When I read the topic of this issue of the newsletter, I realized that the training that we provide to students, postdoctoral fellows and residents is a particularly noble calling. We make such a difference in the lives of these individuals. When we are working on a project, are confronted by a novel task, or perhaps struggling with a difficult issue, we frequently hear ourselves saying, “What would my major professor have done?” or perhaps, “What would my best supervisor have suggested?” or even, “Is this problem similar to any that I have encountered previously where I received excellent advice?” Indeed, trainees frequently have internalized what we told them many years ago and often still remember what we said about how to manage a situation or how to handle a particular problem. It is sometimes frightening when I meet a student or trainee from several years ago and they begin to repeat what I once told them, almost like a tape recorder.

I realize that my graduate training nearly four decades ago is really obsolete for the purpose of addressing important clinical and research questions. In response to questions that I would raise, the frequent response among the faculty was, “Is there a literature pertaining to that area?” After all, there was no literature in behavioral medicine or pediatric psychology but one was being created during my graduate training and shortly thereafter. Thus, I did not learn to be an academic health center psychologist who specialized in children and adolescents. Rather, I learned to think about psychological issues and children in the context of a developmental framework. I learned issues that are now pervasive today in an academic health center. For example, when I received my training there were no transplantations available except potentially on an experimental basis, the HIV-AIDS virus did not exist, and there clearly was a dearth of intervention research to guide treatment on an in-patient or out-patient setting. In fact, we learned about diagnosing psychopathology based on the Diagnostic and Statistical Manual –II (American Psychiatric Association, 1975). Nonetheless, my fellow students and I learned how to think about problems and situations, how to problem-solve and construct cognitive thought processes like a psychologist, and draw from the extant literature in various areas of psychology for the purpose of addressing important clinical and research questions. In this issue, I love reading about folks starting new programs and rotations in integrated care—as Britt Nielsen, Lisa Shah, and Billie Schwartz have done. Also don’t miss opportunities within APAHC highlighted in the newsletter—the Early Career Boot Camp and the Reviewer Training Program. Equally compelling are articles from Laura Daniels and Sonia Rubens about their training experiences and from Ron Brown and Alexandra Zagoloff about opportunities, rewards, and responsibilities associated with mentoring.

Thanks to all who have participated over the past several years: by writing, editing, photographing and sharing your ideas! I can’t wait to find what our next editor has in store for Grand rounds.
Announcing the Reviewer Training Program for APAHC Student Members!

Laura Daniels, (photo below) M.A., Clinical Health Psychology Program, East Carolina University, Cherokee Health Systems Psychology Intern
Desiree Azizoddin, M.A., Clinical Psychology Program, School of Behavioral Health, Loma Linda University
Gerald Leventhal, Ph.D., Editor-in-Chief, Journal of Clinical Psychology in Medical Settings (JCPMS), Official journal of the Association of Psychologists in Academic Health Centers

The Reviewer Training and Mentoring Program is a collaborative project of the Journal of Clinical Psychology in Medical Settings (JCPMS) and APAHC. The program offers APAHC student members supportive training and hands-on experience in peer reviewing and exposure to peer-review procedures used in psychology journals like JCPMS. APAHC student members who participate in the program are expected to identify a faculty member who can provide mentorship through at least one cycle of the peer-review process. In addition to the student's mentor, JCPMS Editor-in-Chief, Jerry Leventhal, provides feedback and training to assist student participants in mastering the peer-review process.

APAHC student member, Desiree Azizoddin, is currently involved in the peer-review training program. She describes her experience thus far as follows. “The reviewer training program has been an extremely valuable learning and collaborative process. I joined the program with the goal of building new perspectives and becoming more integrated within research in the field of clinical psychology. In line with these goals, I have utilized and broadened my ability to critically analyze information and contribute to the integrity of psychological science. To be able to integrate and advance the skills I acquired throughout my education and clinical career in the role of peer reviewer has been validating and inspiring.”

APAHC student members and trainees who are interested in learning more about the program are encouraged to contact Laura Daniels, APAHC’s student/trainee representative, for application materials and inquiries (danielsla08@students.ecu.edu).

to write like a psychologist when my papers came back to me with pencil marks all over my manuscripts (there were no computers back then and track changes did not exist) and when I met with my major professor who taught most of what I know today about being an academic. She taught me how to think and how to communicate like a psychologist. I have no doubt that in another 30 or 40 years the literature again will be quite different and perhaps there will be novel areas that were not even thought of today but what we will have taught our trainees is about how to think about problems and situations within a psychological and scientific context. Our trainees will remember what we have to say and how we thought about issues. They will even quote us! That is the legacy of what we leave our students and trainees.

