VA Central Western Massachusetts Postdoctoral Neuropsychology Residency Program Policies & Procedures

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COVID-19 Impact on Training

In response to the pandemic, the VA Central Western Massachusetts psychology training program quickly transitioned to primarily telehealth, telework, and virtual training during the 2019-2020 training year. As we have continued to re-open as a facility, we have resumed on-site face-to-face clinical services for Veterans, while also continuing to offer some services via telehealth. Our trainees spend 4 days per week on-site at this time. While it is difficult to predict how mental health service delivery and psychology training will continue to evolve, it is likely that the use of telehealth and associated technology will continue to be a significant part of the experience. We remain very dedicated to providing the highest quality training for our trainees. We will continue to be vigilant about the changing landscape of service delivery and will help trainees to further enhance their flexibility and adaptability.

Mission Statement and Aims

The mission of the VA Central Western Massachusetts Healthcare System (VA CWM) Clinical Neuropsychology Postdoctoral Residency program is to advance the clinical training of future neuropsychologists at the postdoctoral level. The program adheres to the guidelines set forth by the Houston Conference and the expectations laid out by the American Board of Professional Psychology for the pursuit of specialty board certification in Clinical Neuropsychology. The specific objectives of this program rest in the development of the following foundational and functional competencies: (1) Integration of science and practice; (2) Ethical and legal standards; (3) Individual and cultural diversity; (4) Professionalism; (5) Assessment; (6) Intervention and feedback; (7) Consultation; (8) Multidisciplinary systems; (9) Supervision / Teaching; and (10) Research.

Department of Veterans Affairs

The Department of Veterans Affairs comprises three organizations: the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and the National Cemetery Administration. We fall under the auspices of the VHA. The VHA mission is to "honor America's Veterans by providing exceptional health care that improves their health and well-being."

The Facility: VACWM

VA Central Western Massachusetts Healthcare System (VA CWM) has a long tradition of psychology training. The Edward P. Boland Department of Veterans Affairs Medical Center has been training interns since 1955, and the internship training program has been continuously APA-accredited since 1979. Historically, the Medical Center has been a tertiary care hospital in the Northeast group of VA Medical Centers (VAMCs) since 1924. In May 1922, President Harding approved construction of the hospital, making it the first Veterans hospital in Massachusetts and the first psychiatric hospital for Veterans in New England. The Northampton VA was renamed in 2011 to VA CWM following a realignment in which it was joined by two additional Community Based Outpatient Clinics (CBOCs)—Worcester and Fitchburg—which had formerly been part of the VA Boston Healthcare System and the VA Bedford Healthcare System, respectively. VA CWM also then became affiliated with the University of Massachusetts Medical School and resumed research activities. VA CWM adheres to the VA three-part mission of service, training, and research, and functions primarily as a service delivery setting, providing medical and mental health care for veterans.

The Edward P. Boland Medical Center is situated on park-like grounds in the center of the five-college area of Western Massachusetts and the foothills of the Berkshire Mountains, on 105 acres of "Old Bear Hill," and has 26 buildings in red brick colonial style. The Northampton Campus Medical Center presently operates 46 psychiatric beds, 25 Specialized Inpatient PTSD Unit (SIPU) beds, 16 off-campus Compensated Work Therapy Transitional Residence Domiciliary beds, and a 30-bed nursing home care unit. Over one thousand employees, including teams of primary care physicians, medical and other

specialists, psychiatrists, nurses, dentists, social workers, psychologists, and support staff combine with consultants and attending physicians to provide an interdisciplinary approach to patient care within the VA CWM. The healthcare system consists of the Medical Center and five CBOCS: Fitchburg, Greenfield, Pittsfield, Springfield, and Worcester, spanning a 75 mile radius. This residency takes place at both the Worcester and Northampton sites.

Worcester is the second-largest city in New England. In 2016, the Worcester CBOC outgrew its old building and was temporarily divided into 3 separate clinics, distributed around a several-block radius. The old Outpatient Clinic still houses primary care, Primary Care Mental Health Integration, and the pharmacy. The Plantation Street clinic houses rehabilitation services. The Worcester Lake Avenue Clinic, which is the primary setting for this residency, houses the entire Mental Health Unit, as well as the homelessness program and several specialty services, such as neurology and cardiology. The clinic is co-located on the 7th floor of the Ambulatory Care Center, a new building on the University of Massachusetts Memorial Medical Center campus, heralding the burgeoning relationship between UMass and our VA. In the future, the Worcester VA clinics will come together once again and form a super-CBOC, in a new and larger facility.

Program Administration

The Neuropsychology Residency program is our system's first psychology postdoctoral training program. It is housed within the Mental Health Service Line of VA CWM. The program is supervised by a team of seven staff members, including five neuropsychologists, two of whom are board certified. The program is independent of, but collaborative with and supported by, the psychology internship training program (co-Directors Brad Brummett, Ph.D., and Christina Hatgis, Ph.D.). The neuropsychology training committee meets monthly to discuss the management of the program and trainees' progress. Decisions regarding the training program require a consensus of present and voting members, and no changes are implemented until a consensus has been reached.

A list of supervisory staff and their biosketches can be found at the end of this handbook.

The Neuropsychology training program is aligned with the Education Service and is also collaborative with disciplines in other areas of training, particularly psychiatry, and enjoys a healthy relationship with the UMass Medical School postdoctoral fellowship program in neuropsychology.

Application Procedures

To be eligible for this residency position, applicants must:

(1) Be US citizens;
(2) Be graduates of doctoral programs in clinical psychology or neuropsychology that have been accredited by the American Psychological Association (APA), Canadian Psychological Association (CPA), or Psychological Clinical Science Accreditation System (PCSAS);
(3) Have completed dissertation and earned their doctorate *prior to* the start of residency;
(4) Have completed an APA-approved predoctoral internship (brand-new not-yet-accredited programs are exempt from this requirement);
(5) Have significant prior experience in clinical neuropsychology and have demonstrated a strong interest in practicing clinical neuropsychology as a profession.

Applications should include:

- Cover letter of intent, outlining career goals and goodness of fit
- Current curriculum vitae
- Two (2) de-identified sample reports
- Graduate school transcript (scanned unofficial copies preferred)
- (If dissertation is not yet completed) Letter from dissertation chair regarding dissertation status and expected completion date
- Three (3) letters of recommendation *sent directly by the letter-writers*. At least one must be from an internship supervisor.

We are *not* participants in the APPCN postdoc match.

VA Employment Policies

Nondiscrimination Policies

The Department of Veterans Affairs (VA) adheres to all Equal Employment Opportunity and Affirmative Action policies. The selection of residents is made without discrimination on the basis of race, color, religion, sex, national origin, politics, marital status, physical handicap, or age.

Trainees receive term employee appointments and must meet eligibility requirements for appointment as outlined in VA Handbook 5005 Staffing, Part II, Section B. Appointment Requirements and Determinations. https://www.va.gov/vapubs/viewPublication.asp?Pub_ID=646&FType=2

As a Veterans Health Administration (VHA) Health Professions Trainee (HPT), you will receive a Federal appointment, and the following requirements will apply prior to that appointment:

1. **U.S. Citizenship.** HPTs who receive a direct stipend (pay) must be U.S. citizens. Trainees who are not VA paid (without compensation-WOC) who are not U.S. citizens may be appointed and must provide current immigrant, non-immigrant or exchange visitor documents.

2. **U.S. Social Security Number.** All VA appointees must have a U.S. social security number (SSN) prior to beginning the pre-employment, on-boarding process at the VA.

