60,446
Annual Stipend/Salary for Half-time Residents	NA
Program provides access to medical insurance for Residents?	Yes
If access to medical insurance is provided:	
Trainee contribution to cost required?	Yes
Coverage of family member(s) available?	Yes
Coverage of legally married partner available?	Yes
Coverage of domestic partner available?	No
Hours of Annual Paid Personal Time Off (PTO and/or Vacation)	104
Hours of Annual Paid Sick Leave	104
In the event of medical conditions and/or family needs that require extended leave, does the program allow reasonable unpaid leave to interns/residents in excess of personal time off and sick leave?	Yes
Other Benefits (please describe):	Authorized absence for professional development; 5 days
*Note. Programs are not required by the Commission on Accreditation to provide all benefits listed in this table.	
Initial Post-Residency Positions	
(Provide an Aggregated Tally for the Preceding 3 Cohorts)	TY 2021-2024
Total # of residents in the 3 cohorts	2
Total # of residents who remained in the training program	0
Academic teaching	PD=0, EP=0
Community mental health center	PD=0, EP=0

Consortium	PD=0, EP=0
University Counseling Center	PD=0, EP=0
Hospital/Medical Center	PD=0, EP=0
Veterans Affairs Health Care System	PD=0, EP=1
Psychiatric facility	PD=0, EP=0
Correctional facility	PD=0, EP=0
Health maintenance organization	PD=0, EP=0
School district/system	PD=0, EP=0
Independent practice setting	PD=0, EP=0
Other	PD=0, EP=1
Note: "PD" = Post-doctoral residency position; "EP" = Employed Position. Each individual represented in this table should be counted only one time. For former trainees working in more than one setting, select the setting that represents their primary position.	

VI. Faculty and Consultants

Director of Training- Postdoctoral Residency in Geropsychology

Valerie Abel, Psy.D., ABPP
Ferkauf Graduate School of Psychology, 1997
Clinical Psychologist and Neuropsychologist
Section Chief of Psychology – Brooklyn Campus
Postdoctoral Certification, Fielding Institute, Neuropsychology
Board Certified in Geropsychology
Board Member, New York State Association of Neuropsychology (2015-2018)
Board Member, Council of Professional Geropsychology Training Programs (2017-2020)
Clinical activities: Neuropsychological assessment; geropsychology; psycho-oncology; health psychology; evidence-based psychotherapy with older adults; LEAN technology; telehealth
Research and writing interests: Health care delivery systems; integrated health care; new models in geropsychology services.

Other Psychology Supervisors

Shane S. Bush, Ph.D., ABPP
California School of Professional Psychology-Alameda, 1995
Clinical Psychologist and Neuropsychologist, St. Albans Extended Care
Board Certified in Rehabilitation Psychology, Clinical Neuropsychology, Clinical Psychology, and Geropsychology
Fellow, American Psychological Association and National Academy of Neuropsychology
President, American Board of Geropsychology
Past-Chair, Council of Professional Geropsychology Training Programs (CoPGTP)

Past President (2010), National Academy of Neuropsychology
Activities: Psychological and neuropsychological assessment and treatment, cognitive-behavioral therapy
Research/Scholarly Interests: Ethical and professional issues, symptom and performance validity

Sabrina Esbitt, PhD
Ferkauf Graduate School of Psychology, Yeshiva University, 2014
Certificate in Public Health, Institute for Public Health Sciences, Albert Einstein College of Medicine, Yeshiva University, 2011
Clinical Psychologist, Brooklyn Campus, New York Harbor Healthcare System
LGBTQ+ Veteran Care Coordinator
Fellow, New York State Psychological Association, NY
Past Federal Advocacy Coordinator, New York State, American Psychological Association Practice Organization
Past President, Early Career Psychology Division, New York Psychological Association
Activities: Psychological and neuropsychological assessment and treatment, cognitive-behavioral therapy
Clinical/Scholarly Interests: Psychosocial aspects of adjustment to chronic illness and end of life, palliative care psychology, self-reflective practice for medical providers, structural inequities in healthcare, integrated care, interdisciplinary health service provider education and training.

Wing Jin (Angel) Mak, Psy.D.
Ferkauf Graduate School of Psychology - Yeshiva University 2020
Clinical psychologist at Brooklyn VA in Homebased Primary Care (HBPC)
Co-chair of the Alliance for Healthcare, Equity, Accountability, and Diversity (AHEAD)
Co-director of the Brooklyn VA Externship Program
Clinical Supervisor for the Ferkauf Older Adult Program (FOAP)
Clinical/Research Interests: Caregiver burden, integrated care, dementia and aging, late-life sexuality, suicide and suicidal behavior in older adults, disparities in mental health

Julija Stelmokas, Psy.D., ABPP
Board Certified in Clinical Neuropsychology
Pacific University
Psychologist at Brooklyn VA in Outpatient Neuropsychology and Geriatric Patient Aligned Care Team (GeriPACT)
Clinical Assistant Professor University of Michigan Department of Psychiatry
Clinical Interests: Geriatric and rehabilitation neuropsychology, integration of motivational interviewing in mental health interventions and neuropsychological assessment/feedback, and implementation of empirically supported treatment, specifically Acceptance and Commitment therapy and Problem-Solving therapy

Research/Scholarly Interests: Neuropsychology service delivery (i.e., tele-neuropsychology, co-located care), social determinants of health, aging and dementia, cognitive screening.

Consultants Involved in Training

Anthony J. Brinn, Psy.D., Yeshiva University
Clinical Psychologist (NYHHS – Manhattan campus)
Didactic Seminars

Karenjot Kaur, Ph.D., Yeshiva University
Clinical Psychologist (NYHHS – Manhattan Campus)
Didactic Seminars

Justin Pomerenke, Ph.D., Hofstra University
Clinical Psychologist (NYU Steven A. Cohen Military Family Center)
Didactic Seminars

VII. Application Information

VA New York Harbor Health Care System
Brooklyn Campus
Postdoctoral Residency in Geropsychology
2024-2025 Training Year

We are recruiting 2 residents for our one-year Postdoctoral Residency in Geropsychology. Geropsychology residents will have experiences in neuropsychological assessment, geriatric primary care and memory disorders clinic, geriatric cognitive rehabilitation, palliative care, psycho-oncology, and home-based primary care. Training in supervision, teaching, and quality improvement projects are additional components of the training year.

The VA is an Equal Opportunity Employer. We are committed to diversity in the VA and in our training programs. Applicants from all diverse backgrounds regarding ethnic, racial, gender and personal backgrounds are strongly encouraged to apply.

Deadline for submission of application materials: December 1, 2023; 11:59PM ET
Start Date: August 26, 2024
Stipend: $60,446
Benefits: 13 days annual leave, up to 13 days sick leave, health insurance

The Postdoctoral Residency Program in Geropsychology is accredited by the Commission on Accreditation of the American Psychological Association and is expecting an APA site visit for re-accreditation in March 2024.

General Qualifications
Eligible candidates must:

- be a U.S. citizen.
- be a student in good standing in an APA-accredited Clinical or Counseling psychology doctoral program, AND
- have completed a doctoral degree, including dissertation defense, from an APA or CPA-accredited Clinical or Counseling, or Combined Psychology or PCSAS accredited Clinical Science program prior to the start date of the fellowship. Note: Persons with a Ph.D. in another area of psychology who meet the APA criteria for respecialization training in Clinical or Counseling Psychology are also eligible to apply.
- successfully complete an APA or CPA-accredited psychology internship or completed a VA-sponsored internship. Exceptions: new VHA psychology internship programs that are in the process of applying for APA accreditation are acceptable in fulfillment of the internship requirement, provided that such programs were sanctioned by the VHA Central Office Program Director for Psychology and the VHA Central Office of Academic Affiliations at the time that the individual was an intern.

Additional Resources for Psychology Trainees (Eligibility/Benefits/Onboarding)
Resources for Health Professions Trainees Coming to VA | Eligibility and Forms - Office of Academic Affiliations

Trainee Qualifications and Credentials Verification Letter (TQCVL) - Office of Academic Affiliations (va.gov).

Policies

The VA New York Harbor postdoctoral residents program complies with all guidelines set forth by the Association of Psychology, Postdoctoral and Internship Centers (APPIC). These policies can be accessed at the APPIC website www.appic.org.

The residents program also abides by all American Psychological Association guidelines and requirements. The program is scheduled for an APA re-accreditation site-visit in March 2024. Questions related to the program's accredited status should be directed to the Commission on Accreditation:

Office of Program Consultation and Accreditation
American Psychological Association
750 First Street, NE
Washington, DC, 20002
(202) 336-5979
E-mail: apaaccred@apa.org
Web: www.apa.org/ed/accreditation

Application, Selection and Interview Process

We participate in the APPIC Psychology Postdoctoral Application Centralized Application Service (APPA-CAS). Please submit all the following application materials to the APPIC portal (https://appicpostdoc.liaisoncas.com).

They must be received by December 1, 2023; 11:59PM ET.

- Statement of Interest
- Three letters of recommendation from clinical supervisors
- A letter of support from current Internship Training Director indicating that you are in good standing to successfully complete your predoctoral internship, including completion date. If already completed, mail a copy of your predoctoral internship certificate.
- If you have not completed your doctoral degree, include a letter from your dissertation chairperson describing your dissertation status and timeline.
- Current CV
- Graduate transcript

All completed applications are reviewed by the Training Committee. Based on a systematic review of all applications, some candidates are invited to interview**. We aim to notify all applicants regarding their interview status by December 22, 2023. All interviews will be held over a virtual platform due**

to our commitment to reducing barriers to travelling to NYC. We plan to hold interviews the first and second weeks of January.

Please note: We will begin making offers by the second or third week of January and will abide by the Common Hold Date (February 26, 2024). Please refer to Postdoctoral Selection Standards Postdoctoral Selection Standards (appic.org) **for standards and procedures for programs and applicants.**

Please direct questions to: Valerie Abel, Psy.D., ABPP
Section Chief of Psychology
Director of Training
Postdoctoral Residency in Geropsychology
VA NY Harbor Healthcare System
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Brooklyn, NY 11209
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APPENDIXES

Appendix A: Pikes Peak Geropsychology Knowledge and Skill Assessment Tool

Version 1.4, Council of Professional Geropsychology Training Programs

Purpose

This evaluation tool is for learners who are working to develop knowledge and skills for providing optimal care to older adults, their families, and related care systems. Psychology trainees, their supervisors, and practicing psychologists may use this tool to evaluate progress in developing geropsychology competencies, and to help define ongoing learning goals and training needs.

Pikes Peak Competencies

Competencies for professional geropsychology practice were delineated during the 2006 National Conference on Training in Professional Geropsychology. Taken together, the competencies are aspirational, rather than "required" of any particular psychologist. Even the most accomplished geropsychologist will have relative strengths and weaknesses across the spectrum of competencies for geropsychology. The conference produced the Pikes Peak Model for Geropsychology Training (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009), and created the Council of Professional Geropsychology Training Programs (CoPGTP, see http://www.copgtp.org/). CoPGTP developed this competency evaluation tool for learners and supervisors to have a measure by which to gauge competence in serving older adults.[1] For the purposes of this evaluation tool, each Pikes Peak 24geropsychology knowledge and skill competency is specified by behaviorally descriptive items, and can be rated along a continuum from Novice to Expert. Some redundancy is inherent in this measure. The intent is to evaluate both the learner's knowledge base and skill set separately for the same domains, as the awareness of information and ability or experience in applying it may differ.