I also am reminded that the limits of our teaching and training activities do not end with our students and trainees. There always are the junior faculty members that we are responsible for mentoring, the associate professor who is attempting to be promoted to the rank of professor, the “boot camp” that the Association of Psychologists in Academic Health Centers sponsors at the biannual conferences, the dean who mentors the professor and the president who mentors the provost. And so the list goes on and on. When faculty and administrators come to see me and the day had been tough (these days are not uncommon at universities), I remind them of the difference that we make on a daily basis to the students and trainees who we are entrusted to train. I become acutely aware of this during the late spring at graduation and also when I see former trainees and students who I have mentored over the years such as at the annual meeting of the American Psychological Association last August. The difference we make is not insignificant and the training that we do today will live on in perpetuity over the years.

Indeed, I am pleased that training has been chosen as the topic for this edition of the newsletter for the Association of Psychologists of Academic Health Centers. It reminds us that we not only make a difference to the patients that we serve and their families but to the education and training of so many individuals in their quest to become psychologists in academic health centers. For those of you who spend much of your time in training activities whether it be undergraduate, graduate, internship or postdoctoral training, I salute you in all of your endeavors and want you always to remember that you do make a difference.
How to Start an Internship in Less than a Year

Britt A. Nielsen, PsyD, ABPP, MetroHealth Medical Center, Cleveland, Ohio

Starting an internship in less than a year seems impossible—and yet, we did just that! Using resources available to us, knowing what different agencies wanted, and taking a few calculated risks allowed us to make it happen.

Our pediatric psychology group at MetroHealth Medical Center in Cleveland, Ohio is relatively small. Training is not new to us. Our department has trained graduate level practicum students for over 30 years. With the internship crisis, we recognized the need to help. We considered collaborating with other internships, though we were not sold on that idea—then in October 2013 the pieces quickly started falling into place. In fact, we welcomed our first class of interns on July 1st, 2014. If you are considering starting an internship, even if you have more than a year to plan, here is what we learned from our experience:

What you need:

- A leader—Ideally, this person would have dedicated time. The leader will organize program development, set time lines, and keep track of deadlines.
- Core faculty—For curriculum development, training, and didactics.
- A supportive administration—Needed to help justify and support the internship.

Before you begin, review:

- American Psychological Association (APA)'s education website and Association of Psychology Postdoctoral and Internship Center (APPIC)'s website for guidance.
- The Internship Toolkit (http://www.apa.org/education/grad/internship-toolkit.pdf) gives pointers on advocating for a program at your institution.
- The APPIC website (www.appic.org) outlines requirements for APPIC Membership, explains the APPIC Match. APPIC will also provide a mentor for support.
- Take advantage of Training Meetings: Attend APPIC Membership meeting and sign up for the APA self-study workshop.

Take action:

Create a business plan. Consider faculty time costs, intern salaries, equipment costs, and cost for APPIC Membership and APA Accreditation. With help from our business administrators, we developed a viable business plan that made our program cost neutral.

Develop an internship handbook. The handbook informs interns of the structure of the program, the plan for training, program goals, objectives and competencies. The plan for rotations, the schedule of didactics, procedures, due process, and grievance policies are also explained in the handbook.

We talked to directors of other internship programs to help guide us. We used resources of our Graduate Medical Education (GME) office. They provided us with procedures, grievance and due process policies. The GME also gave us access to an online evaluation system. This system allows interns to track patient contacts, duty hours and provides a graphic representation of their achievement of competencies.

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Mentoring-Related Activities for Junior Faculty in Academic Health Centers

Alexandra Zagoloff, Ph.D. (photo below)
Katharine J. Nelson, M.D., University of Minnesota Medical School, Department of Psychiatry

As junior faculty members begin their careers within academic health centers and medical schools, several mentoring opportunities are available. While mentoring has received less attention in the literature than supervision, authors seem to agree that mentoring includes a “personal relationship in which a more experienced (usually older) individual acts a guide, role model, teacher, and sponsor of a less experienced (usually younger) protégé” (Johnson & Nelson, 1999). This article will review ways in which the authors have involved themselves in activities related to mentoring—as mentees of senior faculty, as mentors of trainees, and as peer mentors of colleagues.

We were fortunate to begin our careers in a department that recently implemented a career-mentoring program. Initially, a list was created of full and associate professors interested in mentoring assistant professors. Next, assistant professors requested mentors from those available. Each assistant professor was paired with two mentors—one primary, the other secondary. Each mentor-mentee pair agreed to the following: confidentiality, participating in regularly scheduled meetings (frequency established by the pair), respectful feedback, review of the mentee’s short- and long-term goals, and reviewing the mentoring relationship (University of Minnesota Department of Psychiatry, 2013). The relative roles and contributions of the primary mentors were clearly outlined.