3. **Selective Service Registration.** Male applicants born after 12/31/1959 must have registered for the Selective Service by age 26 to be eligible for U.S. government employment, including selection as a paid or WOC VA trainee. For additional information about the Selective Service System, and to register or to check your registration status visit https://www.sss.gov/. Anyone who was required to register but did not register before the age of 26 will need to apply for a Status Information Letter (SIL) and request a waiver. Waivers are rare and requests will be reviewed on a case by case basis by the VA Office of Human Resources Management. This process can take up to six months for a verdict. The requirements, benefits and penalties of registering vs. not registering are outlined here: https://www.sss.gov/Registration/Why-Register/Benefits-and-Penalties

4. **Fingerprint Screening and Background Investigation.** All HPTs will be fingerprinted and undergo screenings and background investigations. Additional details about the required background checks can be found at the following website: http://www.archives.gov/federal-register/codification/executive-order/10450.html. Please note that applicants are not automatically eliminated from consideration based solely on the existence of a criminal conviction.

5. **Drug Testing.** Per Executive Order 12564, the VA strives to be a Drug-Free Workplace. HPTs are not drug-tested prior to appointment, however are subject to random drug testing throughout the entire VA appointment period. You will be asked to sign an acknowledgement form stating you are aware of this practice. See item 8 below. Also, be aware of VA Directive 5383 - VA Drug Free Workplace Program: The VA is a drug-free workplace, including a prohibition against recreational

and medical use of marijuana/cannabis, regardless of its legal status on the state level. Although trainees are exempt from applicant drug testing, as federal employees, staff and trainees are subject to drug screens for other reasons specified in the VA Directive.

6. **Affiliation Agreement.** To ensure shared responsibility between an academic program and the VA there must be a current and fully executed Academic Affiliation Agreement on file with the VHA Office of Academic Affiliations (OAA). The affiliation agreement delineates the duties of VA and the affiliated institution. For the purposes of this post-doctoral residency, there is no affiliation agreement, as the resident is no longer enrolled in an academic program, and the program in which they are enrolled is VA sponsored.

7. **TQCVL.** To streamline on-boarding of HPTs, VHA Office of Academic Affiliations requires completion of a Trainee Qualifications and Credentials Verification Letter (TQCVL). An Educational Official at the Affiliate must complete and sign this letter. For post-graduate programs where an affiliate is not the program sponsor, this process must be completed by the VA Training Director. Your VA appointment cannot happen until the TQCVL is submitted and signed by senior leadership from the VA facility. For more information about this document, please visit https://www.va.gov/OAA/TQCVL.asp

    a. **Health Requirements**. Among other things, the TQCVL confirms that you, the trainee, are fit to perform the essential functions (physical and mental) of the training program and immunized following current Center for Disease Control (CDC) guidelines and VHA policy. This protects you, other employees and patients while working in a healthcare facility. Required are annual tuberculosis screening, Hepatitis B vaccine as well as annual influenza vaccine. *Declinations are EXTREMELY rare*. If you decline the flu vaccine you will be required to wear a mask while in patient care areas of the VA.
    b. **Primary source verification of all prior education and training** is certified via the TQCVL. Training and Program Directors will be contacting the appropriate institutions to ensure you have the appropriate qualifications and credentials as required by the admission criteria of the training program in which you are enrolled.

8. **Additional On-boarding Forms.** Additional pre-employment forms include the Application for Health Professions Trainees (VA 10-2850D) and the Declaration for Federal Employment (OF 306). These documents and others are available online for review at https://www.va.gov/oaa/app-forms.asp. Falsifying any answer on these required Federal documents will result in the inability to appoint or immediate dismissal from the training program.

9. **Proof of Identity per VA.** VA on-boarding requires presentation of two source documents (IDs). Documents must be unexpired and names on both documents must match. For more information visit: https://www.oit.va.gov/programs/piv/_media/docs/IDMatrix.pdf

Specific suitability information from Title 5 (referenced in VHA Handbook 5005):

(b)*Specific factors.* In determining whether a person is suitable for Federal employment, only the following factors will be considered a basis for finding a person unsuitable and taking a suitability action:

(1) Misconduct or negligence in employment;

(2) Criminal or dishonest conduct;

(3) Material, intentional false statement, or deception or fraud in examination or appointment;

(4) Refusal to furnish testimony as required by § 5.4 of this chapter;

(5) Alcohol abuse, without evidence of substantial rehabilitation, of a nature and duration that suggests that the applicant or appointee would be prevented from performing the duties of the position in question, or would constitute a direct threat to the property or safety of the applicant or appointee or others;

(6) Illegal use of narcotics, drugs, or other controlled substances without evidence of substantial rehabilitation;

(7) Knowing and willful engagement in acts or activities designed to overthrow the U.S. Government by force; and

(8) Any statutory or regulatory bar which prevents the lawful employment of the person involved in the position in question.

Additional considerations. OPM and agencies must consider any of the following additional considerations to the extent OPM or the relevant agency, in its sole discretion, deems any of them pertinent to the individual case:

(1) The nature of the position for which the person is applying or in which the person is employed;

(2) The nature and seriousness of the conduct;

(3) The circumstances surrounding the conduct;

(4) The recency of the conduct;

(5) The age of the person involved at the time of the conduct;

(6) Contributing societal conditions; and

(7) The absence or presence of rehabilitation or efforts toward rehabilitation.

Funding/Salary

Funding for the Clinical Neuropsychology Postdoctoral Residency program is annually renewed through dedicated funds from VA Central Office's OAA. The current annual stipend for our residents is $51,744 during the first year and $54,541 during the second, paid over 52 bi-weekly pay periods. You will be paid every other Friday via direct deposit. Benefits include the opportunity for group health insurance, vision and dental insurance as well as 10 paid federal holidays per year and up to 13 paid vacation and sick days as well.

Resources

Residents have a dedicated private staff office. This space is used for completing clinical evaluations as well as conducting other assigned duties. A VA laptop with a full range of VA-installed software is provided. Psychological and neuropsychological assessment tools are readily available. The VA online medical library is state-of-the-art, and our resource librarian is very accessible and knowledgeable. The VA has access to a broad range of professional journals. Administrative support is provided by the Mental Health Service Line.

Training Model

The training program adheres to a scientist-practitioner model of training. Skills are developed through a wide range of focused clinical, didactic, and research training opportunities in psychology and neuropsychology.

Clinical Training and Procedures (28 hours/week)

Residents spend approximately 70% of their time conducting clinical work. This primarily involves neuropsychological assessment of outpatient and inpatient veterans, though it may also entail individual or group neuropsychological intervention. First-year residents will complete 2 neuropsychological evaluations per week at WLA—one with each supervisor—and 1 evaluation per week at Leeds.

Outpatient Clinic. The Neuropsychology clinic is housed within the Mental Health Service Line and is currently staffed by four neuropsychologists across two sites. The primary mission of the clinic is to provide neuropsychological evaluation and consultation to Veterans and providers throughout the facility. The clinic collectively receives approximately 700 consults per year from Mental Health, Neurology, Primary Care, Polytrauma/TBI team, and other disciplines. The resident evaluates Veterans at both WLA and the Northampton VAMC. Outpatient neuropsychological evaluations at VA CWM are requested for a variety of clinical purposes, including but not limited to evaluations for dementia and/or decisional capacity, traumatic brain injury, psychiatric differential diagnosis (ADHD, PTSD, bipolar disorder, etc.), or other neurological disorders. A flexible battery approach is used for these cases, and test selection is discussed in advance with the designated supervisor for the case.