Geropsychology Practice

Geropsychologists provide assessment, intervention, consultation, and other professional services across a wide range of medical, mental health, residential, community, and other care settings with a population of demographically and socioculturally diverse older adults. The Pikes Peak competencies are applicable across varied geriatric care settings and populations. It is recognized also that each work area or training setting may call for the development of particular competencies, not all of which may be addressed in this document. Both the APA Guidelines for Psychological Practice with Older Adults (APA, 2004) and the Pikes Peak Model highlight core attitudes for practice with older adults. Although this tool does not evaluate attitudes explicitly, the knowledge and skill competencies reflect core geropsychology practice attitudes, including: recognition of scope of competence, self-awareness of attitudes and beliefs about aging and older adults, appreciation of diversity among older adults, and

commitment to continuing education.

Using the Competency Evaluation Tool

This tool is intended to be used both by supervisors to assess trainees, and by psychologists to assess their own knowledge and skills. Supervisors in geropsychology training programs may choose to evaluate the domains relevant to the goals of their program. Evaluation should include the learner's perspective (self-assessment), observation of the learner's work (e.g., direct observation, audiotape, videotape, co-therapy), as well as regular supervision involving case discussion. Psychologists and trainees conducting self-assessments can use the tool to evaluate their training and supervision needs in each area. The tool also can gauge a learner's progress over time.

The learner can be rated on each Pikes Peak knowledge domain and skill competency as Novice (N), Intermediate (I), Advanced (A), Proficient (P), or Expert (E), as described below. Each Pikes Peak competency (highlighted in light gray in the chart below) is delineated by several specifiers (indicate by letters a., b., c., etc. in the chart). The specifiers are designed to help define the knowledge domain or skill competency and do not need to be rated separately. However, the specifiers can be rated individually if that level of assessment is desired.

Rating Scale Anchors

This rating scale assumes that professional competence is developed over time, as learners develop knowledge and skills with ongoing education, training, and supervision. The anchors, then, reflect developmental levels of competence, from Novice through Expert. The scale is adapted from previous efforts, as summarized by Hatcher and Lassiter (2007). Because the scale reflects development of competence, the same scale can be used at different levels of training. For example, graduate practica students would be expected to perform at Novice through Advanced levels, while Postdoctoral Fellows in Geropsychology would be expected to perform from Intermediate to Proficient levels. Development of knowledge and skills may differ significantly across domains, depending upon previous training experiences.

To illustrate use of the scale, we provide a brief vignette and how an individual at each level might approach the case.

Vignette: *A 78-year-old Irish-American man is referred to the mental health clinic by his primary care physician because his daughter-in-law complained that, in recent months, he has become depressed and forgetful and is no longer involved in his hobbies. He has several chronic medical problems including mild diabetes and hypertension. His Korean-American wife o/52 years is angry that he is not completing his household chores. His three adult children have varied levels of involvement in his life, with one daughter and one son living nearby. He comes to the clinic for an initial evaluation.*

Novice (N): Possesses entry-level skills; needs intensive supervision.

Novices have limited knowledge and understanding of case conceptualization and intervention skills, and the processes and techniques of implementing them. Novices do not yet recognize consistent patterns of behavior relevant for diagnosis and care planning and do not differentiate well between important and unimportant details.

Example: The learner is able to identify salient symptoms, but does not appreciate possible contributions of medical, neurological, and family system factors to the older adult's presentation, and does not know how to formulate differential diagnosis questions.

Intermediate (I): Has a background of some exposure and experience; ongoing supervision is needed.

Experience has been gained through practice, supervision, and instruction. The learner is able to recognize important recurring issues and select appropriate strategies. Generalization of skills is limited and support is needed to guide performance.

Example: The learner recognizes multiple possible contributions to the older adult's presentation, is able to collect history from the patient (and his daughter-in-law, with his permission), administer depression and cognitive screening tools, and consult with supervisor to discuss possible implications and to plan further evaluation. Learner may not appreciate complex, late life family and cultural systems issues affecting patient's coping.

Advanced (A): Has solid experience, handles typical situations well; requires supervision for unusual or complex situations.

Knowledge of the competency domain is more integrated, including application of appropriate research literature. The learner is more fluent in the ability to recognize patterns and select appropriate strategies to guide diagnosis and treatment

Example: The learner is able to integrate multiple sources of information (e.g., behavioral observation, cognitive testing data, medical records, collateral reports) and complex history (medical, psychiatric, family, occupational, and cultural context) to rule out possibility of early dementia plus depression, and make recommendations to the primary care provider and family about further assessment and treatment options. Learner consults with supervisor about local resources for older adults, and how best to handle issues around wife's difficulty coping with patient's changes, related marital conflict, family dynamics, culture, and treatment planning.

Proficient (P): Functions autonomously, knows limits of ability; seeks supervision or consultation as needed.

Proficiency is demonstrated in perceiving situations as wholes and not only summations of parts, including an appreciation of longer term implications of current situation. The psychologist has a perspective on which of the many existing attributes and aspects in the present situation are important ones, and has developed a nuanced understanding of the clinical situation.

Example: Learner is able to integrate information, as above, collaborate with family and medical (e.g., psychiatrist, neurologist) and social service providers for ongoing assessment and intervention for the patient and family (e.g., psychoeducation, couple's therapy, explore community support options). Learner functions as a full member of an interdisciplinary team to address the biopsychosocial needs of the client and his family, and is able to assume a leadership role.

Expert (E): Serves as resource or consultant to others, is recognized as having expertise.

With significant background of experience, the geropsychologist is able to focus in on the essentials of the problem quickly and efficiently. Analytical problem solving is used to consider unfamiliar situations, or when initial impressions do not bear out.

Example: Learner is frequently contacted by other psychologists in her community to provide consultation regarding care of older adults with dementia. Learner is able to use the above case as a teaching example for the need to provide a thorough biopsychosocial assessment in geriatric care, to implement an interdisciplinary team plan, and to be knowledgeable about geriatric resources in the community.

NOTE: Ratings are only needed where the anchors are provided (highlighted in light gray). Specifiers (indicated by letters a., b., c., etc. in the chart) are designed to help define the knowledge domain or skill competency and do not need to be rated separately, unless that level of assessment is desired.

I. **General Knowledge about Adult Development, Aging and the Older Adult Population**					
A. The psychologist/trainee has *KNOWLEDGE* OF:					
1. Models of Aging	**N**	**I**	**A**	**P**	**E**
a. Development as a life-long process encompassing early to late life, and encompassing both gains and losses over the lifespan					
b. Different theories of late-life development and adaptation					
c. Biopsychosocial perspective for understanding an individual's physical and psychological development within the sociocultural context					
d. Concept of, and variables associated with, positive or successful aging					
e. Relevant research on adult development and aging, including methodological considerations in cross-sectional and longitudinal research.					
2. Demographics	**N**	**I**	**A**	**P**	**E**
a. Demographic trends of the aging population, including gender, racial, ethnic, and socioeconomic heterogeneity					
b. Resources to remain updated on the demographics of aging, including internet sites for: U.S. Census, Centers for Disease Control and Prevention, Social Security Administration, Bureau of Labor Statistics, National Institutes of Health, World Health Organization.					
3. Normal Aging - Biological, Psychological, Social Aspects	**N**	**I**	**A**	**P**	**E**
a. Physical changes in later life					
b. Normal aging as distinct from disease, regarding both physical and mental health					
c. Interactions among physical changes, health behaviors, stress, personality, and mental health in older adults					
d. Aging-related changes in sensory processes including vision, hearing, touch, taste, and smell					
e. Aging-related changes in sexual functioning					
f. Aging-related changes in cognitive processes, including attention, memory, executive functioning, language, and intellectual functions					
g. Aging-related changes in personality					
h. Aging-related changes in emotional expression and coping mechanisms					
1. Factors that influence vocational satisfaction, job performance, leisure activities, retirement satisfaction, and volunteer participation					
J. Family dynamics and role changes in aging families					
k. Changing social networks in late life, and value of close friendships in later life					
4. Diversity in Aging Experience	**N**	**I**	**A**	**P**	**E**
a. The diversity of the older adult population, and that age alone is a poor predictor of an individual's functioning					
b. The unique experience of each individual - based on demographic, sociocultural, and life experiences - and that multiple factors interact over the lifespan to influence an older individual's patterns of behavior					
c. Historical influences affecting particular cohorts					

II. Foundations of Professional Geropsychology Practice

A. Knowledge base - The psychologist/trainee has *KNOWLEDGE* OF:

1. Neuroscience of aging	N	I	A	P	E
a. The parameters of cognitive changes in normal aging, including their basis in age-related changes in the brain.					
b. Factors that influence levels of cognitive performance in older adults (e.g., genetics, socioeconomic status, cohort effects, health status, mood, medications/ substances)					
c. Common types of dementia in terms of onset, etiology, risk factors, clinical course, associated behavioral features, and medical management of these disorders					
d. Characteristics and causes of mild cognitive impairment and reversible cognitive impairment, including delirium, and the pathway to their management or reversal					
e. Clinical interventions which target behavioral features and psychological problems in individuals with cognitive disorders and their caregivers					
2. Functional Changes	**N**	**I**	**A**	**P**	**E**
a. Relationships between age, environment and functional level					
b. Definition and assessment of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)					
c. Relationship between functional abilities and decisions older adults make with regard to employment, healthcare, relationships, lifestyle and leisure activities, and living environment					
d. Relationship between functional ability and psychopathology in older adults, including how functional ability of older persons affects family members					
e. Strategies commonly used by older adults to cope with functional limitations					
3. Person-Environment Interaction and Adaptation	**N**	**I**	**A**	**P**	**E**
a. Interaction of an eider's abilities and needs with the demands and opportunities provided by various living and treatment environments (e.g., private homes, assisted living facilitates, nursing facilities)					
b. Impact of aging stereotypes on an older individual's functional status and self-efficacy					
c. Importance and complexities around issues of maintaining optimal independence and optimal safety, particularly when medical conditions and cognitive disorders impair the eider's functioning					
d. Ethical and legal issues which arise in the context of markedly impaired functional status and decision making capacity					
e. Situations and signs that suggest risk for abuse and neglect					
4. Psychopathology	**N**	**I**	**A**	**P**	**E**
a. Biopsychosocial etiological models, applied within a lifespan developmental and cohort relevant context, for major psychological disorders affecting older adults					
b. Differential presentation, associated features, age of onset, and course of common psychological disorders and syndromes in older adults (e.g., anxiety, depression, dementia, etc.)					
c. Variations in presentations of psychopathology in later life due to cohort, cognitive, medical and pharmacological issues, including lifelong mental illness and late onset mental illness					
d. Under-recognized aspects of psychopathology in late life which affect functional impairment and safety (e.g., suicide risk, substance use, complicated grief)					