The Spring issue of Grand rounds will soon be underway, and we’re seeking articles of approximately 500-1000 words by February 2, 2015. Please send ideas, comments, and best yet, offers to contribute to:

Cesar A. Gonzalez, Ph.D., ABPP, LP at Gonzalez.Cesar@mayo.edu
A Brief Interview on How to Survive The Match 2015

Laura Daniels, M.A., Clinical Health Psychology Program, East Carolina University, Cherokee Health Systems Psychology Intern

Rose Gonzalez, Ph.D., Post-Doctoral Fellowship: HIV/HepC Primary Care Clinical Psychology. Doctoral Program: Counseling Psychology, The University of Southern Mississippi. Michael E. DeBakey VAMC Intern

The clinical psychology internship crisis seems to be improving as the quantity of sites and positions, Match rates, and quality of matches have improved (Keilin, 2014). This is largely due to APAGS and the APA Education Directorate raising awareness of the imbalance, lobbying Congress for funding, and awarding grants to create quality training sites (e.g. Internship Stimulus Program, DeAngelis, 2013). Nonetheless, students continue to report genuine uncertainty and distress about the APPIC Match process. In this article we attempt to alleviate some of this distress by answering questions submitted by this year's applicants.

What is the best approach for building my list of potential sites and keeping it manageable?

Rose: The first step towards successfully matching is knowing your "identity." What are your goals, interests, and gaps in training? How do you plan to "brand" yourself? After reflecting on these questions, developing your list of potential sites will become less daunting. When making my list, I kept sites that excited me, added some "reach" and "safe" sites.

Laura: Some of my peers opted to search state-by-state in the APPIC directory for sites that fit their training needs. I created my initial list of 50 sites using three sources:

- Sites associated with professionals who I came to respect via listservs and my training.
- Alumni from my program who were happy to provide advice and information about sites where they interviewed.
-Focused searches of the APPIC directory, APA divisions, associations, etc.

After I clarified my training goals, I could better determine which training models excited me the most and which to cut. I ranked them using three categories (top-tier, middle, safe-choice) based on competitiveness/goodness-of-fit and applied to a few from each tier.

Tip: Due to increased funding for developing internship programs, there are many sites that are either receiving or have received a site visit this year and waiting for official notice of accreditation. If you discover unaccredited sites that excite you, consider emailing the training directors to inquire about their accreditation timeline.

Once my references have agreed to write letters of recommendation, how do I convey what aspects of my CV and training that (s)he should focus on?

Laura: I sent my references my site list, CV, and a “Summary of Contributions.” The summary was a bulleted list of: contributions I made to their clinical and research projects; competencies I developed while training with them and specific examples of how I demonstrated these skills; or unique clinical cases or professional experiences that served as excellent training opportunities.

Rose: Think of your references as your "team," so pick strategically. I asked individuals whom I could be open and honest with to write letters. I sent them my CV, a list of my sites grouped by type (e.g., academic health centers), and a bulleted lists of what I preferred them to emphasize in the letter for each type. This way, the letters are customized and help you stand out.

Tip: You might consider asking your writers if they are open to your edits, which allows for the greatest amount of involvement.

What is the best approach for responding to interview offers? Should I book right away or wait until all offers are in?

Rose: Slots fill up quickly, so book as soon as possible (i.e. 'you can't count your chickens before they hatch'). As your interview schedule fills up, it will become more difficult to fit in interviews, so try to leave a few days between each one to allow for last minute additions.

Laura: I created a calendar of interview dates that provided a visual aid of the sites that overlapped or had only one interview option. I felt extremely prepared to book right away. (Sites often specify their interview dates or "Fridays in January" and I emailed program secretaries to inquire about unknown dates.)

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A Brief Interview on How to Survive The Match 2015

What was the most unexpected experience you had during interviews? How did you handle it? What are some things that you had to speak to during the interview process that were not easily prepared for?

Laura: You will be surprised at how often you utilize your clinical skills. One interviewer opened with a statement about how interviews are poor predictors of intern success and that he was going to ask very specific questions about my graduate training. I responded with a genuine smile and told him I appreciated his honesty and looked forward to answering his questions. I followed his lead, mirrored his behavior, and provided concise complete answers. Half way through, I asked him 1 or 2 specific questions. Fortunately, he concluded the interview with positive feedback.

Rose: What surprised me was the competitiveness among interviewees during Q and A's and group interviews. The intentions of ultra-competitive applicants are thinly veiled and detrimental. Resist the reflex to "one-up"; avoid vapid speech and empty questions which are ultimately not worth the efforts of being seen or heard. Remain composed and respectful. Speaking for myself, I set the bar high for what was a valuable contribution in these settings. I wanted to be remembered as insightful and my words meaningful.

Questions that were more common than I expected included reasons for seeking a career as a psychologist, my identity as a therapist, and life goals and aspirations. Be able to speak about yourself fluidly and with depth and forethought. As interviews progressed I found myself responding with more complex and interesting answers. Since being involved in the internship interview process as an intern "on the other side," I am even more convinced that this strategy will make you memorable and seem mature beyond your years of training.

What is the Number 1 skill that you believe a doctoral candidate needs to be successful in the Match process?

Laura: Self-awareness: Engaging in self-care and clarify your training goals and professional identity will help you maintain self-awareness. Self-awareness will truly help you in identifying sites that are a good fit, managing stress, and maintaining focus and your sense of self during interview travel.