Polytrauma/TBI Clinic. This interdisciplinary rehabilitation team provides evidence-based evaluation and treatment of mild-to-severe traumatic brain injuries and Polytrauma. The team meets twice monthly and consists of staff from physiatry, physical therapy, neurology, occupational therapy, audiology, recreational therapy, speech therapy, neuropsychology, and social work. The TBI/Polytrauma Team serves approximately 200 Veterans per year.

The VA screens all Veterans from the recent conflicts in Afghanistan and Iraq for possible history of traumatic brain injury. If the screen is positive, the Veteran is referred to the Polytrauma/TBI clinic, where a “second-level screen” is performed. This screen consists of an interview, with particular focus on history of deployment-related TBI and current neurobehavioral symptoms, as well as a basic physical exam. Individuals who have cognitive concerns are often then referred for a neuropsychological evaluation. This is included among the potential referrals that may be assigned to the resident. In addition, the resident attends multidisciplinary team meetings as a contributing member.

Inpatient Clinics. This rotation includes both the Community Living Center (CLC) and inpatient psychiatry units.

The CLC at the Edward P. Boland Medical Center is a 30-bed nursing care unit. Residents include Veterans with geriatric and/or extended-care needs. A multidisciplinary team including representatives

from primary care (medical doctors, nurse practitioners), nursing, social worker, and psychology hold bi-weekly meetings to discuss care of residents.

The Medical Center campus also contains acute and sub-acute settings (including substance detox), as well as a specialized PTSD unit (one of only 4 VA programs of its kind in the nation). Daily rounds occur with engaged work teams consisting of psychiatry, nursing, primary care, and social work.

***Cognitive Rehabilitation Clinic*.** There are currently two groups held at the Worcester Lake Avenue clinic, and potential inpatient group opportunities at the VAMC. We have one group for Veterans of the recent conflicts in Iraq and Afghanistan, and we have one group for older adults with memory concerns. The resident may also engage in individual intervention with Veterans who have cognitive concerns but would not be appropriate for either group. Intervention approaches include provision of psychoeducation and teaching compensatory strategies.

Health Psychology Rotation. Residents complete two rotations (one per year) in health psychology services.

The Y1 resident rotates for 4 hours per week conducting health psychology services with our Health Behavior Coordinator. The resident's intervention rotation will primarily involve behavioral interventions involving behavior change in diabetes, pain, insomnia, tobacco cessation, and other medical conditions.

The Y2 resident rotates for 4 hours per week in the WLA Sleep Disorders Program, which is housed within the Mental Health Unit. The clinic provides behavioral sleep evaluations and groups for behavioral treatment of sleep. It also provides individual therapy for sleep disorders. Training is available in Cognitive Behavioral Therapy for Insomnia (CBT-I), Imagery Rehearsal Therapy (IRT) and Exposure, Relaxation, and Rescription Therapy (ERRT) for nightmare processing.

Didactic Opportunities (4 hours/week)

Worcester Neuropsychology Seminar (required). This is a weekly seminar, held on the UMass Medical School campus, operated by neuropsychology faculty from the VA and UMass. It is primarily a lecture-format seminar focusing on advanced neuropsychology-related topics, though the syllabus also includes discussion topics, case challenges, and trainee presentations. The seminar topics are organized in a 2-year rotation, so residents are expected to attend both years.

Interfacility VTC Neuropsychology Fellowship Didactic (required). This is a weekly seminar that includes several VA postdoctoral training programs across the country; it is based out of the Miami VA. Attendance is via video conference. The first hour every week consists of case presentations or fact-finding case challenges. The second hour is discussion-based and is organized around a specific neuropsychology topic. Residents are expected to complete assigned readings and generate questions for discussion every week. The topics for this seminar are organized in a 2-year rotation, so residents are expected to attend both years.

Neuropsychology Classics Journal Club (required). This is a monthly journal club in which we review truly "classic" journal articles in neuropsychology. These are the articles on which many modern studies and clinical procedures are based, but many of us have simply never read them.

Fact-Finding Seminar (required). This is a monthly seminar designed to mimic the fact-finding component of the board exam, in which a case is presented by a faculty member and trainees gather information to reach a diagnostic conclusion.

Brain Cuttings (required)*.* We take occasional field trips to the Bedford VA to observe brain cuttings. The brains that are presented in this forum are usually either of deceased veterans or of former athletes, as many brains from the Boston University Brain Bank are also processed here. This has been on hiatus for the past two years, and we hope to revive it soon. We will in the meantime participate in group viewings of brain cuttings online.

WLA Psychology Journal Club (required). Our monthly psychology journal club takes place on the fourth Thursday of every month. The subject matter of the selected article is at the discretion of the designated discussant, and this responsibility rotates throughout the year.

Grand Rounds*.* Residents are invited, but not required, to attend Psychiatry Grand Rounds at UMass and/or grand rounds at Baystate Medical Center. These consist of presentations on a variety of topics by either departmental faculty or invited speakers.

Neurobehavioral Grand Rounds*.* We are invited to attend these grand rounds at the Boston VA, which take place monthly. Complex neuropsychological cases are presented, usually with a neuropsychologist or neurologist serving as discussant.

UMass-Amherst presentations. Offerings are in the form of clinical psychology colloquia or behavioral neuroscience research presentations.

Research Activities (2-8 hours/week)

Residents have up to 1 day/week of protected time for research, to be decided on an individual basis. Some of the available opportunities include on-site archival research, prospective neuropsychological data collection, or collaborative investigations with the VISN 1 Mental Illness Research, Education, and Clinical Center (MIRECC) or other researchers. The minimum expectation by the end of residency is to have at least one finished research product that can be presented as a poster at a national conference and/or submitted to a professional journal. If desired, the year 2 resident may adjust the time allotted to research.

Supervision Activities

Each resident has weekly hour-long individual supervision with 3 neuropsychology supervisors (2 at WLA and 1 at Leeds). This is scheduled at the convenience of all parties. The resident also has 30 minutes of weekly individual supervision with their current health psychology rotation supervisor.

The advanced (year 2) resident serves as a supervisor for the neuropsychology practicum student, supervising 1-2 cases per month. There is a biweekly hour-long supervision-of-supervision peer group in which all neuropsychology supervisors on site—including the advanced resident—meet to discuss supervision topics.

Neuropsychological Evaluation Procedures

Scheduling. Cases will be scheduled for you by the Medical Support Assistants (MSAs). Always check your upcoming schedule in CPRS and your check-ins for the day via the VetLink Kiosk View program. Sometimes Veterans cancel last-minute, so you should always check CPRS right up until the Veteran checks in for his or her appointment. We also recommend making reminder calls the day before the evaluation. If a veteran fails to show up for a scheduled appointment, please notify the MSAs and ask your supervisor to discontinue the consult.

Interview. All veterans should be advised of your status as a resident in training and that the evaluation is being completed under the supervision of a licensed staff member. Veterans should also be advised of the limits to confidentiality. Risk assessment is a component of every clinical interview and should never be omitted. If there is concern about safety, the supervisor for the case should be consulted. In case of acute immediate concern about safety to the veteran or the resident, the resident should be familiar with all emergency procedures for the facility.

Testing. The resident should have reviewed the testing plan with his/her supervisor in advance. All testing materials are available in the testing cabinets or on the SharePoint. The resident should plan in advance so there are no last-minute competitions over any materials that may be in short supply.

Reports. Reports are to be entered into the chart within 2 weeks of the appointment. To meet this goal, we recommend the following timeline:

1) By the 1st supervision session after evaluation: all scoring should be completed
2) Within 1 week after evaluation: report draft should be completed and uploaded to Sharepoint
3) By the 2nd supervision session after evaluation: supervisor will be able to review report
4) Within 2 weeks after evaluation: report can be entered

All reports should be completed in a format that is approved by your supervisors. This format will differ among supervisors, so residents should be prepared to adapt to a variety of styles. Reports are to be uploaded to the Sharepoint site, and residents should email their supervisors when the report draft is ready for review.