e. Interaction of common mental illnesses with the more common medical illnesses and medications and implications involved for assessment and treatment	
f. Psychosocial, psychotherapeutic and psychopharmacological approaches to treating psychological disorders in older adults, as well as the health-related consequences of not treating and side effects of the possible treatments	
5. Medical Illness	**N I A P E**
a. Common medical and neurological problems (e.g. cardio- and cerebra-vascular disorders), syndromes (e.g. falls, incontinence), and substances or medications (e.g. alcohol, benzodiazepines, narcotics, over-the-counter remedies) associated with psychopathology in older adults	
b. Multiple pathways of interaction between medical illness and psychopathology in late life	
c. Common medical tests (e.g. thyroid function, urinalysis, CT/ MRI) relevant to differentiating medical and psychological illness in late life	
d. Relationships between chronic pain, functioning, and mental health in older adults (e.g. relationship of depression to pain)	
6. End of Life Issues	**N I A P E**
a. Physical, cognitive, emotional, and spiritual components of advanced illness and the dying process	
b. Diversity in ethnic, cultural, and spiritual beliefs and rituals involved in death and the dying process	
c. Models of hospice and palliative care	
d. Impact of advanced illness, caregiving, dying and death on family members	
e. Differences between normal grief reactions and complicated grief	
B. Professional Geropsychology Functioning - Foundational <u>SKILLS</u> – The psychologist/trainee is *ABLE TO:*	
1. Apply Ethical and Legal Standards by identifying, analyzing, and addressing:	**N I A P E**
Identify complex ethical and legal issues that arise in the care of older adults, analyze them accurately, and proactively address them, including:	
a. Tension between sometimes competing goals of promoting autonomy and protecting safety of at-risk older adults	
b. Decision making capacity and strategies for optimizing older adults' participation in informed consent regarding a wide range of medical, residential, financial, and other life decisions	
c. Surrogate decision-making as indicated regarding a wide range of medical, residential, financial, end of life, and other life decisions	
d. State and organizational laws and policies covering elder abuse, advance directives, conservatorship, guardianship, multiple relationships, and confidentiality	
2. Address Cultural and Individual Diversity with older adults, families, communities, and systems/providers by being able to:	**N I A P E**
a. Recognize gender, age, cohort, ethnic/racial, cultural, linguistic, socioeconomic, religious, disability, sexual orientation, gender identity, and urban/rural residence variations in the aging process	

b. Articulate integrative conceptualizations of multiple aspects of diversity influencing older clients, psychologists, and systems of care	
c. Adapt professional behavior in a culturally sensitive manner, as appropriate to the needs of the older client	
d. Work effectively with diverse providers, staff, and students in care settings serving older adults	
e. Demonstrate self-awareness and ability to recognize differences between the clinician's and the patient's values, attitudes, assumptions, hopes and fears related to aging, caregiving, illness, disability, social supports, medical care, dying, grief	
f. Initiate consultation with appropriate sources as needed to address specific diversity issues	
3. Recognize Importance of Teams	**N I A P E**
a. Understand the theory and science of geriatric team building	
b. Value the role that other providers play in the assessment and treatment of older clients	
c. Demonstrate awareness, appreciation, and respect for team experiences, values, and discipline-specific conceptual models	
d. Understand the importance of teamwork in geriatric settings to address the varied bio-psycho-social needs of older adults	
4. Practice Self-Reflection	**N I A P E**
a. Demonstrate awareness of personal biases, assumptions, stereotypes, and potential discomfort in working with older adults, particularly those of backgrounds divergent from the psychologist	
b. Monitor internal thoughts and feelings that may influence professional behavior, and adjust behavior accordingly in order to focus on needs of the patient, family, and treatment team	
c. Demonstrate accurate self-evaluation of knowledge and skill competencies related to work with diverse older adults, including those with particular diagnoses, or in particular care settings	
d. Initiate consultation with or referral to appropriate providers when uncertain about one's own competence	
e. Seek continuing education, training, supervision, and consultation to enhance geropsychology competencies related to practice	
5. Relate Effectively and Empathically	**N I A P E**
a. Use rapport and empathy in verbal and nonverbal behaviors to facilitate interactions with older adults, families, and care teams	
b. Form effective working alliance with wide range of older clients, families, colleagues, and other stakeholders	
c. Communicate new knowledge to patients and families, adjusting language and complexity of concepts based on the patient and family's level of sensory and cognitive capabilities, educational background, knowledge, values, and developmental stage	
d. Demonstrate awareness, appreciation, and respect for older patient, family, and team experiences, values, and conceptual models	
e. Demonstrate appreciation of client and organizational strengths, as well as deficits and challenges, and capitalize on strengths in planning interventions	
f. Tolerate and understand interpersonal conflict and differences within or between older patients, families, and team members, and negotiate conflict effectively	

6. Apply Scientific Knowledge	N	I	A	P	E
a. Demonstrate awareness of scientific knowledge base in adult development and aging; biomedical, psychological, and social gerontology; and geriatric health and mental health care; Incorporate this knowledge into geriatric health and mental health practice					
b. Apply review of available scientific literature to case conceptualization, treatment planning, and intervention					
c. Acknowledge strengths and limitations of knowledge base in application to individual case					
d. Demonstrate ability to cite scientific evidence on aging to support professional activities in academic, clinical and policy settings					
7. Practice Appropriate Business of Geropsychology	**N**	**I**	**A**	**P**	**E**
a. Demonstrate awareness of Medicare, Medicaid, and other insurance coverage for diagnostic conditions and health and mental health care services					
b. Demonstrate appropriate diagnostic and procedure coding for psychological services rendered					
c. Demonstrate medical record documentation that is consistent with Medicare, Medicaid, HIPAA, and other federal, state, or local or organizational regulations, including appropriate documentation of medical necessity for services					
d. Remain updated on policy and regulatory changes that affect practice, such as through professional newsletters and e-mail forums					
e. Demonstrate understanding of quality indicators for the care of older adults with mental disorders					
8. Advocate and Provide Care Coordination	**N**	**I**	**A**	**P**	**E**
a. Demonstrate awareness of potential individual and psychosocial barriers to the ability of older adults to access and utilize health, mental health, or community services					
b. Collaborate with patients, families, and other organizational and community providers to improve older adults' access to needed health care, residential, transportation, social, or community services					
c. Advocate for clients' needs in interdisciplinary and organizational environments when appropriate					

III. Assessment

A. Knowledge base -- The psychologist/trainee has *KNOWLEDGE* OF:

1. Geropsychology Assessment Methods	N	I	A	P	E
a. Current research and literature relevant to understanding theory and current trends in geropsychology assessment					
b. Assessment measures or techniques which have been developed, normed, validated and determined to be psychometrically suitable for use with older adults					
c. Importance of a comprehensive interdisciplinary assessment approach (e.g. including other health professionals' evaluations of medical or social issues)					
d. Multi-method approach to assessing older adults (including cognitive, psychological, personality, and behavioral assessments, drawn from self-report, interviews, and observational methods)					
e. Importance of integrating collateral information from family, friends, and caregivers, with appropriate consent, especially when cognitive impairment is suspected					

f. Need for baseline and repeated-measures assessments in order to understand complex diagnostic problems					
g. Assessment of domains unique to older adults (e.g., potential elder abuse)					
2. Limitations of Assessment Methods	**N**	**I**	**A**	**P**	**E**
a. Criterion and age requirements, as well as specific standard normative data, for testing instruments					
b. Limitations of testing instruments, including those validated in older samples, for assessing diverse older adults					
3. Contextual Issues in Geropsychology Assessment	**N**	**I**	**A**	**P**	**E**
a. The range of potential individual factors that may affect assessment performance (e.g., medications, substance use, medical conditions, cultural, educational, language background)					
b. The potential impact of the assessment environment on test performance (e.g., noise, lighting, distractions)					
c. The older person's environmental context and resources in deriving recommendations from assessment data					
B. SKILLS - The psychologist/trainee is *ABLE TO:*					
1. Conduct Clinical Assessment and Differential Diagnosis	**N**	**I**	**A**	**P**	**E**
a. Distinguish between signs of normal aging versus pathology in making diagnoses					
b. Consider base rates, risk factors, and distinct symptom presentations of psychological disorders in older adults when making diagnoses					
c. Conduct differential diagnosis (e.g., dementia versus depression), including consideration of co-morbid medical issues that may influence an older adult's presentation					
d. Identify subsyndromal disorders and implications for treatment					
e. Assess older adult's motivation for treatment					
f. Utilize biopsychosocial case conceptualization based on clinical evaluation to inform initial treatment plan or recommendations					
2. Utilize Screening Instruments	**N**	**I**	**A**	**P**	**E**
a. Utilize screening tools for mood, cognition, substance use, personality, and other clinical issues to guide and inform comprehensive assessment					
b. Evaluate age, educational, and cultural appropriateness of assessment instruments					
c. Consider reliability and validity data in using standardized instruments with older adults					
d. Assess older adult's ability to provide informed consent for psychological evaluation					
e. Recognize sensory impairments and makes environmental modifications accordingly					
f. Consider impact of medical conditions and medications on test performance					
g. Make specific and appropriate recommendations, based on testing results, to inform treatment planning					
3. Refer for Other Evaluations as Indicated	**N**	**I**	**A**	**P**	**E**
a. Acknowledge personal level of expertise regarding geriatric assessment and know when to refer or consult with other health care professionals					
b. Utilize screening data to inform need for more comprehensive, multidisciplinary assessment					

c. Recognize when a medical evaluation is indicated to rule out underlying medical or pharmacological causes of presenting symptoms					
4. Utilize Cognitive Assessments	**N**	**I**	**A**	**P**	**E**
a. Integrate knowledge of normal and pathological aging, including age related changes in cognitive abilities, into geropsychological evaluations					
b. Interpret meaning and implications of cognitive testing data or reports for case conceptualization					
c. Demonstrate ability to translate cognitive testing results into practical conclusions and recommendations for patients, families, and other care providers					
5. Evaluate Decision Making and Functional Capacity	**N**	**I**	**A**	**P**	**E**
a. Evaluate older adults' understanding, appreciation, reasoning, and choice abilities with regards to capacity for decision making					
b. Utilize clinically specific assessment tools designed to aid evaluation of decision making and other functional capacities					
c. Integrate testing results with information from clinical interview with older adult and collateral sources, including behavioral observations and interviews with family members, to formulate impressions and recommendations					
d. Collaborate with professionals from other disciplines to assess specific functional capacities (e.g., independent living, driving)					
e. Appreciate legal and clinical contexts of capacity/competence evaluations (e.g., need for guardianship, loss of right to drive)					
6. Assess Risk	**N**	**I**	**A**	**P**	**E**
a. Identify risk factors for harm to self or others					
b. Screen and comprehensively assesses suicide risk					
c. Screen and assesses capacity for self-care including ADL's and IADL's					
d. Screen and assesses risk of elder abuse in emotional, physical, sexual, financial, and neglect domains					
7. Communicate Assessment Results and Recommendations	**N**	**I**	**A**	**P**	**E**
a. Communicate results within the confines of federal, state, local, and institutional privacy and confidentiality rules and regulations					
b. Translate assessment results into practical recommendations for patient, family, and team, providing written recommendations and relevant psychoeducational materials understandable to stakeholders					
c. Provide recommendations to other providers to assure that treatment plans are informed by assessment results					