Rose: Enthusiasm: Be hopeful and happy; the Match paves the way towards your future! Enthusiasm, devoid of debilitating anxiety and insecurity, will be what drives you through writing essays, and more importantly, will set you apart during interviews (especially towards the end of your interview tour when travel begins to wear on you).

What would you say is the most important part of your application aside from logged hours?

Laura: While quantity of hours is important, the quality of the training is critical. It is critical to clearly articulate in your AAPI packet (cover letters, CV, and essays) how the breadth and depth of your training (i.e. modality, setting, population) and unique experiences align with your internship goals.

Rose: It is a misconception that hours are everything. Your essays will take you very far and can make up for gaps in hours. Be original, thoughtful, unique, and even humorous. Set yourself apart. Investing in my essays was a decision I did not regret. By the time you interview, you have already proven yourself qualified. Interpersonal style and personality will, at this stage, be the most vital aspect to success.

How important is it to have specific and extensive experience in any specific track that one applies for?

Laura: Your AAPI should tell a clear story of your professional development. When I lacked experience in a specific area, I emphasized my strengths and how the site was a good Match for me as it provided training in that area. Reviewers should never be left with the onus of making the connection for why you and the site are an excellent Match.

Rose: Not as important as you may think. If you don’t have direct experience to speak of, clearly articulate in your essays why a specific track is a good fit and what you have to offer, based on the various experiences you do have. Work to make these components fit into one cohesive theme, so that your interests, experiences, and personal proclivities work together in your essays.
Integrated Behavioral Health in Urban Pediatric Primary Care: A Step Forward In Preventative Care


Equal access to high quality behavioral health (BH) care for children is an ongoing, unmet need in the United States. Numerous factors contribute to the underutilization of BH services, including family beliefs and access barriers (Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005). It is estimated that only 25% of children with BH problems actually receive care, and that 50% of healthy children are at risk for developing serious health and mental health conditions (Kataoka, Zhang, & Wells, 2002). This is particularly true for the urban poor who are at significant risk for chronic health and mental health conditions (Van Cleave, Gortmaker, & Perrin, 2010).

Healthcare changes in response to the Affordable Care Act highlight the importance of a Patient-Centered Medical Home (Rittenhouse, Shortell, & Fisher, 2009), which emphasizes evidence-based, continuous, and integrated healthcare linked with community services (Institute of Medicine, 2001). Pediatric primary care has emerged as a major “de-facto” venue for the delivery of BH services to children; however, BH services currently offered in primary care are inadequate. Generally, primary care providers (PCPs) are not able to provide the range of BH services needed due to limitations in professional competence as well as role and time constraints (Power, Blum, Guevara, Jones, & Leslie, 2013). Therefore, mental health providers based in primary care can help improve the quality of preventative healthcare in these settings.

Integrated Behavioral Health

Integrating BH in urban primary care settings requires a shift from relatively long-term, office-based therapy to consultation and brief intervention. In the traditional mental health model, clinicians typically see patients for several 50-minute sessions over the course of a few months. In contrast, in an Integrated Behavioral Health (IBH) model, clinicians are consultants to patients and providers over a longer period of time. The consultation model allows rapid access to professionals providing brief, evidence-based care. This is consistent with a population-based approach promoting incremental changes in behavioral health that translates to significant prevention effects over time (Whitlock et al., 2002). Consultation typically involves brief evidence-based intervention and occurs with the medical team during routine well-child or sick visits. This integrated approach promotes higher quality of care both through direct patient contact and interprofessional education.

Training Competencies

There are emerging opportunities for psychology trainees interested in providing BH intervention in pediatric primary care settings. Trainees can participate in the development of models of care and effectiveness research to help shape the future of this service delivery. To support this, training competencies specific to primary care should be considered. In primary care, trainees will likely encounter a new approach to treatment in addition to pediatric health issues that are seldom the focus of traditional psychology training programs. Didactic instruction and case-centered discussion are needed to enhance trainees’ knowledge of evidenced-based interventions, behavior change strategies, and medical diagnoses commonly seen in primary care. Training should be general and widespread to adequately address the needs of the range of patients seen in this setting. Consistent with an integrated, interprofessional approach, didactic training should be provided by and to a diverse group of professionals who work within the practice (e.g., PCPs, nurses, social workers) and outside of the practice (e.g., psychologists, child psychiatrists, and other specialty medical providers).