Feedback. Residents are required to offer a feedback appointment, which should be scheduled for 2-3 weeks after the original evaluation. If the Veteran declines to return for feedback, it should be offered by VVC or phone. The Veteran is not *required* to agree to a feedback session, but all efforts should be made to facilitate one.

Policies and Procedures

The VA Central Western Massachusetts Healthcare System (VA CWM) Clinical Neuropsychology Postdoctoral Residency program is committed to making its policies and procedures available to residents at the start of residency. The policies include program and institutional requirements, expectations of residents, and the training program's commitments to residents. All policies and procedures are consistent with the current APA ethics codes, and adhere to the Veterans Health Administration's regulations and local state and federal statutes regarding due process and fair treatment.

Expectations of Residents

All residents practice under the licenses of their supervisors. No resident will practice a procedure for which her/his supervisor does not hold clinical privileges and for which the supervisor is not willing to assume responsibility. Supervisors must approve assessment and treatment activities of their supervisees. Supervisors co-sign all health record entries of supervisees.

Residents are expected to work a 40-hour week unless otherwise authorized by their supervisor.

Residents will be readily located by their supervisors on work days.

Residents, like all staff members, might occasionally need to handle emergencies that interfere with otherwise-protected activities, such as seminars. When possible a supervisor might cover such an emergency. However, a resident is expected to follow through on such situations even if doing so results in missing a training activity. Efforts should be made by supervisors to keep such events to a minimum.

Residents will represent themselves as "Neuropsychology Postdoctoral Resident" to veterans and to colleagues, including in their signature in the electronic medical record.

Residents always clarify their status with veterans by advising them that their work is being supervised by a licensed staff member in their discipline.

Documentation in the chart will be completed in a timely fashion, in keeping with rotation policy, medical staff bylaws, and supervisors' expectations.

It is expected that all residents will be familiar with, and follow, the APA Ethical Principles of Psychologists and Code of Conduct, which can be found on the APA website at: http://www.apa.org/ethics/code/index.aspx.

Hours

The default tour of duty for Neuropsychology is 8:00am to 4:30pm. You may work a different schedule only if it will contribute to your training experience and is approved by your supervisors and training director.

There is no formal clocking-in procedure, but you are expected to show up on time and not leave early. Not having a case or meeting scheduled early in the morning or late in the afternoon would not be a valid reason to arrive late or leave early. If you need to arrive late or leave early on rare occasion, you must have your supervisor's approval. If you arrive more than 15 minutes late or leave more than 15 minutes early, you must take annual or sick leave for the missed time.

You are expected to work 40 hours per week. You are not required to work more than 40 hours, and you cannot be reimbursed for work that you do outside of the scheduled work week. Residents may end up working longer hours depending on efficiency and time management.

Any extra hours on station may be used for report writing but not for clinical contact. You may not work in direct contact with veterans when your supervisors are not present on station. The only exception to the hours of clinical contact rule would be if there is an emergency and a licensed member of the resident's discipline is on station and available during those hours outside the routine tour.

At WLA, the clinic is open for business from 8am to 4pm. No clinical work should take place at WLA outside of those hours.

Leave Policy

The government pay system provides gradual accrual of leave hours. For each 2-week pay period, you accrue 4 hours of sick leave and 4 hours of annual leave. Residents may use their leave as needed, but they do need to notify their supervisor.

Advanced sick leave can be requested at the discretion of the training director if a need for sick leave arises before sufficient leave hours have been accrued. The approval of this advanced leave is at the discretion of HR.

Annual leave not used earlier in the residency can be used up at the end of training (to move up the end date). Unused annual leave will be paid in the final paycheck of the residency. Please note that, for departing residents heading off to VA jobs, accrued leave can usually be transferred to the new job after the residency ends.

Maternity Leave

Residents are not eligible for FMLA, but there is a standard policy for maternity leave.

- Residents who need to take maternity leave should first use any available sick leave and then any available annual leave.
- After exhausting those two reserves, leave advancement and leave donation should be requested.
    - For leave advancement, we would ask HR to advance the leave that will be accrued over the remainder of the current training year. Whether *all* of this potential leave is requested is at the discretion of the resident, who might want to hold back some leave for use during the remainder of the year.
    - For leave donation, colleagues and other VA employees have the option to donate some of their annual leave time to a resident whose request is approved by HR.
- If these options are all exhausted, we would look to initiate leave without pay (LWOP), which would yield no salary over that time period but it would maintain the resident's appointment and insurance benefits. The government may require that insurance dues be retroactively paid upon return from LWOP.

Other Time Off

Residents may also be granted up to a total of 10 days of "authorized absence" across the two years of residency. Determination of appropriate use of authorized absence is made by your supervisor and team leader, and requires approval of the Service Chief. A written request should be submitted to the training director well in advance of the requested dates. This type of leave, which does not utilize your own accrued hours, will be granted only for the following reasons:

- Special education workshops or conferences deemed important to your training experience at the VA;
- Taking the psychology licensing exam;
- Job interviews during the second year of residency.

Holidays

There are 11 legal holidays during the calendar year. Mental Health Service clinics are closed on those days. These holidays are:

Labor Day	Thanksgiving	MLK Birthday	Juneteenth
Columbus Day	Christmas Day	President's Day	Independence Day
Veterans Day	New Year's Day	Memorial Day	

Absences

If you *plan* to be absent, you need to:

(1) Receive approval from your clinical supervisors via e-mail.
(2) Alert Sara Lawson, the Lead MSA for Mental Health, so she can have your clinic(s) blocked.

Include regional Mental Health manager Dr. Cavallaro on all e-mails.

In the event of an *unplanned* absence (that is, if you are sick), you need to alert these people:

(1) Call Sara Lawson (**x2336**) and leave a message saying (a) that you're going to be out and (b) whether you have any clinical appts to cancel. Even if you do not, still say in the message that you do not, so it's not left up in the air. If you're not sure, say so.

(2) If you do have to cancel any clinic appointments—or if you're not sure—also immediately notify your assigned MSA. If you definitely have no clinic appointments *then* you can skip this step.

(3) **Email** Dr. Cavallaro and your supervisors (I recommend creating an email group of all of your supervisors so you don't have to worry about remembering whom to include for each day of the week—better to be overinclusive than underinclusive). Mention in this email, too, whether you have any clinic cancellations.

Be sure to enter any missed time into VATAS.

Using VATAS

As soon as you know you will be out, or as soon as you return from an unplanned absence, be sure to enter your leave into VATAS (vatas.va.gov/webta, or click the link on the intranet homepage). Once you are logged in, on the main menu, click "Leave Requests", then click the "Add Leave Request" button. On the form, select your Leave Type, the start and end date (if it overlaps a weekend, use two separate entries—do not leave a weekend or holiday between your start and end dates), and the start time and end time. It automatically calculates meal time and total hours. If you are requesting annual leave, click Submit at the bottom. If you are requesting sick leave, you need to select the reason for your sick leave, and then click Submit. You will receive a confirmation e-mail, and then another one when the leave request is approved.

Maintenance of Records

The Training Program maintains records in accordance with requirements of the accrediting body, APA CoA. This consists of permanently maintaining records of residents' training experiences, evaluations, and certificates of residency completion, as evidence of residents' progress through the program and for future reference and credentialing purposes. In addition, the Training Program keeps information and records of all formal complaints and grievances of which is aware that have been submitted or filed against the program since its last accreditation visit. The program will make these records available when the Commission on Accreditation examines the program's records of resident complaints as part of its periodic review of the program.