IV. Intervention

A. Knowledge - The psychologist/trainee has *KNOWLEDGE* OF:

1. Theory, Research, and Practice	**N**	**I**	**A**	**P**	**E**
a. Broad research findings regarding the effectiveness of psychological interventions with older adults (e.g., application of behavioral, cognitive, interpersonal, psychodynamic, family, environmental, psychoeducational, group interventions)					
b. Specialized interventions in working with older adults and how they evolve from and are consistent with theory in life span development (e.g., reminiscence therapy, validation techniques, behavioral interventions for disruptive behavior)					

c. Modifications of therapeutic techniques to address common aging changes (e.g., sensory difficulties, cognitive impairment), care setting (e.g., community, hospital, nursing home), education, and cultural background					
2. Health, Illness, and Pharmacology	**N**	**I**	**A**	**P**	**E**
a. The complexity and interplay of common late life medical problems, sensory changes and their impact on treatment approaches					
b. The possible impact of medications and procedures for medical and psychiatric problems, including detrimental side effects, on symptom presentation, mental status, and treatment effectiveness in older adults					
c. The frequent comorbidity between chronic medical and psychiatric problems, and need to address both medical and mental health issues					
d. The importance of setting realistic treatment goals (neither too high nor too low) for older adults with severe, chronic medical and psychiatric problems (e.g., remission of symptoms or maintenance of current functioning rather than cure)					
3. Specific Settings	**N**	**I**	**A**	**P**	**E**
a. The varied preferences older adults have in discussing emotional problems with family, primary care providers, spiritual advisors and, thus, the importance of allying with others, with appropriate consent, to assure proper psychological care is rendered					
b. The salience and presentation of ethical issues when employing interventions across varied care settings (e.g. confidentiality in context of team treatment planning; privacy constraints in institutional settings)					
c. Adaptations of interventions appropriate to particular settings (e.g., focus on staff education and behavioral, environmental interventions in long-term care settings)					
4. Aging Services	**N**	**I**	**A**	**P**	**E**
a. Specific referral sources including facilities (e.g., day care, residential), transportation, legal/safety (e.g., protective services), health, multicultural, caregiver, and other support services					
b. Referral processes and procedures to local community resources (e.g., via phone, Internet)					
c. Follow-up mechanism(s) regarding referrals					
5. Ethical and Legal Standards	**N**	**I**	**A**	**P**	**E**
a. Informed consent procedures for services to older adults, and challenges to some older adults' capacity to provide informed consent					
b. Indications for and role of surrogate decision makers in health and mental health treatment of older adults					
c. Older client's right to confidentiality and to be informed of limits of confidentiality					
d. State and organizational laws and policies covering elder abuse, advance directives, conservatorship, guardianship, restraints, multiple relationships, and confidentiality					
B. SKILLS - The psychologist/trainee is *ABLE TO:*					
1. Apply Individual, Group, and Family interventions	**N**	**I**	**A**	**P**	**E**
a. Prioritize treatment goals as appropriate, taking into account multiple problem Areas					
b. Integrate relevant treatment modalities					
c. Modify evidence-based and clinically informed intervention strategies to accommodate chronic and acute medical problems, sensory impairments, mobility limitations, cognitive abilities, generational and cultural factors, late-life developmental issues and possible client-therapist age differences					

d. Provide psychoeducation as needed to help the older adult client understand the therapeutic process					
2. Base Interventions on Empirical Research, Theory, and Clinical Judgment	**N**	**I**	**A**	**P**	**E**
a. Articulate theoretical case conceptualization and empirical support guiding choice of intervention strategies					
b. Describe the integration or adaptation of various strategies to meet the needs of particular older clients					
c. Measure the effectiveness of intervention					
d. Make appropriate adjustments to treatment based on client response					
3. Use Available Evidence-based Treatments for Older Adults	**N**	**I**	**A**	**P**	**E**
a. Choose evidence-based treatment for older adult clients based on diagnosis and other relevant client characteristics					
b. Choose and implement intervention strategies based on available evidence for effectiveness with older adults					
c. Measure the effectiveness of intervention					
d. Make appropriate adjustments to treatment based on client response					
4. Use Late Life Interventions -- Provide effective, evidence-based interventions for particular issues affecting older adults, including:	**N**	**I**	**A**	**P**	**E**
a. For older adults with dementia (and other disabling illnesses) and their family caregivers					
b. For patients and families facing advanced illness, dying, and death					
c. For adjustment difficulties secondary to bereavement					
d. Inclusion of reminiscence and life review into psychotherapeutic interventions					
e. Psychoeducation for patients and families regarding normal aging and a range of medical and mental health concerns					
f. Group interventions for a range of aging-related health, mental health, and adjustment concerns					
g. For older adults adjusting to age-related changes in relationships and sexuality					
5. Use Health-Enhancing Interventions	**N**	**I**	**A**	**P**	**E**
a. Determine which aspects of physical, mental and behavioral health can be improved in older clients via available psychological interventions					
b. Prioritize health issues to be addressed when multiple targets are possible					
c. Effectively intervene regarding health issues as part of overall mental health treatment plan, recognizing close link between medical and mental health and related disability in older adults					
d. Monitor impact of intervention on health behaviors and evaluates outcomes					
6. Intervene Across Settings	**N**	**I**	**A**	**P**	**E**
a. Intervene in common geriatric settings (e.g., home, community centers, nursing homes, assisted living facilities, retirement communities, medical clinics, medical and psychiatric hospitals)					
b. Intervene at the level appropriate to older adult client's needs, ranging from individual to family, systemic, and environmental contexts					
c. Modify interventions to adapt to the setting's particular environmental and social characteristics					
V. Consultation					
A. Knowledge Base-The psychologist/trainee has *KNOWLEDGE* OF:					

1. Prevention and Health Promotion	N	I	A	P	E
a. Incidence and prevalence rates of health problems in the older adult population					
b. How to partner with family and local community resources for health promotion					
c. Strategies for community-based training/education for promoting preventive interventions					
2. Diverse Clientele and Contexts	**N**	**I**	**A**	**P**	**E**
a. Multiple levels of geropsychological intervention/consultation, including individuals, families, healthcare professionals, organizations, and community leaders					
b. Systems-based consultative and intervention models and their use with appropriate modifications in different geriatric settings					
c. Strategies and methods for collaboration to address individual- and organizational-based needs					
3. Interdisciplinary Collaboration	**N**	**I**	**A**	**P**	**E**
a. The distinction between types of treatment teams (e.g., multidisciplinary and interdisciplinary)					
b. The roles, and potential contributions, of a wide range of healthcare professionals in the assessment and treatment of older adult with mental disorders					
c. How team composition and functioning may differ across settings of care					
B. SKILLS - The psychologist/trainee is *ABLE TO:*					
1. Provide Geropsychological Consultation	**N**	**I**	**A**	**P**	**E**
a. Recognize situations in which geropsychological consultation is appropriate					
b. Demonstrate ability to clarify and refine a referral question					
c. Demonstrate ability to gather information necessary to answer referral question					
d. Advocate for quality care for older adults with their families, professionals, programs, health care facilities, legal systems, and other agencies or organizations					
2. Provide Training	**N**	**I**	**A**	**P**	**E**
a. Assess learning needs of trainees related to varying levels of training and amount of experience within and across disciplines					
b. Define learning goals and objectives as a basis for developing educational sessions					
c. Provide clear, concise education that is appropriate for the level and learning needs of the trainees					
3. Participate in Interprofessional Teams	**N**	**I**	**A**	**P**	**E**
a. Work with professionals in other disciplines to incorporate geropsychological information into team treatment planning and implementation					
b. Communicate psychological conceptualizations clearly and respectfully to other providers					
c. Appreciate and integrate feedback from interdisciplinary team members into case conceptualizations					
d. Work to build consensus on treatment plans and goals of care, to invite various perspectives, and to negotiate conflict constructively					
e. Demonstrate ability to work with diverse team structures (e.g., hierarchical, lateral, virtual) and team members (e.g., including the ethics board, chaplains, and families in palliative care teams)					
4. Communicate Geropsychological Conceptualizations	**N**	**I**	**A**	**P**	**E**
a. Provide clear and concise written communication of geropsychological conceptualizations and recommendations					
b. Provide clear and concise oral communication of geropsychological conceptualizations and recommendations					

c.	Uses appropriate language and level of detail for the target audience of the communication	
5. Implement Organizational Change	**N I A P E**	
a.	Conduct needs assessment for service delivery within the setting or program that serves older adults	
b.	Develop policies and procedures for service delivery that involve all appropriate disciplines and staff members	
c.	Evaluate effectiveness of service delivery model or program	
6. Participate in a Variety of Models of Aging Services Delivery	**N I A P E**	
a.	Differentiate goals and models of care in long-term, rehabilitation, acute, primary, home, assisted living, hospice, and other care settings	
b.	Appreciate a variety of models of geriatric mental health care , including integrated mental health services in primary care, specialty consultation, and home- or community-based services	
c.	Demonstrate awareness of strengths and constraints of various care models	
d.	Demonstrate flexibility in professional roles to adapt to the realities of work in a variety of aging or healthcare delivery systems	
7. Collaborate and Coordinate with Other Agencies and Professionals	**N I A P E**	
a.	Work with team members to create smooth and efficient transitions across health care settings for older adults and their families	
b.	Demonstrate respect for confidentiality and informed consent, as well as continuity of care, in coordinating with family members, other professionals, and agencies regarding care of an older client	
c.	Establish working relationships with local and national agencies and organizations, such as Elder Services, Alzheimer's Association, and Hospice	
8. Recognize and Negotiate Multiple Roles	**N I A P E**	
a.	Identify the client and explicate the expectations of the relationship at the outset of the consultation	
b.	Advocate on behalf of the well-being of older adults within each professional role, including when the individual or group of older adults is not the direct client	
c.	Discuss potential conflicts of interest with colleagues and teams as indicated	
d.	Discuss financial arrangements with all stakeholders	

Summary

It may help learners and/or supervisors to summarize the geropsychology knowledge and skill strengths, and areas for growth, based on this assessment. Areas for growth may then be linked to further goals for education and training.

Strengths: Knowledge and skill domains in which the learner feels most confident and competent in geropsychology practice.

Areas for Growth: Knowledge and skill domains in which the learner wishes to develop further competency.

Education and Training Goals (within a practicum, internship rotation, fellowship, or post-licensure program of self-study)

[1]Development of this evaluation tool was informed by several important previous efforts, including the APA policies on multicultural and evidence-based practice, extensive work on the assessment of competencies for professional psychology practice, competencies for geriatric and palliative care, and evaluation tools that have been used by geropsychology internship and fellowship programs. An abbreviated reference list follows:

American Psychological Association (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58,* 377-402.

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APA Board of Educational Affairs and Council of Chairs of Training Councils (CCTC) (2007). Assessment of Competency Benchmarks Workgroup: A developmental model for the defining and measuring competence in professional psychology. Accessed at http://www.apa.org/ed/graduate/comp_benchmark.pdf

APA Presidential Task Force on Evidence Based Practice (2006). Evidence based practice in psychology. *American Psychologist, 61*, 271-285.

Hatcher, R. L. & Lassiter, K. D. (2007). Initial training in professional psychology: The Practicum Competencies Outline. *Training and Education in Professional Psychology, 1,* 49-63.

Kaslow, N. J., Rubin, N. J., Bebeau, M. J., Leigh, I. W., Lichtenberg, J. W., Nelson, P. D., et al. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice, 38*(5), 441.

Knight, B. G., Karel, M. J., Hinrichsen, G. A., Qualls, S. H., & Duffy, M. (2009). Pikes Peak Model for Training in Professional Geropsychology. *American Psychologist, 64,* 205-214.

Rodolfa, E., Bent, R., Eisman, E., Nelson, P. D., Rehm, L., & Ritchie, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice, 36,* 347-354.

The CoPGTP Task Force on Geropsychology Competency Assessment developed this tool. Task Force members are: Michele J. Karel, Chair; Jeannette Berman, Jeremy Doughan, Erin E. Emery, Victor Molinari, Sarah Stoner, Yvette N. Tazeau, Susan K. Whitboume, Janet Yang, Richard Zweig

Publications regarding tool development and evaluation:

Karel, M. J., Emery, E. E., & Molinari, V. (2010). Development of a tool to evaluate geropsychology knowledge and skill competencies. *International Psychogeriatrics, 22,* 886-896.

Karel, M. J., Holley, C. K., Whitboume, S. K., Segal, D. L., Tazeau, Y. N., Emery, E. E., Molinari, V., Yang, J., & Zweig, R. A. (2012). Preliminary validation of a tool to assess competencies for professional geropsychology practice. *Professional Psychology: Research and Practice, 43,* 110- 117.