Developing a Model of Care

The integration of behavioral health services into urban pediatric primary care centers at The Children’s Hospital of Philadelphia (CHOP) has been a developmental process that has evolved in response to the needs of our partners in pediatric practice, families, and trainees. Our model utilizes three modes of referral or “warm-handoff”: (a) Direct consultation with the PCP outside of the medical visit; (b) Screen and refer, which includes brief screening within the existing medical appointment and referral to community-based services; and (3) Assess and refer, which involves a more comprehensive assessment of patient/family concerns and concludes in referral to community-based services. In addition, IBH clinicians provide very short-term intervention (i.e., 1-3 problem-focused sessions) and in a limited number of cases, longer-term child and family therapy (i.e., 8-12 sessions). This latter component of the model was designed to address the needs of trainees to develop intervention skills while also helping to meet additional patient needs within the practice. For patients for whom long-term, ongoing treatment is indicated, existing protocols are followed to ensure connection to appropriate community-based treatment options (e.g., referral to a practice-based social worker, crisis center, or community-based mental health agency).

Conclusion

The integration of BH into primary care marks an important step forward in preventative care. Although this model limits clinician availability to provide long-term, traditional outpatient mental health services, it enables BH services to be highly integrated with pediatric care. The IBH model promotes accessibility and family engagement in behavioral health services and reduces barriers to care that are especially salient in urban, low-income settings. This approach affords opportunities for providers to reach a greater number of families than standard

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Facilitating Interprofessional Training and Learning

Lisa Ramirez, Ph.D., Assistant Professor; Associate Psychology Internship Training Director—Department of Child and Adolescent Psychiatry and Psychology; Director of Behavioral Health-School Health Program, MetroHealth Medical Center, Cleveland, OH

As a pediatric psychologist, most of my graduate school, internship and postdoctoral training took place in children's hospitals, usually in some type of specialty or primary care pediatric clinic with preceptors who specialized in specific chronic illness or behavioral intervention (e.g., sleep, feeding, toileting, etc.). Post-training, I have been fortunate to have the experience of working in an academic, urban county hospital that is the region's only level 1 trauma center and specializes in treating individuals with Medicaid, or who are uninsured. There are 20 psychologists in the entire medical system (in pediatrics, adult psychiatry, family medicine and rehabilitation), which allows each of us to have the opportunity to participate in a variety of interprofessional teams. Consequently, interprofessional collaboration and cross training are hallmarks of many of the behavioral health and medical training programs here at MetroHealth Medical center.

My leadership and/or curriculum development roles in the residency training programs within child and adolescent psychiatry and psychology, pediatrics, and family medicine allow for easy creation of shared rotation experiences and enhanced exposure and competence related to behavioral health principles and challenges.

The following are four examples of exciting new interprofessional initiatives within the hospital:

1. **Psychology fellow and psychiatry resident collocation in family medicine clinics:** MetroHealth Medical Center has a strong tradition of having psychologists and psychology trainees embedded in pediatric and family practice clinics, either in co-located or fully integrated models. MetroHealth's department of family medicine now offers senior psychiatry residents weekly opportunities in the primary care clinic. This new model allows for side-by-side training with family practice residents, psychology postdoctoral fellows and junior psychiatry residents. In the best case scenario, adult patients are referred for mental health evaluations by their PCPs and the family practice resident, psychiatry resident, and psychology fellow all have access to the EMR and conceptualize the patient's pathology and associated needs together. When possible, the family medicine resident will sit in on the psychiatry resident or psychology fellow's diagnostic intake in order to follow up and see how their hypotheses about their patient's functioning mapped on to the outcome of the diagnostic evaluation. In this model, the three specialties are able to learn from each other and adopt best practices in to their own practice.

2. **Interprofessional case conference:** To further solidify the interprofessional collaboration and sharing of theoretical frameworks in family medicine, there is a monthly interprofessional case presentation. During this hour, a family medicine resident presents a case with a mental health component. During the hour, which is facilitated by myself and another psychologist, residents and faculty from family medicine, psychiatry, social work, and psychology all discuss the case conceptualization and how each discipline might approach the problem. This has led to some wonderful discussions and education around important mental health issues, such as borderline personality traits, suicidality, and 'pink slipping' patient, substance use and abuse, and the importance of rapport building. Since starting this monthly meeting, the medical residents are more adept at seeking targeted consultation and support from their behavioral health counterparts, and often will adapt their practice to reflect concepts addressed and processed during these interprofessional case conferences.

3. **School health clinics:** MetroHealth and the Cleveland Municipal School District began a partnership last academic year that establishes primary care clinics at several elementary and high school campuses. The school clinics include a physician, nurse, medical assistant, and a behavioral health professional (usually a psychologist). All levels of interprofessional learners are encouraged to participate in these clinics to understand the intersection between the medical, educational, and psychosocial needs of our school-aged patients. Precepting these learners has been an invaluable experience, and allows for a creative extension of our integrated primary care team clinics, while meeting the needs of underinsured or children with transportation challenges.

4. **Shared clinics and didactics for psychology and pediatrics residents:** This is the inaugural year for MetroHealth's postdoctoral internship in pediatric and child clinical psychology. We designed the program with the intention of having our psychology interns spend 30% of their time in pediatric primary care continuity clinics. The spirit behind the shared clinics is to encourage shadowing between interprofessional continuity clinic team members so that each may appreciate the components of others’ responsibilities and contributions to integrated pediatric primary care teams. In addition to encouraging the psychology and medical residents to observe each other and collaborate on clinic cases, we created complementary didactic schedules. The similar schedules allow for joint didactics sessions when appropriate, further encouraging cross training and awareness of team member roles and relevant issues affecting multiple disciplines.