Licensure

You are requested to complete the EPPP no later than the midpoint of your second year of residency. Having this completed will significantly increase your chances of obtaining desired employment. If you have not already done so, you are also strongly encouraged to apply for the ABPP Early Entry program.

Resident Evaluation Procedures:

Progress in your residency will be assessed via our Core Competencies rating system for the neuropsychology residents. The competencies represent professional skills, knowledge, and behaviors that must be demonstrated in order for you to graduate from the residency program.

At the beginning of your training, you are asked to set learning goals/objectives for your residency. You also complete an initial fact-finding pre-test to identify any potential weaknesses that need further development during your training. From this and your own goals and objectives a formal, individualized training plan will be established. At least six times during your 24-month training, your supervisors will be asked to formally evaluate your progress in training as well as progress towards your training objectives. If you are having problems, this is the time to address them in order to enhance your training experience. If your supervisors rate your functioning as "below resident level" in important practice areas on the core competencies, a meeting will occur between you, the supervisor, and the Training Director to develop a remediation plan. The **MINIMAL GRADUATION REQUIREMENT** is that the median supervisor ratings of all of your core competencies are at a rating of "7" or above (at the level of "independent practice") on a 9-point scale by the end of your residency.

As we are invested in training and strive to continually improve, you will be asked to complete an evaluation of the various training experiences and rate your supervisors at various points of the residency. It is expected you will review these evaluations with the director. These evaluations will be kept in your trainee folder.

You will also be asked to evaluate your overall residency experience, anonymously, at the end of the training experience. There are several specific areas that you will be asked to address. This feedback will be used to plan and make programmatic improvements going forward.

Due Process

Mechanisms for Addressing Impaired or Deficient Performance:

The purpose of this section of the handbook is to describe processes in place for responding to and correcting deficient and/or problematic behavior exhibited by residents and the grievance policy procedures afforded to all trainees. Potential domains of problematic resident behavior include two general areas: 1) Professional skills, competence and functioning, and 2) Adherence to professional ethics.

Relatively minor problems identified at formal evaluations may result in the modification of training experiences. Such modifications are the responsibility of the primary supervisor but may be based on consultation with the Training Director and/or the Training Committee. Minor problems identified at the end of a quarter will be communicated to relevant supervisors of that resident and/or the Training Committee.

Problems deemed to be sufficiently serious to pose a potential threat to the resident's successful completion of the program will be referred to the Training Committee for consideration. Such problems may be identified at any time. In case of a serious breach of ethical principles, the Training Committee may recommend to the Mental Health Service Line that the resident be terminated immediately. In most cases, though, the Training Committee will develop a written remediation plan to help the resident achieve an acceptable level of performance. The remediation plan specifies the skills and/or behaviors to be changed and stipulates a date for remediation completion. The remediation plan may include a revision of the resident's training schedule. A copy of this plan will be given the resident. Within one week of the stipulated date for the completion of remediation, the Training Committee will make a determination of progress. The Training Committee will consider input from supervisor(s) and the resident. All Training Committee decisions will be by majority vote and communicated in writing to the resident. Three determinations by the Training Committee are possible, each followed by a different course of action:

(1) If a determination of satisfactory progress is made, the remediation plan will be terminated.

(2) If the Training Committee determines that sufficient progress is being made so that it seems possible the resident will successfully complete the residency but that further remediation is necessary, a revised remediation plan with completion date will be developed.

(3) If a determination of unsatisfactory progress is made, the Training Committee will conduct a formal hearing with the resident within one week of the meeting in which it is determined that unsatisfactory progress has been made. The resident will receive a minimum 3 days' notice to prepare for this hearing. Issue(s) of concern will be addressed to the resident by the Training Committee and any other staff electing to attend. The resident will be afforded an opportunity to respond and may invite anyone of his/her choice to attend the hearing to provide additional information. (However, trainees are not covered under union representation so this is not an option). Within one week of the hearing, the Training Committee will either develop a revised remediation plan or will recommend termination of the

residency to the Chief of Mental Health, Training Director, and ACOS of Education. Proceedings of the hearing will be documented in a summary transcript.

At any time prior to termination from the residency program, a resident may be permitted to resign his/her residency.

DUE PROCESS IN ACTION: THE IDENTIFICATION AND MANAGEMENT OF RESIDENT PROBLEMS/CONCERNS

This section provides residents and staff a definition of impairment, a listing of possible sanctions and an explicit discussion of the due process procedures. Also included are important considerations in the remediation of problems or impairment.

Definition of Problematic Behavior

Problematic behavior is defined broadly as an interference in professional functioning which is reflected in one or more of the following ways: 1) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior; 2) an inability to acquire professional skills in order to reach an acceptable level of competency; 3) an inability to control personal stress, strong emotional reactions, and/or psychological dysfunction which interferes with professional functioning; and 4) violation of the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (2002, with 2010 Amendments), or of laws governing the practice of psychology established by the Commonwealth of Massachusetts.

It is a professional judgment as to when a resident's behavior becomes problematic, rather than merely of concern. Trainees may exhibit behaviors, attitudes or characteristics, which, while of concern and requiring remediation, are not unexpected or excessive for professionals in training. Problems typically become identified as impairments when they include one or more of the following characteristics: the resident does not acknowledge, understand, or address the problem when it is identified; the problem is not merely a reflection of a skill deficit, which can be rectified by academic or didactic training; the quality of services delivered by the resident is sufficiently negatively affected; the problem is not restricted to one area of professional functioning; a disproportionate amount of attention by training personnel is required; and/or the resident's behavior does not change as a function of feedback, remediation efforts, and/or time.

Identification of Problematic Behavior

Problematic behavior on the part of a resident may be identified through a number of channels. For example, a resident may receive an “unacceptable” rating from any of the evaluation sources in any of the major categories of evaluation. Alternatively another staff member may report concerns about a resident's behavior (ethical or legal violations, professional incompetence).

If the staff member who observes concerning behavior is not the resident's primary supervisor, the staff member will consult with the Director of Training. Director of Training will discuss the concern with the resident's primary supervisor. The Director of Training may also consult with the full Training Committee or a subset of the Training Committee. If the Director of Training, primary supervisor, and /or Training Committee determine that the alleged behavior in the complaint, if proven, would constitute a serious violation, the Director of Training will inform the staff member who initially raised the concern, and remediation steps will be initiated, as outlined below. If the alleged behavior is not considered a serious violation, informal feedback, or a verbal warning may be deemed sufficient to address the behavior (Step 1 below).

Remediation and Sanction Alternatives

It is important to have meaningful ways to address problematic behavior once it has been identified. In implementing remediation or sanction interventions, the training staff must be mindful and balance the needs of the resident, the clients involved, members of the resident training group, the training staff, and other agency personnel. The following describes the graduated stages of intervention in the case of problematic behavior or impairment on the part of a resident:

- Step 1 - Verbal warning to the resident emphasizes the need to discontinue the inappropriate behavior under discussion. No record of this action is kept. Typically this feedback is given in the context of supervision with a direct supervisor, or in a face-to-face meeting with the Training Director. The resident will have the opportunity to respond to the feedback in the context of these face-to-face meetings. If Step 1 is insufficient to address the behavior, then we proceed to Step 2.