Appendix B: Postdoc Evaluation Form

POSTDOCTORAL RESIDENCY IN GEROPSYCHOLOGY

VA NEW YORK HARBOR HEALTHCARE SYSTEM – BROOKLYN CAMPUS
Competency Evaluation Form

Resident: Period Covered:
Rotation Areas:
Supervisor(s):

Ratings are agreed upon by all supervisors and supervisors provide feedback regarding strengths and weaknesses in comments section below. Supervisors should meet individually with the resident to discuss all ratings. When giving feedback, please provide examples of both strengths and areas for improvement, including discussion of how the resident might address any areas of concern in future training.

The following guidelines should be used in making ratings:	
1 – Remedial. The resident requires some instruction and close monitoring of the competency with which tasks are performed and documented.	
2 – New Skill. The resident requires instruction and close monitoring of the competency with which tasks are performed and documented.	
3 – Some supervision needed (postdoc entry level). The resident's skills are more developed and the focus is on integration and greater autonomy. Less supervision is required, and it is more collaborative in nature.	
4 – Minimal supervision (postdoc mid-level). The resident possesses advanced level skills. Supervision is mostly consultative, and the supervisor can rely primarily on summary reports by the resident.	
5 – No supervision needed (advanced postdoc level). The resident can work autonomously and has well-developed, flexible skills; can generalize skills and knowledge to novel and/or complex situations; demonstrates expertise in a broad range of clinical and professional activities, and: demonstrates the ability to serve as an expert resource to other professionals.	
6 – Advanced practice. Competency attained at full psychology staff privilege level (but requires supervision as trainee).	
N/A – Insufficient basis for making a rating. This rating should be used when the resident has not engaged in the target activities or skills or the supervisor has not had the opportunity to observe or evaluate the resident in this area.	
The expected level of competence is 4 or above on mid-year evaluations and 5 or above on final evaluations for all global scores.	
This evaluation is based on the following methods of supervision (required at least once per rotation per rating period): ___ Discussion in supervision ____ Direct observation (including co-facilitation) ____ Review of audio recordings ____ Review of video recordings	

Competencies (Rating score for each competency domain is average of scores for behavioral anchors rounded to the nearest half point)	Rating Score
I. Integration of Science and Practice	
Demonstrate ability to cite scientific evidence on aging to support professional activities in clinical settings.	
Applies review of available scientific literature to assessment, case conceptualization, treatment planning and intervention.	
Recognizes strengths and limitations in knowledge base about older adults in application to individual cases and seeks consultation when necessary.	
II. Ethical and Legal Standards	
Demonstrates knowledge of and acts in accordance with each of the following: • The current version of the APA Ethical Principles of Psychologists and Code of Conduct • Relevant laws, regulations, rules, and policies governing health service psychology at the organizational, local, state, regional, and federal levels; and • Relevant professional standards and guidelines	
Recognizes ethical dilemmas in general and applies ethical decision-making processes to resolve dilemmas.	
Understands how to apply relevant laws, regulations and policies covering issues related to older adults (e.g. elder abuse, advance directives, conservatorship, guardianship, multiple relationships and confidentiality).	
Conducts self in an ethical manner in all professional activities.	
III. Individual and Cultural Diversity	
Demonstrate and understanding of how their own personal cultural history, attitudes and biases that may affect how they understand and interact with people different from themselves.	
Demonstrates knowledge of current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities, including research, training, supervision/consultation, and service.	
Demonstrates the ability to integrate awareness and knowledge of individual and cultural differences in the conduct of professional roles (e.g. research, services, and other professional activities). This includes the ability to apply a framework for working effectively with areas of individual and cultural diversity not previously encountered over the course of their careers. Also included is the ability to work effectively with individuals whose group membership, demographic characteristics, or worldviews create conflict of their own.	
Demonstrates the ability to independently apply knowledge and demonstrate effectiveness in working with multiple aspects of diversity influencing older clients, psychologists, and systems of care.	
Initiates consultation with appropriate sources as needed to address specific diversity issues.	
Works effectively with diverse providers, staff, and students whose group membership, demographic characteristics or worldviews create conflict with their own.	
IV. Communication and Interpersonal Skills	

Develops and maintains effective relationships with a wide range of individuals, including colleagues, communities, organizations, supervisors, supervisees, and those receiving professional services.	
Produces and comprehends oral, nonverbal, and written communications that are informative and well-integrated and adapted to the abilities and needs of various stakeholders (e.g. older adults, families, healthcare teams, other psychologists).	
Demonstrates effective interpersonal skills and the ability to manage difficult communication well.	
V. Assessment	
Conducts differential diagnosis including consideration of co-morbid medical issues that may influence an older adult's presentation, including but not limited to the ability to distinguish dementia from delirium, depression, and other medical conditions and medications that impact cognitive functioning.	
Integrates knowledge of normal and pathological aging, including age related changes in cognitive abilities, into assessment.	
Selects and applies assessment methods that draw from the best available empirical literature and that reflects the science of measurement and psychometrics; collects relevant collateral data using multiple sources (including family, formal caregiver or care partner, team perspectives) and methods appropriate to the identified goals and questions of the assessment as well as sensory, cognitive, generational, and other relevant diversity characteristics of the service recipient.	
Demonstrates the ability to assess older adults' understanding, appreciation, reasoning, and choice abilities with regards to capacity for decision making.	
Communicates orally and in written documents the findings and implications of assessment in an accurate and effective manner sensitive to a range of audiences.	
Conducts assessment of risk for suicide, abuse and neglect, and demonstrates appropriate response to high-risk situations in a geriatric population.	
Demonstrates awareness of varying etiologies of neurocognitive and psychiatric disorders and understands the role of family history, symptom presentation and onset, and comorbidities.	
Demonstrates the ability to assess older adults' understanding, appreciation, reasoning, and choice abilities with regards to capacity for decision making and independent activities of daily living.	
VI. Intervention	
Chooses and implements evidence-based treatments for older adults, groups, family members/caregivers based on diagnosis, other relevant client characteristics, and settings.	
Modifies evidence-based interventions to accommodate the unique sensory, cognitive, generational, and cultural experiences of each older adult.	
Evaluates intervention effectiveness and adapts interventions methods and goals consistent with ongoing evaluation.	
VII. Consultation and Interprofessional/Interdisciplinary Systems	

Demonstrates knowledge and respect for the roles and perspectives of other professions and refers patients and families to services as appropriate.	
Conceptualizes referral questions and incorporate understanding of the roles of patient, caregiver or care partner, other provider, and/or health system to answer the consultation questions effectively.	
Applies knowledge of consultation with individuals and their families, other health care professionals, interprofessional groups, or systems related to health and behavior.	
Demonstrates ability to work in at least one setting that is a common location for care of older adults (e.g. primary care, home-based primary care, specialty medicine (inpatient/outpatient), long-term care/rehab facility/Community Living Center)	
Demonstrates the ability to provide education and professional training about aging to other staff/teams serving older adults.	
VIII. Professional Values, Attitudes, and Behaviors	
Engages in self-reflection regarding one's personal and professional functioning; engages in activities to maintain and improve performance, well-being, and professional effectiveness.	
Behaves in a way that reflects the values and attitudes of psychology and Geropsychology, such as integrity, deportment, professional identity, accountability, lifelong learning and concern for the welfare of others.	
Actively seeks and demonstrates openness and responsiveness to feedback and supervision.	
Responds professionally in increasingly complex situations with a greater degree of independence.	
Demonstrates knowledge of the negative impact of ageism in self, others, institutions, and society such as heterogeneity in aging, the intersection of aging and diversity, and how age and diversity factors impact older adults' well-being and care.	
Demonstrates an emerging professional identity consistent with the Geropsychology specialty.	
IX. Supervision and Teaching	
Demonstrates knowledge of supervision models and practices related to Geropsychology.	
Applies this knowledge in direct practice with psychology trainees, or other health professionals.	
X. Advocacy	
Demonstrates the ability to advocate for older adults' needs in interdisciplinary and organizational environments.	
Demonstrates the ability to collaborate with patients, families, and other organizational and community providers to improve older adults' access to needed health care, residential, transportation, social, or community services.	

Overall Comments:

Areas of Strength:

Areas of Improvement:

The resident has completed this training assignment satisfactorily:

____Yes ____No ____N/A

If no, please explain:

Resident signature:_____ Date:_____

Supervisor signature(s):_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

Director of Training signature:_____ Date:_____

Appendix C: Due Process, Remediation, and Grievance Procedures

GEROPSYCHOLOGY POSTDOCTORAL RESIDENCY PROGRAM
VA NEW YORK HARBOR HEALTHCARE SYSTEM – BROOKLYN CAMPUS
Due Process, Remediation, and Grievance Procedures

This policy provides an accounting of trainee and supervisor responsibilities, a definition of problematic trainee performance and how these situations are handled by the program, as well as a discussion of due process and grievance procedures. The procedures outlined in this policy are intended to assure that adequate measures are in place to address problems and concerns and to protect due process for everyone involved in Psychology training.

All of our Psychology training programs follow due process guidelines to assure that decisions are fair and nondiscriminatory. During the orientation process (first two-weeks of employment), trainees are given the training program's Policy and Procedures Handbook which includes this document as an addendum. This is reviewed by the Director of Training. These two documents together include written information regarding:

- Supervisor and trainee rights and responsibilities
- Problematic trainee performance/conduct
- Remediation of Problematic Performance and/or Conduct
- The evaluation process, including the format and schedule of evaluations
- Procedures for reporting problematic behavior on the part of supervisors or trainees
- Procedures for making decisions about problematic performance and/or conduct
- Remediation plans for identified problems, including time frames and consequences for failure to rectify problems
- Procedures for appealing the program's decisions or actions

At the end of orientation, trainees sign a form indicating that they have read and understood these policies outlined in the Policies and Procedures Handbook and the Due Process, Remediation, and Grievance Procedures. Supervisors also sign a yearly Training Agreement indicating their understanding and agreement to abide with the supervisor responsibilities outlined below in this document.

I. Rights & Responsibilities

Our Psychology training programs are committed to providing trainees with opportunities that foster clinical and professional growth. At the same time, our programs are responsible for informing trainees as soon as possible if there is a concern about their performance. The program has the responsibility to monitor trainees' progress in order to benefit and protect the public and the profession, as well as to facilitate trainees' professional growth. The program also has the responsibility to inform trainees of

program requirements and expectations for successful completion of the program. The program assumes responsibility for continual assessment of and feedback to trainees in order to help them improve their skills, remediate problematic behaviors, and/or to prevent individuals who may be unsuited in skills or who have interpersonal limitations from entering the professional practice of psychology. While our training programs provide opportunities for professional growth and learning, these experiences may also increase trainees' stress and uncertainty. It is the responsibility of the program to provide structure, procedures, and opportunities that allow for growth and minimize stress. Examples of such measures include (but are not limited to) providing orientation meetings and trainings, providing quality clinical supervision and guidance from licensed psychologists, setting clear and realistic expectations and goals for the training year, providing ongoing supervisory support and feedback from supervisors and the Directors of Training, giving clear and timely evaluations of trainees' performance, providing a process group with an outside facilitator not involved in the evaluation process, and offering didactic instruction (including specific didactics related to professional development). The program is dedicated to responding sensitively to trainees' needs and to protecting their rights.

1. **Trainees' responsibilities include the following:**
   - Functioning within the bounds of the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct and in a manner consistent with the program's Policy and Procedure Handbook and with the laws, regulations, and policies governing the Department of Veterans Affairs (VA), Veterans Health Administration (VHA), and the VA NY Harbor Healthcare System Bylaws and Rules and Regulations of the Medical Staff.
   - Demonstrating the required competencies outlined by the program and evaluated on each clinical rotation and assignment.
   - Demonstrating active participation in all training, didactic, and service opportunities.
   - Demonstrating an openness and receptivity to professionally appropriate input and feedback from supervisors.