I am always pleasantly surprised by the shifts in residents’ thinking that coincide with increased exposure to psychosocial

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**“From A to Zzzzz”: Training Considerations in a Pediatric Sleep Clinic**

Sonia L. Rubens, Ph.D., Postdoctoral Fellow, Dana-Farber/Boston Children’s Hospital Cancer and Blood Disorders Center

Word seems to have gotten out about the importance of sleep. Increasingly, news outlets are reporting on consequences of poor sleep in youth and adults, and new sleep tracking devices seem to pop up all the time. Given that sleep influences one’s ability to function across domains (including mental health), teaching psychology students to address sleep problems is increasingly important. Within the Sleep Clinic at The Children’s Hospital of Philadelphia (CHOP), an interdisciplinary consultation clinic, practicum students and predoctoral interns are able to get such training. Trainees work within the medical team to provide care to families presenting with a range of sleep issues. The day starts with an hour-long didactic meeting with the entire team, followed by back-to-back patient care, and ending with group supervision for psychology students and supervisors. For a psychology trainee, a typical patient visit involves three stages: First, the trainee independently completes an intake with the family to collect background information on the case. Next, the trainee presents the case to the psychology supervisor and the patient’s medical doctor in a separate room. Finally, the trainee, along with the supervisor and the physician, see the patient together. During that time the physician conducts a brief medical exam, the team follows up on some questions, and then they discuss a plan with the family. Trainees type up the plan for the family to take home. With the complexity of sleep issues among youth and families, equipping students with the skills to adequately address sleep issues comes with a number of considerations. The following are five considerations that stood out during my time in CHOP’s Sleep Clinic.

The first consideration is related to building foundational skills. Although sleep disorders are not considered traditional mental health disorders, training students in a sleep clinic can provide a platform to develop basic psychotherapy, assessment, and consultation skills. For example, although sleep problems may be considered medical concerns, behaviorally based interventions for some sleep problems have been widely studied and supported in the literature. Thus, a sleep clinic can be a way to teach evidence-based behavioral interventions in an applied setting. Other skills that can be developed in this environment and later applied to other clinical experiences include interview skills, differential diagnosis, collaboration across disciplines, and addressing issues around safety. Given the relation between depression and insomnia, for instance, many adolescent patients may require further assessment and safety planning if they present with insomnia but also report depressive symptoms. Thus, the sleep clinic can be a useful way to develop core clinical skills that can be utilized in other clinical contexts.

The second consideration is training psychologists to work alongside physicians. For instance, differences in case presentation styles across disciplines can create confusion and lower student confidence, particularly if a physician begins to quiz a psychology trainee on questions related to the etiology and symptoms of a medical condition or medication. Teaching psychology trainees how to present a case to a physician without losing site of their identity or their confidence as a psychologist-in-training is important in this kind of setting. Our supervisors provide guidance on the overall structure of this presentation model and in-vivo support during case presentations. In addition, our supervisors work with their medical colleagues on how to collaborate with and utilize a psychology trainee as an effective team member.

When training psychology students in a sleep consultation clinic, another important consideration is similar to the question of the chicken versus the egg, or rather, recognizing when a patient is presenting for sleep issues and when they are presenting with other disorders that affect sleep. This can often be difficult to tease apart and can go beyond the scope of a consultation clinic. As one of my supervisors put it, “sleep clinic is like a window into a person’s overall well-being,” as we often discover other concerns that need to be addressed before we can address sleep problems. Our standard intake provides a brief assessment of psychiatric and medical conditions. When items are endorsed, such as anxiety symptoms, we investigate further to determine what role this might play in a patient’s sleep and what interventions are currently in place to address these symptoms. Trainees work with the team to differentiate symptoms, to identify what the primary treatment goals of the family are, and to develop recommendations that are useful to the family. Sometimes referral to another mental health is our first recommendation.

Training students to work with diverse patient populations is another important consideration, as sleep problems affect all kinds of people. Within the context of the sleep clinic, issues around diversity can arise when working with families of diverse socioeconomic status, across various cultures, religions, and languages, and with regards to parenting practices.

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Search for funding sources. In October, 2014 I received funding through the Case-Children’s Access Now program. This is part of a Medicaid workforce development initiative and supported faculty time to develop the program. This was the catalyst that put things into motion.

In November, 2014 we applied for the APA seed funding grant. This grant supports new internships seeking accreditation by supporting the cost of accreditation, membership fees, and equipment needed for the program. Once we are accredited, we plan on applying for other Graduate Psychology Education Grants to help support this program.