- Step 2 - Written acknowledgment to the resident formally documents that the Director of Training are aware of and concerned with a performance rating on the resident's evaluation; that the concern has been brought to the attention of the resident; that the Director of Training will work with the resident to rectify the problem or skill deficits; and that the behaviors associated with the rating are not significant enough to warrant more serious action. The resident is given the opportunity for a meeting or "hearing" with the Training Director, during which the problematic behavior is discussed, and the resident has an opportunity to respond. The written acknowledgment may be removed from the resident's file when the resident adequately addresses the behavior and successfully completes the residency. Alternatively the document may remain in the resident's file if they do not adequately address the problematic behavior. If Step 2 is insufficient to address the behavior, then we proceed to Step 3.

- Step 3 - Competency Remediation Plan:

    - Notification: the resident will be formally notified of the need to discontinue an inappropriate action or behavior. The written notification letter will contain: a clear

description of the resident's unsatisfactory performance or problematic behavior; expectations for acceptable performance; actions needed by the resident, and responsibilities of the supervisor or training committee, to correct the unsatisfactory behavior; a brief specified timeline for correcting the problem; assessment methods to verify successful correction of the problem; the date of the evaluation to determine if successful remediation has been achieved; and consequences if the problem is not corrected. This written notification may follow the format of the Competency Remediation Plan recommended in the APA Competency Assessment Toolkit for Professional Psychology (http://www.apa.org/ed/graduate/competency.aspx).

  - Hearing: There will be a meeting in which staff will articulate to the resident the specific nature of the problematic behavior, and the resident will have an opportunity to respond. This meeting will include the resident and the Training Director, and if appropriate, the supervisor or staff member who noticed/evaluated the problematic behavior. The notification process will provide for the resident to respond to the assessment of problematic behavior and remediation plan.

  - Appeal: The resident may request that a higher ranking psychologist review the assessment and remediation plan. The resident also has the right to appeal the final decisions and actions taken by the training program by requesting review by a higher ranking psychologist.

  - Documentation: A copy of the notification will be kept in the resident's file. Documentation will contain the position statements of the parties involved and the Competency Remediation Plan. When the remediation is complete and all benchmarks are met, this will be clearly documented on the Remediation Plan which will remain in the resident's file. If remediation is not completed, further steps may be undertaken, including another remediation plan, schedule modification, probation, suspension, administrative leave, or dismissal from residency (see below for discussion of Further Options).

  - Communication: This process will in most cases include communication with the Director of Clinical Training at the resident's academic program. Consultation with the APPIC Informal Problem Consultation service may also be initiated.

  - Maintaining performance: During remediation, the resident is expected to maintain minimally acceptable levels of performance in other competency areas.

- Step 4 - Further Options: If successful remediation is not achieved through Steps 1-3, further options may include:
  - Schedule Modification is a time-limited, remediation-oriented, closely supervised period of training designed to return the resident to a more fully functioning state. Modifying a resident's schedule is an accommodation made to assist the resident in responding to

situations such as personal reactions to environmental stress, with the full expectation that the resident will complete the residency. This period will include more closely scrutinized supervision, conducted by the regular supervisor in consultation with the Director of Training. Several possible and perhaps concurrent courses of action may be included in modifying a schedule. These include:

- increasing the amount of supervision, either with the same or other supervisors;
- changing the format, emphasis, and/or focus of supervision;
- recommending self-care interventions outside of the training program such as medical or mental health care (the resident can use his/her health insurance to pay for this, if they so desire);
- reducing the resident's clinical or other workload; requiring specific academic coursework.

- The length of a schedule modification period will be determined by the Director of Training, in consultation with the primary supervisor and an advisory subset of the Training Committee. The termination of the schedule modification period will be determined, after discussions with the resident, by the Director of Training in consultation with the primary supervisor and an advisory subset of the Training Committee.

- Probation is also a time-limited, remediation-oriented, more closely supervised training period. Its purpose is to assess the ability of the resident to complete the residency and to return the resident to a more fully functioning level of performance. Probation defines a circumstance in which the Director of Training systematically monitor for a specific length of time the degree to which the resident addresses, changes, and/or otherwise improves the behavior associated with the inadequate rating. The resident is informed of the probation in a written statement, which includes: the specific behaviors associated with the unacceptable rating; the recommendations for rectifying the problem; the time frame for the probation during which the problem is expected to be ameliorated; and, the procedures to ascertain whether the problem has been appropriately rectified. If the Director of Training determine that there has not been sufficient improvement in the resident's behavior to remove the probation or modified schedule, then the Director of Training will discuss with the primary supervisor and the Training Committee other possible courses of action to be taken. The Director of Training will communicate in writing to the resident that the conditions for revoking the probation or modified schedule have not been met. This notice will include the course of action the Director of Training and Training Committee have decided to implement. These may include continuation of the remediation efforts for a specified time period or implementation of another alternative. Additionally, the Director of Training will communicate to the Academic Director of Training from the resident's school,

that if the resident's problematic behavior is not adequately rectified, the resident will not successfully complete the residency.

- Suspension of Direct Service Activities requires a determination that the welfare of the resident's patient(s) or consultee(s) has been jeopardized. Therefore, direct service activities will be suspended for a specified period as determined by the Director of Training in consultation with the Training Committee. Again, the Director of Training will communicate with the Academic Director of Training from the resident's school regarding the suspension. At the end of the suspension period, the resident's supervisor, in consultation with the Director of Training and Training Committee, will assess the resident's capacity for effective functioning and determine when direct service can be resumed.

- Administrative Leave involves the temporary withdrawal of all responsibilities and privileges in the agency. If the Probation Period, Suspension of Direct Service Activities, or Administrative Leave interferes with the successful attainment of training hours needed for completion of the residency, this will be noted in the resident's file and the resident's Academic Director of Training will be informed. The Director of Training will inform the resident of the effects the Administrative Leave will have on the resident's stipend and accrual of benefits.

- Dismissal from the Residency involves a permanent withdrawal of all agency responsibilities and privileges. When specific interventions do not, after a reasonable time period, rectify the impairment and the resident seems unwilling or unable to alter his/her behavior, the Director of Training will discuss with the Academic Director of Training from the resident's school the possibility of termination from the training program or dismissal from the agency. Either administrative leave or dismissal would be invoked in cases of severe violations of the APA Code of Ethics, or when imminent physical or psychological harm to a patient is a major factor, or the resident is unable to complete the residency due to physical, mental or emotional illness. When a resident has been dismissed, the Director of Training will communicate to the resident's academic department that the resident has not successfully completed the residency.

Due Process - Summary

Whenever a formal decision has to be made by the Director of Training about a change in the resident's training program (i.e. Step 3 above), or status in the agency (i.e., Step 4 above), the Director of Training will: (a) inform the resident in writing and (b) meet with the resident to review the decision, and hear the resident’s response to the assessment, plan, and decision. This meeting may include the resident's primary supervisor. Any formal action taken by the Training Program may be communicated in writing to the resident's academic department. This notification includes the nature of the concern and the specific alternatives implemented to address the concern. Finally, the resident may choose to accept the

conditions and decisions, or may choose to challenge or appeal the action. The procedures for challenging the action are presented below under “Grievance Procedures”.

Due Process - General Guidelines

Due Process guidelines provide a framework to respond, act, or dispute, when the program has concerns about a resident’s performance. Due Process ensures that decisions about residents are not arbitrary or personally based. It requires that the Training Program identify specific evaluative procedures, which are applied to all trainees, and provide appropriate appeal procedures available to the resident. All steps need to be appropriately documented and implemented. General due process guidelines include: presenting to the residents, in writing during the orientation period, the program's expectations related to professional functioning, and discussing these expectations in both group and individual settings; stipulating the procedures for evaluation, including when and how evaluations will be conducted; articulating the various procedures and actions involved in making decisions regarding impairment; communicating, early and often, with graduate programs about any suspected difficulties with residents and when necessary, seeking input from these academic programs about how to address such difficulties; instituting, when appropriate, a remediation plan for identified inadequacies, including a time frame for expected remediation and consequences of not rectifying the inadequacies; providing a written procedure to the resident, which describes how the resident may appeal the program's action; ensuring that residents have sufficient time to respond to any action taken by the program; using input from multiple professional sources when making decisions or recommendations regarding the resident's performance; and documenting, in writing and to all relevant parties, the actions taken by the program and its rationale.