2. **Trainees have the right:**
   - To be trained by licensed supervisors who behave in accordance with APA ethical guidelines
   - To receive clear communications of the competencies and standards expected by the program. These are reviewed during orientation and throughout the training year as part of the evaluation process. Trainees typically receive 2-4 hours of individual supervision per week (2 hours minimum), in order to support their clinical and professional growth and development and a minimum of 2 hours of group supervision per week
   - To evaluation of their performance that is specific, respectful, and personal; feedback is ongoing and formal evaluations occur at specific intervals, as outlined in the Policy and Procedure Manual.
   - To be treated with professional respect and in a manner that recognizes the wealth of experience they bring with them.
   - To initiate informal resolution of problems that may arise in the training experience directly with the individual(s) involved, through the Directors of Training, or through APPIC's informal problem consultation process (detailed later in this policy).

- To due process should informal resolution of problems or grievances prove insufficient.
- To provide input to and suggestions for the program; these can be made during regularly scheduled supervision times or meetings with the Directors of Training, or at any time a concern arises.

3. **Supervisor Duties & Responsibilities:** Clinical supervision and teaching are considered auxiliary duties for licensed staff psychologists. Staff may volunteer to participate in one or more of our Psychology training programs.

Supervisory staff meet with the Director of Training to review expectations and responsibilities and sign the Training Agreement, with the understanding that their participation will be discussed and voted upon by the full Training Committee. The Training Committee minutes will reflect the discussion of the staff member's participation in training and any objections will be noted. The Directors of Training will maintain the signed Training Agreement along with other program records. The Training Agreement is outlined below.

Supervisors will:

- Provide trainees with ongoing feedback related to competency-based goals, including the functional and foundational competencies of professional psychology (as enumerated in our evaluation forms).
- Assist in the development of goals and tasks to be achieved in supervision specific to assessed competencies.
- Provide formal, summative evaluative feedback at the midpoint and end of each rotation.
- Maintain patient information as confidential and treat supervisee disclosures with discretion. Sensitive information will be shared on a need-to-know basis only.
- Oversee and monitor all aspects of patient case conceptualization and treatment planning.
- Conduct direct observation and review video/audio recordings both during and/or outside of the supervision session as applicable.
- Identify delegated supervisors who will provide supervision/consultation when the supervisor is not available. This includes signing progress notes if the time of absence is greater than 24 hours.
- Adhere to APA Ethical Standards.
- Recognize the inherent role that cultural identity and intersectionality plays in clinical practice and supervision, as well as seek to understand how historical and contemporary experiences with power, privilege, and oppression affect both clinical and supervisory relationships. As part of demonstrating their ongoing commitment to developing their own cultural competence and providing culturally responsive supervision, supervisors will participate in one or more of the following: staff diversity trainings, small diversity consultation groups, the Multicultural and Diversity Committee (MDC), the Alliance for Healthcare Equity, Accountability and Diversity (AHEAD), Safe/Brave Spaces Groups (facilitated by AHEAD), and/or the medical center's Diversity, Inclusion and Advisory Council (DIAC), **or** independently complete 3-hours of Continuing Education Units (CEUs) related to multicultural competence and supervision approved by the American Psychological Association (APA).

- Maintain the responsibility to provide feedback to trainees in a timely and ongoing manner. If a supervisor believes that a trainee is not functioning at the minimum level of achievement, it is the supervisor's responsibility to make this observation known to the trainee as soon as possible and to notify the Directors of Training. Trainees at risk of falling below the minimum level of achievement must be given a chance to address the deficiency prior to receiving that rating.
- Determine and discuss the Graduated Levels of Responsibility for each trainee (room, area, available for both in-person and remote telework) at the beginning of supervision. Any changes in this level will be discussed in supervision and with the Directors of Training and documented on the Graduated Levels of Responsibility form.
- Regularly attend monthly Training Committee meetings.
- Discuss the trainee's development, strengths, and growth areas with the Directors of Training and the Training Committee.
- Be responsible for knowing the program's grievance, due process, and remediation plan policies.
- Maintain awareness of the trainee's workload and program expectation of a 40-hour work week.
- Expected to achieve ratings indicating fully satisfactory performance on Evaluation of Supervisor forms (average rating of 5 or higher over a 1-year period). Ratings of 4 or lower are potentially problematic and may necessitate review for appropriateness of continued supervisor responsibilities.
- Understand that unprofessional behavior may necessitate an immediate review of supervision responsibilities, including repeated complaints from trainees that are not addressed appropriately or remedied; discriminatory comments and/or behavior related to trainees' race, ethnicity, gender identity, sexual orientation, religion, etc., as well as any other ethical and/or professional violations.
- Must follow the policies and recommendations set form by the NYH Medical Staff By-Laws, VA Handbook for Supervision of Associated Health Trainees (1400.04), the VA Handbook for Education of Associated Health Trainees (1400.08), and VHA Directive 1027 addressing Supervision of Psychologists and Social Workers Preparing for Licensure. These policies are available on the shared MH drive (S drive).
- Not be disruptive to training leadership or the training program. Disruption (as defined in the Unethical or Illegal Behaviors section below) to training leadership or the training program is problematic and will necessitate review for appropriateness of continued supervisory responsibilities. Disruptive behavior will be brought to the attention of the supervisor, who will be given an opportunity to respond and/or resolve the problem. If disruptive behavior cannot be resolved, or is sufficiently severe, the supervisor may be required to take a temporary or permanent leave of absence from involvement in training. If one of the Directors of Training is the supervisor in question, the aforementioned processes and decisions regarding appropriate actions will involve the Section Chief, Psychology, the ACOS for MH, and/or the ACOS for Education.
- Trainees also receive direct feedback from their clinical supervisors in the form of both formal and informal evaluations that occur at regularly scheduled intervals throughout the year.

- All written evaluations become a part of the trainee's permanent file with the Psychology Section. These records are maintained by the Directors of Training Director and kept in secure, locked cabinets in their office and/or password protected electronic files.

II. Problematic Trainee Performance and/or Conduct

This section describes the program's procedures for identifying, assessing, and, if necessary, remediating problematic trainee performance.

Definition of Problematic Behaviors

Problematic behaviors are broadly defined as those behaviors that disrupt the trainee's professional role and ability to perform required job duties, including the quality of the trainee's clinical services; their relationships with peers, supervisors, or other staff; and their ability to comply with appropriate standards of professional and/or ethical behavior. Problematic behaviors may be the result of the trainee's inability or unwillingness to a) acquire professional standards and skills that reach an acceptable level of competency, or b) to control personal issues or stress.

Behaviors reach a problematic level when they include one or more of the following characteristics:

- The trainee does not acknowledge, understand, or address the problem
- The problem is not merely a deficit in skills, which could be rectified by further instruction and training
- The trainee's behavior does not improve as a function of feedback, remediation, effort, and/or time
- The professional services provided by the trainee are negatively affected
- The problem affects more than one area of professional functioning
- The problem requires a disproportionate amount of attention from training supervisors

Some examples of problematic behaviors include:

- Engaging in dual role relationships
- Violating patient confidentiality
- Failure to respect appropriate boundaries
- Failure to identify and report patients' high-risk behaviors
- Failure to complete written work in accordance with supervisor and/or program guidelines
- Treating patients, peers, and/or supervisors in a disrespectful or unprofessional manner
- Plagiarizing the work of others or giving one's work to others to complete
- Repeated tardiness
- Unauthorized absences

NOTE: this list is not exhaustive. Problematic behaviors also include behaviors discouraged or prohibited by APA's Ethical Guidelines and VA NYHHS policies and procedures, as outlined during New Employee Orientation.

III. REMEDIATION OF PROBLEMATIC TRAINEE PERFORMANCE AND/OR CONDUCT

It should be noted that every effort is made to create a climate of access and collegiality within the service. The Directors of Training are actively involved in monitoring the training program and frequently check informally with trainees and supervisors regarding trainees' progress and potential problems. In addition, Trainee-Director meetings are held once a month to provide another forum for discovery and resolution of potential problems. Trainees are also encouraged to raise concerns with the Directors of Training as they arise. It is our goal to help each trainee reach their full potential as a developing professional. Supervisory feedback that facilitates such professional growth is essential to achieving this goal.

The Training Committee consists of all psychology supervisors and staff involved in planning for the Training Program. The Committee meets two times per month to discuss training issues and trainee performance. Supervisors discuss skills and areas of strength, as well as areas for growth and concerns regarding clinical or professional performance and conduct. Trainees also receive direct feedback from their clinical supervisors in the form of both formal and informal evaluations that occur at regularly scheduled intervals throughout the year.

Trainees are continuously evaluated and informed about their performance with regard to the aims and competencies of the program. It is hoped that trainees and supervisors establish a working professional relationship in which constructive feedback can be given and received. During the evaluation process, the trainee and supervisor discuss such feedback and, in most cases, reach a resolution about how to address any difficulties. Although trainees are formally evaluated at regular intervals, problematic behaviors may arise and need to be addressed at any given time. All written evaluations become a part of the trainee's permanent file with the Psychology Section. These records are maintained by the Directors of Training and kept in secure, locked cabinets in their office. The Directors of Training also communicate with graduate programs about each trainee's progress. This occurs at mid-year and again at year's end when copies of the trainee's evaluation forms are sent to the graduate program.

In regard to remediation, the Training Directors will consult with the trainee's Director of Clinical Training as soon as deficiencies in minimal levels of achievement become apparent and/or problematic behavior that may interfere with the trainees successful completion of the training program arises. The Director of Clinical Training at the trainee's university will be sent a copy of the written remediation plan and given the opportunity to approve the plan or suggest changes in the plan.

The expected level of competence as indicated in trainees' written evaluations are as follows:

The minimum expected level of competence, for all Level 1 profession-wide competencies and Level 3 Geropsychology specialty competencies is as follows: 4 (mid-year) and 5 (end of year). See below for each rating.

- Rating of 1 (remedial, mid practicum level)
- Rating of 2 (new skill; close supervision needed, intern entry level)
- Rating of 3 (postdoc entry level, less supervision required and collaborative)
- Rating of 4 (postdoc mid-level; possesses some supervision needed, intern rotation exit level of equivalent)
- Ratings of 5 (minimal supervision needed, postdoc level or equivalent)

Responding to Problematic Trainee Performance:

At any time, a trainee may be given verbal feedback—considered verbal warning—that they are not performing up to expected standards. In particular, supervisors are expected to give a verbal warning if they believe the trainee is not performing up to expected standards, and if the trainee is likely to be rated below the expected level on any of the defined competencies during formal written evaluation periods. If the trainee addresses the feedback appropriately and brings their performance up to the expected standard, then no further action is necessary.

Problems seen as normal professional development issues will be communicated to the university training director in the regular evaluations sent at the middle and end of the training year. If, however, the deficiency is viewed by the training committee as potentially serious (i.e., may interfere with the intern's successful completion of the internship) or is not resolved after two weeks of the implementation of the formal remediation plan, the Training Directors will consult with the intern's university training director as soon as this becomes apparent to the Training Committee. The academic training director will be sent a copy of the written remediation plan and given the opportunity to approve the plan or suggest changes in the plan.

If the trainee fails to meet expectations at the time of a written evaluation, the following procedures to address problematic performance and/or conduct will be initiated:

1. Within 10 working days of receipt of the rating, the Training Directors, rotation supervisor(s), and other relevant supervisors will meet as a Review Committee to discuss the ratings and determine what action needs to be taken to address the problem reflected by the ratings.

2. The trainee will be notified verbally and/or in writing, immediately upon receipt of the ratings, that such a review is occurring, and the Review Committee will receive any information or statement from the trainee related to their response to the rating.