Register for the National Match Service. You might be concerned about the paradox: Interns are encouraged to apply to accredited internships; however, internships cannot join APPIC or get APA accredited until there are interns on site. Do not let that discourage you. In the world of the internship imbalance you can still get high quality interns.

Get the word out. APPIC does not publish information about non-member internships on the APPIC website during Phase I of the match; however, during Phase II; all sites that have available slots are listed on the site. We chose to skip Phase I of the match and waited until Phase II. We then posted our available positions on appropriate listservs and sent messages to psychology training programs in our area. At the end of Phase II, we filled our three internship positions with highly qualified interns.

Prepare APA Self Study. The bright side: APA has added a new accreditation status “Accredited on Contingency,” which is for sites who have successfully completed their self-study (all but the outcome data) and a site visit. So, with some effort, it is possible that your first class could be Accredited on Contingency.

Submit APPIC Membership. This helps prepare the program for APA accreditation.

Secrets of our success:

Know the need: For us, the overarching need of all agencies involved was the focus on diverse, underserved Medicaid population, and increasing access to quality mental health care. When it came to APA internship seed funding grant, our program met all the goals expected. We are adding new internship positions, focusing on an underserved population, and focusing on training in integrated primary care. Similarly, the MedTAPP grant was a workforce development grant with the goal of preparing professionals for working with the underserved.

Convincing the hospital administrators to add a new educational program was our toughest challenge. Working with our business administrators, we crafted a business plan that will make our program self-sustaining. A unique feature of our internship, is that we are a hospital based community mental health center. This financial arrangement allows our interns to bill for services, which will at a minimum make our program cost neutral. In our argument, we highlighted the need for mental health care for children and teens in our area, and explained how the program would help the hospital in their efforts to control costs as an Accountable Care Organization. Our hospital also wants to deploy more providers into satellite clinics around the area, we were able to offer the possibility of developing “a farm team” of psychologists that once trained and licensed would be ready to practice in those settings.

Take chances: The first chance we took was applying for the APA seed funding grant. We had been told that the grant was for programs that had interns already on site. We applied anyway. In December, 2013 we were awarded the grant! This helped catapult our timeline forward-now we had the funds to apply for accreditation and APPIC membership! The other benefit of applying—we had a glimpse into what we needed to pull together for accreditation.

The next chance we took was submitting our APPIC membership application before we actually had interns on site. This was actually not intentional-but it worked out for us. We recently got feedback from APPIC with a request to clarify aspects of our due process and grievance policy, which we were able to address and resubmit in September. Had we not taken this chance, we would have submitted our application in September, and possibly would have had to address these concerns and resubmit our application by the next deadline (in April). Now, we will be able to address their concerns and we are hopeful we will learn their decision in time to attract students for Phase I.

Final thoughts:

Working with multiple agencies, with different timelines was a bit of a juggling act. We would hurry up to meet one agency’s deadline, only to have to cool our heels while waiting for a hospital administrator’s approval or a hospital committee’s regularly scheduled meeting. To be honest, we had a couple of nail biters. As I noted earlier, we are very proud to announce that we were successful in filling our three positions with very well qualified, diverse interns.

Of course there are still tasks ahead of us—Applying for APPIC membership and applying for APA accreditation. We are hopeful that all the hard work over the last several months will pay off and help us successfully achieve these goals.

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The Internship program was a 2013 recipient of the American Psychological Association Grants for Internship Programs.
care. Finally, the IBH approach emphasizes prevention to promote the movement of families through the help-seeking process so that children and adolescents are able to receive the necessary services as problems emerge.

There are a number of lessons we learned through this first year of program development. As the initiative is federally grant supported through the Graduate Psychology Education (GPE) and the Mental and Behavioral Health Education Training (MBHET) grants administered through the Health Resources Services Administration (HRSA), there were a number of challenges related to intern recruitment and program development. For example, the notice of the GPE award was released after the APPIC Match process, thereby requiring programs to recruit interns utilizing the post-vacancy Match service and for the new interns to begin their training year off cycle. In addition, as stated above, program development has been an iterative process.

In the first half of Year 1, there was a strong focus on developing a model of care that best met the training needs of interns, the needs of the primary care providers, as well as the needs of the urban and poor patient population served by the primary care site. During the course of the year, the model evolved and was revised. Interns now receive excellent training in consultation and brief interventions, as well as training in longer-term intervention (continuity care) to fulfill requirement of our general clinical child internship program. Finally, sustaining the model will require a reliable and ongoing source of funding outside of federal grant support. As a result, hospital, community, city, and state liaisons are necessary to continue this work.

Applications now being accepted for the 2015 APAHC Early Career Boot Camp!

The APAHC Early Career Boot Camp is a biannual, day-long, interactive workshop intended for post-doctoral fellows and early career faculty/staff. The 2015 Boot Camp will be held on Thursday, February 5th, the first day of the APAHC Conference in Atlanta, GA. Application to the Boot Camp is open to psychologists within 10 years of their doctorate; however, space is limited and preference will be given to those earlier in their careers.