GRIEVANCE PROCEDURES: IF A <u>RESIDENT</u> HAS CONCERNS ABOUT THE PROGRAM

Purpose of Grievance Procedures

While Due Process delineates steps to follow in case of the training program’s concern about a resident, Grievance Procedures outline the steps a trainee would undertake if they had a complaint about a supervisor, a remediation plan or decision, or about the training program.

Grievance Procedure

In the event a resident encounters any difficulties or problems (e.g., poor supervision, unavailability of supervisor, evaluations perceived as unfair, workload issues, personality clashes, other conflict) during his/her training experiences, he/she is encouraged first to seek informal resolution and, if this does not resolve the issue, to then consider formal resolution. (Likewise, if a training staff member has a specific concern about a resident, the staff member is also encouraged to attempt informal resolution first.)

- Step 1- Informal Resolution: The resident will first attempt to discuss the issue with the staff member involved. If the issue cannot be resolved informally between the two parties, the resident (or staff member) should discuss the concern with the Director of Training. If the Director of Training cannot resolve the issue, the resident can move into a formal grievance process and challenge any action or decision taken by the Director of Training, the supervisor, or any member of the Training Committee by following the formal grievance procedure below.

- Step 2 - Formal Grievance Process: The resident should file a formal complaint, in writing with all supporting documents with the Director of Training. The formal complaint consists of a detailed description of the behavior(s) of concern. The resident's Formal Complaint will be shared with the staff member to whom the complaint pertains, as well as with the Training Committee, if needed to consult and assist in crafting a resolution. If the resident is challenging a formal evaluation, the resident must do so within five workdays of receipt of the evaluation.

Within five workdays of a formal complaint, the Director of Training must consult with the Training Committee Review Panel via the procedures described below.

- Step 3 - Training Committee Review and Process: When needed, a Training Committee Review Panel will be convened by the Director. The panel will consist of at least five members of the supervisory staff. Within five workdays of being convened, (i.e., within 10 workdays of the formal complaint) the Review Panel will meet with the resident who filed the Formal Grievance, to review the matter. The Review Panel will determine if further meetings with the other parties involved are required for fair evaluation of the situation. The resident will have the right to hear all facts, or to dispute or explain the behavior of concern, if the resident's grievance is in response to an evaluation of the resident. After having met with the resident, the Review Panel will determine a recommended course of action, which will be made by majority vote. Within three workdays of the completion of the review, the Director of Training will write a report, including the Review Panel's recommendations for further action. The Director of Training will inform the resident of the recommendations and any action to be taken.

If the resident disputes the recommendations of the Training Committee Review Panel, the resident has the right to contact the Mental Health Service Line Manager, who will either accept the Review Panel's recommendations or reject them and offer an alternative. The decision of the Mental Health Service Line Manager is final. Should the Mental Health Service Line Manager recommend further remediation, the Training Committee will develop a plan in accordance with the remediation and sanction guidelines specified above.

Other Resources and References:

- APA Competency Assessment Toolkit for Professional Psychology is available for building remediation plans: http://www.apa.org/ed/graduate/competency.aspx

- APA Commission on Accreditation, Office of Program Consultation and Accreditation is available for resident and program consultation: http://www.apa.org/ed/accreditation/

- APA Ethics Office is available for resident and program consultation: http://www.apa.org/ethics/

- Residents (and/or the training program) may avail themselves of the APPIC Informal Problem Consultation service: http://appic.org/Problem-Consultation

- If informal resolution is unsatisfactory, residents may file a formal complaint with the APPIC Standards and Review Committee: https://www.appic.org/About-APPIC/APPIC-Policies/ASARC

[1]These policies are pending review by Human Resources.

Residency Faculty

Lee Ashendorf, Ph.D., ABPP-CN, Board-Certified Neuropsychologist, Training Director, Worcester

Dr. Ashendorf earned his Ph.D. in 2005 from the University at Albany, State University of New York, completing his internship training in neuropsychology with a minor in health psychology through the VA Connecticut Healthcare System's West Haven campus. He completed a 2-year postdoctoral fellowship in neuropsychology at the Edith Nourse Rogers Memorial Veterans Hospital. He worked there as a clinical neuropsychologist and co-director of neuropsychology training for several years, until 2016, when he joined the Worcester Outpatient Clinic in the VA Central Western Massachusetts (VACWM) Healthcare System. He functions as a clinical neuropsychologist and oversees neuropsychology referrals to this clinic. He is also a member of the VACWM TBI/Polytrauma and Caregiver Program teams. He holds a faculty appointment as Assistant Professor of Psychiatry in the University of Massachusetts Medical School. He also works part-time as a clinical neuropsychologist in a group practice. He was the lead editor of the book, *The Boston Process Approach to Neuropsychological Assessment*, and has presented locally and nationally on this topic. He was elected a Fellow of the National Academy of Neuropsychology in 2014 and was the 2015 recipient of the Massachusetts Neuropsychological Society's Edith Kaplan Award. He has over 30 publications and has served as Associate Editor of the *Archives of Clinical Neuropsychology* and (currently) *Developmental Neuropsychology*. His research interests include psychometric applications of the Process Approach and implementation of forensic neuropsychological tools in Veteran populations.

Megan E. Brault, Psy.D.*,* PCMHI Psychologist, Worcester

Dr. Brault received her Doctorate in Clinical Psychology from La Salle University in Philadelphia in 2014. She completed her Internship training at the University of Central Florida Counseling Center and a Post-Doctoral Fellowship in Primary Care Behavioral Health at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, MA. She also completed training through The Department of Family Medicine of the University of Massachusetts in Worcester, MA and is certified in Primary Care Behavioral Health through the Center for Integrated Primary Care. Dr. Brault has worked in adult, family medicine and pediatric primary care settings and has training in weight management, bariatric surgery evaluations, smoking cessation, diabetes management and pain management. Dr. Brault is the PCMHI Psychologist at the VACWM Worcester clinic.

Brad Brummett, Ph.D., Edward P. Boland VAMC Neuropsychology Service Coordinator, Co-Director of Internship Training, Northampton

Dr. Brummett completed his clinical psychology PhD in 2007 at Fordham University in Bronx, New York, with training in neuropsychology, substance abuse treatment, multicultural issues, and Schema Therapy.

While completing his degree, he spent a year providing counseling services at a methadone clinic in the heart of San Francisco, and he lived overseas. Dr. Brummett completed a 2-year, clinical neuropsychology postdoc from and was employed as a staff neuropsychologist at Kaiser Foundation Rehabilitation Center before moving back east to Massachusetts. Prior to joining the VACWM medical center, he worked at the VA Boston Healthcare System as a clinical neuropsychologist and as a research scientist with the Translational Research Center for Traumatic Brain Injury and Stress Disorders (TRACTS). Dr. Brummett was also a clinician with MedOptions, Inc., and he provided cognitive evaluations, behavioral consultation, and counseling services for Veterans at Holyoke Soldiers' Home. He was the consulting psychologist for our facility's community living center (nursing care unit), where he provided psychotherapy, behavioral consultation, and neuropsychological assessment. Dr. Brummett serves as a site-PI for a funded study examining remote benefits counseling. He is a voting member of the VACWM Research & Development Committee and a former voting member on the VACWM and VA Connecticut IRB. Dr. Brummett previously served on the Massachusetts Psychological Association (MPA) Board of Directors, and he is currently Co-Chair of the MPA Early Career Psychologist committee and member of the MPA Committee on Ethnic Minority Affairs. He maintains research interests in the areas of disability examinations and neuroscience. Dr. Brummett provides clinical services for Neuropsychology, TBI/Polytrauma, and Compensation & Pension.