3. In discussing the ratings that fall below minimum expectations and the trainee's response, if available, the Review Committee may adopt any one or more of the following methods or may take any other appropriate action. The Committee may issue a(n):

a) Written or verbal notice that no further action is necessary

b) "Acknowledgement Notice" which states in writing:
    - That the Committee is aware of and concerned with the rating.
    - That the Rating has been brought to the trainee's attention.
    - That the committee will work with the trainee to remediate the problem or skill deficit addressed by the rating.
    - That the behavior(s) associated with the rating are not severe enough to warrant more serious action

c) "Remediation Notice" which calls for the Review Committee, through supervisors and the Training Directors, to actively and systemically monitor for a specific length of time the degree to which the trainee addresses, changes, and/or otherwise improves the problem performance or behaviors. The Remediation Notice is a written statement that includes the following:
    - The specific behaviors and competencies associated with the inadequate rating.
    - The specific recommendations for rectifying the problem including what is expected of both the trainee and supervisors involved in the plan.
    - The time frame during which the problem is expected to be resolved.
    - The procedures designed to ascertain whether the problem has been appropriately rectified.

When the Review Committee deems that remedial action is required, the identified performance deficit and/or problematic behavior must be systematically addressed. Possible remedial steps include (but are not limited to) the following:

- Increased supervision, either with the same or other supervisors.
- Change in the format, emphasis, and/or focus of supervision.
- Change in the training plan and clinical foci.
- Additional reading and/or didactic instruction
- A recommendation that personal therapy be utilized to address identified behaviors. Trainees have a right to confidentiality should they elect to pursue personal therapy. Remediation plans will not reflect participation in therapy as a condition for successful remediation but will instead focus on monitoring behavioral performance and change. Trainees are eligible to use the Employee Assistance Program (EAP).

After the delivery of an Acknowledgement Notice or Remediation Notice, the Review Committee will meet with the trainee to review its recommended action. The trainee may choose to accept the conditions or may choose to challenge the action. The procedures for challenging the action are described in Trainee Grievance Procedures section of this document. Once the Review Committee has issued an Acknowledgement Notice, the trainee's status will be reviewed within 3 months' time. In the case of a Remediation Notice, the trainee's status will be reviewed within the time frame set by the notice.

A. Failure to Correct Problems:

When the intervention does not rectify the problematic performance within a reasonable period of time, or when the trainee seems unable or unwilling to alter their behavior, the Review Committee may need to take further formal action. If a trainee on Remediation has not improved sufficiently to rectify the problems under the conditions stipulated by the Remediation Plan, the Review Committee will conduct a formal review and then inform the trainee in writing that the conditions have not been met. The Review Committee may then elect to take any of the following steps or other appropriate action:

- Issue a "Probation Notice." This step is implemented when problematic behavior(s) are deemed to be more serious by the Review Committee and/or when repeated efforts at remediation have not resolved the issue. Any ongoing remediation efforts will be reviewed monthly by the Review Committee. Any determination to issue a probation notice will be done within 5 business days following the specified end date of the Remediation Plan. The trainee will be given a written statement that includes the following documentation:
    - A description of any previous efforts to rectify the problem(s) and of any appeals by the trainee.
    - Specific recommendations for resolving the problem(s).
    - A specified time frame (not to exceed 6 weeks) for the probation during which the problem is expected to be rectified and procedures for assessing this.

  Again, as part of this process, the trainee is invited to provide a written statement regarding the identified problem(s) and/or to appeal to the Chief of Psychology (to be submitted no later than 5 business days following the receipt of the probation notice). In the event that the Chief of Psychology is also a primary supervisor for the trainee, the aforementioned appeal should be sent to the Associate Chief of Staff for Mental Health. As outlined in the probation notice, the supervisor(s), Training Directors, and the trainee will meet to discuss the trainee's progress at the end of the probationary period (not to exceed 6 weeks).

- Suspend the trainee for a limited time from engaging in certain professional activities until there is evidence that the problematic performance in question has been rectified. Suspensions beyond the time specified in the Probation Notice may result in termination or failure to graduate from the program.

- Depending on the gravity of the issue, inform the trainee that they will not successfully complete the training program if their problematic performance does not change. If by the end of the training year, the trainee has not successfully completed the training requirements, the Review Committee may recommend that the trainee not be graduated. The Review Committee may specify to the licensing board those settings in which the former trainee can and cannot function adequately.

- Inform the trainee that they are recommending they be immediately terminated from the training program.

B. Unethical or Illegal Behavior

Any illegal or unethical conduct by a trainee must be brought to the attention of the Directors of Training as soon as possible. Any person who observes or suspects such behavior has the responsibility to report the incident. The Directors of Training will document the issue in writing, and consult with the appropriate parties, depending on the situation (see description below).

Infractions of a very minor nature may be resolved among the Directors of Training, the supervisor, and the trainee, as described above.

Examples of <u>significant</u> infractions include but are not limited to:

1. Violation of ethical standards for the discipline, for the training program, or for government employees.
2. Violation of VA regulations or applicable Federal, state, or local laws.
3. Disruptive, abusive, intimidating, or other behavior that disturbs the workplace environment or that interferes or might reasonably be expected to interfere with Veteran care. Disruptive behaviors include profane or demeaning language, sexual comments or innuendo, outbursts of anger, throwing objects, serious boundary violations with staff or Veterans, inappropriate health record entries, and unethical, illegal, or dishonest behavior.

Depending on the situation and the time sensitivity of the issues, the Directors of Training may consult with the Training Committee to get further information and/or guidance. Following review of the issues, the Training Committee may recommend either formal probation or termination of the trainee from the program. Probationary status will be communicated to the trainee, VA OAA, APA, and/or APPIC in writing and will specify all requisite guidelines for successful completion of the program. Any violations of the conditions outlined in the Probation Notice will result in the immediate termination of the trainee from the program.

The Directors of Training may also consult with the Associate Chief of Staff for Mental Health, Human Resources, regional counsel, other members of hospital leadership (e.g., Privacy Officer, Safety Officer, EEO Officer, Chief of Staff, Facility Director, etc.), VA OAA, APA, and/or APPIC in situations where there may be an ethical or criminal violation. Such infractions may be grounds for immediate dismissal. In addition, the Directors of Training may immediately put the trainee on administrative duties or on administrative leave while the situation is being investigated. Under certain circumstances, the program may be required to alert our accrediting body (APA) and/or other professional organizations (e.g., APPIC, state licensing boards) regarding unethical or illegal behavior on the part of a trainee.

As described in the previous section on remediation of problematic performance and/or conduct, at any stage of the process, the trainee may request assistance and/or consultation outside of the program and utilize the resources listed at the end of this document.

All documentation related to remediation, counseling, and/or serious infractions becomes part of the trainee's permanent file with the Psychology Section. These records are maintained by the Directors of Training and kept in secure, locked cabinets in their office.

IV. TRAINEE GRIEVANCE PROCEDURE

Trainees are encouraged to discuss concerns/issues in several ways: with their supervisors, with the Training Committee through the trainee representatives, and with the Training Directors in ongoing administrative meetings and informally. If issues arise that cannot be satisfactorily resolved through the above mechanisms, trainees should follow the Due Process Procedure document for resolving difficulties.

Appealing Notices of Problematic Behavior and/or Conduct

This section outlines the policy regarding a trainee's right to respond to and/or appeal any notice of problematic behavior and/or conduct:

Trainees who receive an Acknowledgement Notice, Remediation Notice, Probation Notice, or who otherwise disagree with any Review Committee decision regarding their status in the program, are entitled to challenge the Committee's actions by initiating a grievance procedure. Within 10 working dates of receipt of the Review Committee's notice or other decision, the trainee must inform the Training Directors in writing that they disagree with the Committee's action and provide the Training Directors with information as to why they believe the Review Committee's action is unwarranted. Failure to provide such information will constitute an irrevocable withdrawal of the challenge. Following receipt of the trainee's grievance, the following actions will be taken:

- Upon receipt of the written notice of grievance, the Training Directors will convene a Grievance Committee consisting of the Training Directors, two training committee members selected by the Training Directors, and two training committee members selected by the trainee. The trainee retains their right to hear all allegations and the opportunity to dispute them or explain their behavior.

- Within 10 working days of receipt of the written notice of grievance by the trainee, a Grievance Hearing will be conducted, chaired by the Training Directors, in which the grievance is heard, and evidence is presented. Decisions made by the Grievance Committee must be made by majority vote. Within 5 working days of the hearing, the Grievance Committee will submit a written report to the Chief of Psychology and/or the ACOS for Mental Health.

- Within 5 working days of receipt of the Grievance Committee's report, the Chief of Psychology and/or ACOS for Mental Health will accept the Grievance Committee's action, reject the Grievance Committee's action and provide an alternative, or refer the matter back to the Grievance Committee for further deliberation. In the latter case, the Grievance Committee then reports back to the Chief of Psychology and/or ACOS for Mental Health within 10 working

dates of the receipt of request for further deliberation. The Chief of Psychology and/or ACOS for Mental Health then makes a final decision regarding what action is to be taken.

- Within 10 working days the final decision, recommendations will be communicated to the trainee and any other appropriate individuals, in writing.

All documentation related to the grievance process becomes part of the trainee's permanent file with the Psychology Section. These records are maintained by the Directors of Training and kept in secure, locked cabinets in their office.

V. PROBLEMATIC SUPERVISOR PERFORMANCE AND/OR CONDUCT

This section details the program's procedures for handling any complaints or concerns about a supervisor's performance. Complaints/concerns may be brought by trainees, Training Committee members, or any VA staff.

Any professional misconduct or problematic behavior by a supervisor must be brought to the attention of the Directors of Training as soon as possible. Any person who observes or suspects such behavior has the responsibility to report it. The Directors of Training will document the issue in writing and consult with the appropriate parties to determine the best course of action for addressing the behavior. Resources for consultation may include the Section Chief of Psychology, the Associate Chief of Staff for Mental Health, Human Resources, regional counsel, other members of hospital leadership (e.g., ACOS/Education, Privacy Officer, Safety Officer, EEO Officer, Chief of Staff, Facility Director, etc.), VA OAA, APA, and/or APPIC, depending on the situation.

A. <u>For complaints/concerns brought by trainees:</u>

1. If a trainee has a grievance of any kind, including a conflict with a supervisor (but also with a peer or other hospital staff), or with a particular training assignment, the trainee is first encouraged to attempt to work it out this issue informally and directly. **In some circumstances, if the trainee feels uncomfortable or unsafe doing so, they may choose to bring the issue directly to the Directors of Training.

2. If unable to resolve the issue, the trainee would then discuss the grievance with the Directors of Training, who would meet with the parties as appropriate. **In the event of a sexual or professional misconduct or other serious, safety-related allegation by a trainee, the Directors of Training may seek consultation to determine the best course of action, as described at the beginning of this section, above.** Serious allegations may then follow the procedures outlined below in the section on complaints/concerns brought by Psychology or other VA staff.

3. If still unable to resolve the problem, the trainee, supervisor, and Directors of Training would then meet with the Chief of Psychology and/or the Associate Chief of Staff (ACOS) for Mental Health, as needed.

4. A meeting with all the involved parties would be arranged within two weeks of notification of the ACOS for MH. The ACOS for MH serves as a moderator and has the ultimate responsibility of making a decision regarding the reasonableness of the complaint.

5. The ACOS for MH would make a recommendation of how to best resolve the grievance. Within one week of the meeting, a written notification of this recommendation will be forwarded to all parties by the ACOS for MH.

6. If a mutually satisfying resolution cannot be achieved, any of the parties involved can move to enlist the services of two outside consultants, a graduate of the traineeship program and a psychologist unaffiliated with the program, but familiar with training issues. If a graduate of the traineeship program is unavailable, a second unaffiliated psychologist who is familiar with training issues may be requested.