This year, we’ll have keynote addresses from Drs. Susan McDaniel, Cheryl King, and Barbara Cubic. We will also have a number of breakout discussions facilitated by APAHC board members and an opportunity to participate in a CV consultation to help prepare for the job market.

There is no charge for the Boot Camp and all selected participants will receive up to 2 free years of membership in APAHC. One randomly chosen participant will also be awarded a free night at the conference hotel. Applications are due by November 7th and final decisions will be made by mid-December. More information on application process can be found by visiting the main conference site (http://www.div12.org/section8/events.html). We hope you (or your mentees!) will consider applying.


The APAHC Tribute Fund

The Association of Psychologists in Academic Health Centers (APAHC) has established a Tribute Fund to remember or recognize colleagues who have made significant contributions to the Association or to medical/health psychology. Donations in any amount are welcomed and all contributions will be acknowledged publicly. Individuals who wish to contribute $500 or more to the fund will be recognized as founding members in the APAHC public materials. Contributions received will serve as discretionary funds to be dispersed upon approval of the APAHC Board. However, no more than 5% of the fund may be expended in any year. It is the hope of the APAHC Board that this fund grows and does honor to our field.

References:
and secondary mentors were determined by the needs of the mentee as well as the resources the mentor has to offer. While the program is still in its infancy, both of us have met with our respective mentors and have found the program fruitful.

Each of us completed a portion of our graduate training within our department and has enjoyed making the transition to a member of the teaching faculty. As part of the psychology internship training committee, the first author mentored one intern last year and is mentoring another this year. Mentoring pairs are assigned prior to the arrival of the interns, but one initial task is evaluating the goodness-of-fit and discussing whether the intern would benefit from changing to another mentor (Psychology Internship Handbook, 2014). At a recent convention, an alternative method was suggested – posting faculty biographies online and allowing interns to make requests prior to their arrival (Vidair, et al. 2013). Mentoring is expected to occur on a monthly basis for the first half of internship and is scheduled based upon the intern's needs for the second half. The following are a sampling of topics addressed during monthly meetings: reviewing curricula vitae, status of dissertation, post-doctoral and job applications, role-playing interviews, networking, licensing, managing internship, and developing one's professional identity. At the end of the year, interns evaluate the mentoring program and suggestions for improvement are solicited.

The University of Minnesota Medical School has designed a promotion criteria pathway designated the Teaching Track for faculty who implement and teach best practices as well as disseminate educational material through scholarship. Within the Medical School, only a handful of faculty have been promoted to the rank of full or associate professor. Consequently, the second author has submitted a proposal for career mentoring that would include group and peer mentoring (Nelson, 2014). We began with a one-day workshop that presented the essential vocabulary and tools necessary for promotion on our track. Next, senior faculty from outside departments will be invited to lecture on particular topics of interest, including curricula vitae review and guidance. Lastly, small groups of junior faculty will review one another’s work (e.g. scholarly work related to education and development of curricula). While these objectives have only recently been established, twenty-nine faculty members in or affiliated with our department are actively dedicated to teaching and consequently it is expected that the project will be enjoyable and productive.

Finally, mentoring can be a vehicle for increased communication between psychologists and professionals from other disciplines. Quality healthcare is increasingly emphasizing collaboration among different disciplines (University of Minnesota Academic Health Center Office of Education, 2013) and mentoring can facilitate these connections. One of the first author's mentors is a physician and the mentoring centers around a clinical expertise (childhood anxiety disorders). This relationship not only affects the career satisfaction of the mentor and mentee, but also directly contributes to more coordinated and integrated care for the patients. Meanwhile, the authors hold different degrees and are involved in peer mentorship related to educational activities. Again, not only do our careers benefit from this partnership, but also the students we teach receive a more comprehensive educational experience that ultimately impacts the patients they treat now and in the future.

Junior faculty members in academic medical centers balance multiple demands and successful mentoring can increase career-satisfaction (Palepu, et al. 1998). Our article highlighted some of the ways in which assistant professors can enhance their career through mentoring and increasing connection with others at all stages of professional development (trainees, junior faculty, senior faculty).

References:

University of Minnesota Department of Psychiatry Career Mentoring Agreement, 2013.


What are some characteristics that set applicants apart from the pack?

**Laura:** Focused training goals, preparedness (e.g., well-practiced concise answers to “standard” questions, prepared site-specific questions), and excellent interpersonal skills for conversing with interviewers and staff.

**Rose:** I cannot emphasize enough the importance of the interview. How you interact with other applicants, carry yourself from the moment you walk through the entrance, and the questions you ask, speak volumes to the staff, interviewers, and current interns. Appear engaged no matter your energy level and avoid checking your phone and cutting off other applicants. Put your best foot forward and present as memorable and dynamic, whether this means being confident and outgoing, or unique and thoughtful. At the end of the day, be the one they want to work with.

**References and Resources:**