Teresa H. Malinofsky, Ph.D.*,* Neuropsychologist, Northampton

Dr. Malinofsky started her professional career as a music therapist, then became clinical psychologist and neuropsychologist. As music therapist at the Creative Arts Rehabilitation Center, in NYC, she worked with children and adolescents with severe autism and adults with psychiatric and neurologic conditions. At the same time, she took courses in physiological psychology at NYU and laboratory experience at Rockefeller University before moving to the University of Cincinnati where she obtained her PhD in clinical psychology. Her PhD dissertation topic was Changes in Object Representation in Hypnosis as Manifested on the Rorschach Test. She interned at Cambridge Hospital (now the Cambridge Alliance) in clinical psychology, and obtained postdoctoral-level training and work experience in neuropsychology for a few years at Harvard-affiliated hospitals, including Massachusetts General Hospital. Her training and this early experience in neuropsychology was with geriatric and psychiatric populations. Then in Western Massachusetts, she first worked at the Weldon Center for Rehabilitation, Mercy Hospital, where she was Director of Neuropsychology and Chief Psychologist for the Inpatient Brain Injury Unit. At the same time, she co-edited a book, The Psychotherapist's Guide to Neuropsychiatry: Diagnostic and Treatment Issues (1994), along with co-editors James Ellison, MD, and Cheryl Weinstein, PhD, from the Harvard-affiliated hospital system. The book was well-received and has been translated into Korean. Dr. Malinofsky also contributed a chapter on a neuropsychological perspective on personality disorders. When her brother contracted HIV-AIDS and she was his primary family member and support, she moved from hospital-based work to consultation for the Statewide Head Injury Program (SHIP/Massachusetts Rehabilitation Commission), which allowed her the freedom and time to travel, both to help her brother, as well as provide consultation throughout Western Massachusetts, to agencies and schools, serving the severely traumatically brain injured and their families. Following her brother's death, and

the birth of her second child, she started her private practice in neuropsychology and also taught at the Antioch New England Graduate School, courses in neuropsychology and biological foundations of clinical psychology. In 2003-2009, she worked three days per week as neuropsychology consultant to the Geropsychiatry team at Baystate Franklin Medical Center. Following that, she returned to full-time private practice in neuropsychology with associated work in cognitive rehabilitation and psychotherapy, and also supervised practicum students from Antioch New England Graduate School. Now at VAMC, Leeds, Dr. Malinofsky does neuropsychological assessments, some psychotherapy, and a weekly C&P exam, and serves as Assessment rotation supervisor and Case Conference facilitator for the internship program. She has developed a new interest in dissociation, a not uncommon symptom of PTSD.

Jeffrey McCarthy, Psy.D., Supervisory Psychologist, Program Manager for Western Region CBOCs, Northampton

Dr. McCarthy is the Program Manager for Outpatient Mental Health Services provided at the five Community Based Outpatient Clinics (CBOCs) of the VACWM HCS. He also provides clinical services in the Mental Health Clinic at the Springfield CBOC including individual and group psychotherapy, as well as psychological and neuropsychological assessment services. He is an intern supervisor for the Community Based Outpatient Psychology Track located at the Springfield Clinic. He previously worked as the psychologist on the TBI/Polytrauma team, and has provided numerous lectures in a number of venues in the local area on the subject matter. He has been actively involved on the OEF/OIF Interdisciplinary Team tasked with improving the integration of Mental Health and Primary Care. He received his doctoral degree in Clinical Psychology in 2004 from the Adler School of Professional Psychology in Chicago, while also completing a specialty in Neuropsychological Assessment. He completed his internship training at the VACWM HCS and a portion of his postdoctoral training in the Psychosocial Rehabilitation Fellowship program at the West Haven VAMC. He then worked for almost two years at Neuro-Psychology Associates of Western Massachusetts evaluating and treating patients with various neurological conditions, including traumatic head injuries, progressive dementing disorders, and neurobehavioral disorders, before returning to the VACWM HCS.

Miriam L. Rubin, Ph.D., CBSM*,* Staff Psychologist, Rotation Supervisor, Coordinator of Sleep Disorders Program, Worcester

Dr. Rubin received her PhD in Clinical Psychology from the University of Missouri-Columbia. Dr. Rubin has served as supervisor to pre-doctoral psychology interns with the VA Brockton - West Roxbury Medical Center from 1992 to 2005, the VA Boston HCS from 2005 to 2011, and VACWM HCS since 2013. When the Worcester Outpatient Clinic was re-aligned to the VACWM HCS in 2011, she led the team in developing a proposal for a VA Interprofessional Mental Health Education Expansion Initiative resulting in the acquisition of 2 recurring full-time training positions (one Psychology and one APRN intern). She has VA certification training in CBT-I and Exposure, Relaxation, and Rescription Therapy for Military populations (ERRT-M) for the treatment of trauma nightmares, and VA training in CPT, EMDR, and

Seeking Safety. She supervises interns in the provision of empirically based diagnostic assessments and CBT-oriented psychotherapy including Seeking Safety, CPT, anger management, smoking cessation, stress management, and weight management. She developed the Managing Anger Program, a series of workshops that combine psycho-educational and experiential techniques. She has provided staff trainings in anger management and the prevention of violence in clinical settings, including PMDB. Dr. Rubin received Certification in Behavioral Sleep Medicine (CBSM) in 2014. Her interest in sleep disruption related to psychological trauma led her to establish the WLA Sleep Disorder Program, which offers evidence-based assessment and treatment of insomnia, nightmares, and sleep-disordered breathing, including CBT-I, ERRT(M), and C-PAP compliance treatment. Her research interests include behavioral and pharmacological treatment of trauma-related sleep disturbances, and she is currently the PI of an IRB-approved VA study examining factors impacting adherence to Prazosin for sleep disturbance in combat veterans with PTSD. She is a member of the American Psychological Association, the Sleep Research Society, and the Society of Behavioral Sleep Medicine (SBSM), and serves on the SBSM Membership Committee.

Sarah Ward, Ph.D., ABPP-CN, Board-Certified Neuropsychologist, Worcester

Dr. Ward earned her doctorate in clinical psychology at the University of Minnesota-Twin Cities in Minneapolis, where she focused on neuropsychological assessment and research in behavioral genetics. She interned at the Massachusetts Medical Center/Beth Israel Deaconess Medical Center/Harvard Medical School, in the neuropsychology track, and with an additional focus on outpatient therapy to individuals with serious mental illness. She completed a two-year clinical neuropsychology post-doctoral fellowship at Beth Israel Deaconess Medical Center/Harvard Medical School, with rotations in outpatient psychiatry, outpatient neurology, Department of Mental Health, and Boston HealthCare for the Homeless. She works as an assessment psychologist at the Worcester clinic of VACWM. She spends part of her time conducting clinical neuropsychological and psychological evaluations for Veterans as part of the Worcester Mental Health Clinic and the TBI/Polytrauma team. She also completes mental health compensation and pension evaluations for the Veterans Benefits Administration. She provides clinical supervision in neuropsychological and psychological assessment in Worcester.