7. The consultants would work with all involved individuals to mediate an acceptable solution. The ACOS for MH will implement this step in the grievance procedure as soon as a request is made in writing.

8. The consultants would meet with the involved parties within one month of the written request. The two consultants and the ACOS for MH would then make a final decision regard how to best resolve the grievance.

9. All parties would be notified of the decision in writing within one week. This decision would be considered binding and all parties involved would be expected to abide by it.

***Please note: if a trainee has an issue with the Directors of Training that they are unable to work out directly, the trainee would discuss the grievance with the Chief of Psychology or their designee, who would then meet with the trainee and Director of Training, as appropriate.*

B. <u>For complaints/concerns brought by Psychology or other VA staff:</u>

1. Any concerns about a supervisor's participation in clinical training should first be brought to the Director of Training.

2. The Director of Training will determine the appropriate course of action based on the severity of the issue; this can include consultation with the Section Chief of Psychology, the Associate Chief of Staff for Mental Health, Human Resources, regional counsel, other members of hospital leadership (e.g., ACOS/Education, Privacy Officer, Safety Officer, EEO Officer, Chief of Staff, Facility Director, etc.), VA OAA, APA, and/or APPIC.

3. Based on these consultations, the Directors of Training may take any of the following actions:

- Informal discussion with clinical supervisor
- Require additional training in order to enhance supervisor competence in a particular area
- Discussion with clinical supervisor, their immediate supervisor, and/or Section Chief
- Report the issue to HR and/or Chief of Staff's office

4. Following discussion with the Training Directors, the Section Chief, and the ACOS for Mental Health, issues of sufficient severity or repeated failure to correct problematic behavior may result in a period of probation, suspension, or removal from the Training Committee.
   - Any such issues would be put to the full Training Committee for a vote; if there are immediate concerns for trainees' safety or well-being, the Directors of Training may temporarily suspend the clinical supervisor until a vote can be held.
   - The Training Committee will outline conditions, if any, for the issue to be reviewed.

VI. RESOURCES FOR TRAINEES:

At any stage of the remediation or grievance processes, the trainee may request assistance and/or consultation outside of the program. Resources for outside consultation include:

- **VA Office of Resolution Management (ORM)** –
  Department of Veterans Affairs
  Office of Resolution Management (08)
  810 Vermont Avenue, NW, Washington, DC 20420
  1-202-501-2800 or Toll Free 1-888- 737-3361
  http://www4.va.gov/orm/

  This department within the VA has responsibility for providing a variety of services and programs to prevent, resolve, and process workplace disputes in a timely and high-quality manner. These services and programs include:

  - **Prevention**: programs that insure that employees and managers understand the characteristics of a healthy work environment and have the tools to address workplace disputes.
  - **Early Resolution:** ORM serves as a resource for the resolution of workplace disputes. ORM has been designated as the lead organization for workplace alternative dispute resolution (ADR) within VA. This form of mediation available to all VA employees. Mediation is a process in which an impartial person, the mediator, helps people having a dispute to talk with each other and resolve their differences. The mediator does not decide who is right or wrong but rather assists the persons involved create their own unique solution to their problem. VA mediators are trainee VA employees who have voluntarily agreed to mediate workplace disputes. They are specially trained and skilled in mediation techniques and conflict resolution. In electing to use mediation, an employee does not give up any other rights.
  - **Equal Employment Opportunity (EEO) Complaint Processing**

- **Association of Psychology Postdoctoral and Internship Centers (APPIC)**
  APPIC has established both an Informal Problem Consultation process and a Formal Complaint process in order to address issues and concerns that may arise during training year.

  http://appic.org/Problem-Consultation

  Informal Problem Consultation (IPC)

  Please complete the IPC form or contact the APPIC Match Coordinator through appic@appic.org.

  To initiate the IPC process: Complete the online IPC Request Form and it will be sent to the APPIC Executive Director, Dr. Jeff Baker . You should receive a response within two business days. Those in the VA, federal prisons or hospitals with restricted access to Online Forms may have to complete this form at home or on their cell phone. The form does not require any identifying information of a trainee thus no PHI is transmitted with this form.

  Formal Complaints

  Questions about the formal complaint process may be directed to Dr. Ellen Teng, Chair of APPIC's Standards and Review Committee, eteng@bcm.edu.

  If you have COMPLETED an Informal Problem Consultation (IPC) with APPIC and the issue was not resolved, the next step to consider is filing a FORMAL COMPLAINT. Complaints should be filed ONLINE:

  ASARC Complaint Form
  Submit any additional attachments as uploads in the form itself.

  (Alternative to Online Submission)

  Submit by email to APPIC:
  Attention: Chair, APPIC Standards and Review Committee
  APPIC
  appic@appic.org

- **APA Office of Program Consultation and Accreditation**:
  750 First Street, NE

Washington, DC 20002-4242
(202) 336-5979
http://www.apa.org/ed/accreditation

- Independent legal counsel

Please note that union representation is not available to trainees as they are not union members under conditions of their VA term-appointment.

Appendix D: Postdoc Training Plan

INDIVIDUALIZED TRAINING PLAN
GEROPSYCHOLOGY POSTDOCTORAL RESIDENCY PROGRAM
VA NY HARBOR HEATLHCARE SYSTEM, BROOKLYN CAMPUS

The purpose of this training plan is to assist the resident in identifying and evaluating their geropsychology competencies and to link these goals to specific training experiences. This form is to be completed in collaboration with the primary mentor/supervisor (with additional input from training faculty as needed). The plan should be completed at the end of orientation, and then integrated into the year-long evaluation process (formal reference at mid- and end of rotation) with additional updates as needed during the training year.

Name of Resident	Training Year

My professional goal(s): Please describe your professional goals – i.e., what you would like to achieve following completion of geropsychology training?

Based on results from the Pikes Peak Self-Assessment Tool, the following are my primary training **STRENGTHS** (knowledge and skills domains in which the learner feels most confident and competent in geropsychology practice). These areas of growth can be linked to further goals for education and training.

Based on results from the Pikes Peak Self-Assessment Tool, the following are my primary training areas of **GROWTH** (knowledge and skill domains in which the learner wishes to develop further competency):

The following additional training needs were identified based on supervisor/training committee review and/or assessment (if in mid-year evaluation):

Training Experiences: The following are a list of training experiences for each rotation, along with opportunity for the resident to identify specific interests or goals in increasing geropsychology competencies. Each rotation will provide a range of competency-focused training to develop knowledge and skills to work with older adults who may seek services across a continuum of care.

Clinic: Geriatric Primary Care Mental Health Integration
Days/hours per week:
Primary supervisor: Julija Stelmokas, Psy.D.. ABPP-CN

Activity (specific interests/goals)

- Complete cognitive/behavioral health screening (curbside and/or scheduled)
    - Anticipated caseload:
    - Specific interests/goals:
- Complete individual therapy (with Veterans and/or care partner/caregiver)
    - Anticipated caseload:
    - Specific interests/goals:
- Consult with multidisciplinary team members on results from assessment and/or intervention services
    - Specific interests/goals:
- Consult with (and incorporate when clinically indicated) family members in therapy and assessment services
- Engage in team-based appointments, including collaborative feedback with GERI-PACT team members and/or observing or participating in key aspects of medical visit with individual team members
    - Specific interests/goals:

Anticipated number of hours per week on this rotation:

Clinic: Oncology/Palliative Care
Days/hours per week:
Primary supervisor: Valerie Abel, PhD, ABPP; Sabrina Esbitt, PhD

Activity (specific interests/goals)

- Complete psychosocial distress screening of oncology and palliative care referrals
    - Anticipated caseload:
    - Specific interests/goals:
- Complete individual therapy (with Veterans and/or care partner/caregiver)
    - Anticipated caseload:
    - Specific interests/goals:
- Consult with multidisciplinary team members on results from assessment and/or intervention services

    - Specific interests/goals:
- Consult with (and incorporate when clinically indicated) family members in therapy and assessment services
- Engage in team-based appointments, including collaborative feedback with medical or other consultative teams, team members and/or observing or participating in key aspects of medical visit with individual team members
    - Specific interests/goals:

Anticipated number of hours per week on this rotation:

1. Palliative Care/Oncology

Initial Evaluations:	Supervisor(s):
Outpatient Therapy Caseload:	Supervisor(s):
Group Therapy:	Supervisor(s):
Comments:	Supervisor(s):

2. Home-Based Primary Care

Comments:	Supervisor(s):

3. CLC – St. Albans

Shared Medical Appointments:	Supervisor(s):

Outpatient Therapy Caseload:	Supervisor(s):
Group Therapy:	Supervisor(s):
Comments:	Supervisor(s):

4. Geriatric Neuropsychology

Shared Medical Appointments:	Supervisor(s):
Outpatient Therapy Caseload:	Supervisor(s):
Group Therapy:	Supervisor(s):
Comments:	Supervisor(s):

5. Teaching & Supervision

☐Intern Geropsychology Seminar - monthly
☐Extern/Intern Supervision on rotation
☐Geriatric team journal club

Comments:

6. Didactic seminars, conferences, and other meetings:

- Palliative Care team meetings: Mondays and Tuesdays @ 9AM
- GeriPACT team meeting: Fridays @ 1PM
- Dementia Steering Committee: every 2 months, the third Friday of the month @ 1PM
- Home-Based Primary Care team meeting: Wednesdays @ 9AM
- Geropsychology VA National Postdoc Seminar: Fridays @ 11AM
- EBP Group Didactics/Supervision with NYH postdocs: 1st, 2nd, 3rd, 5th Fridays @ 9AM
- Supervision of Supervision Didactics with NYH postdocs: 4th Friday of the month @ 9AM
- Interprofessional seminar with chaplain fellows: 1st Friday of the minfuse ethicsonth @ 9AM

• Rotating seminar series: ethics and diversity • Comments:

7. Resident-choice training

a. Choose from "choose your own adventure" here

Fellow signature:_____ Date:_____

Primary Supervisors' signature:_____ Date:_____

_____ Date: _____

Director of Training signature:_____ Date:_____

INDIVIDUALIZED TRAINING PLAN – MID-YEAR UPDATE
GEROPSYCHOLOGY POSTDOCTORAL RESIDENCY PROGRAM
VA NY HARBOR HEALTHCARE SYSTEM, BROOKLYN CAMPUS

1. Please note any changes to training plan since the beginning of the year and reasons for these changes:

2. Is the fellow on track to successfully complete the program (i.e., receiving passing ratings on all evaluations, completing all clinical, documentation, didactic, and administrative requirements, making sufficient progress on fellowship project)? YES or NO

If no, please describe any areas of deficiency and what has been done to address them:

3. Additional comments:

Fellow signature:_____ Date:_____

Primary Supervisors' signature:_____ Date:_____

_____ Date:_____

Director of Training signature:_____ Date:_____

INDIVIDUALIZED TRAINING PLAN – END OF YEAR REVIEW
GEROPSYCHOLOGY POSTDOCTORAL RESIDENCY PROGRAM
VA NY HARBOR HEATLHCARE SYSTEM, BROOKLYN CAMPUS

1. Please note any changes to training plan since mid-year and reasons for these changes:

2. Has the fellow successfully completed the program (i.e., passing ratings on all final evaluations, completion of all clinical, documentation, didactic, and administrative requirements, completion of fellowship project)? YES or NO

If no, please describe any areas of deficiency and what has been done to address them:

3. Additional comments:

Fellow signature:_____ Date:_____

Primary Supervisors' signature: _____ Date:_____

_____ Date:_____

Director of Training signature:_____ Date:_____