Dear VA Psychologist Colleagues-

What a year we have had! It is simply amazing to look back over the past year and recognize what we have accomplished working together in our mission to provide the best health care experience for the men and women who have served our country in the military. Despite decreased resources, resulting from the ill-advised transfer of funds to Choice, VA has continued to provide outstanding comprehensive and integrated care to Veterans. Psychologists and other behavioral health providers unrelentingly deliver evidenced based treatments across a wide range of health care settings and programs. Access is improving despite the lack of necessary resources. Any success we have had is due to the hard work of VA employees across the nation. We need to be proud of all we have accomplished during a particularly challenging time. Despite continuing assaults by the press and self-serving individuals and groups, the men and women of the VA have proven that the VA is capable of both reinventing health care practice and leading in the provision of quality health care in the US.

In my office, I have photographs of my mother and father who served in the United States Navy in World War II. I have a photograph of my brother, a physician assistant, who served 30 years in the United States Navy on active duty and as a reservist. And, in my office, I have copies of documents attesting to the enlistment, prisoner of war status, and line of duty death of my great, great maternal uncle who served in the United States Army and died at Fort Pickering in Memphis during the Civil War. The photos and documents are convincing reminders for me of two realities: 1. Our work in VA is a sacred duty—a mission—on behalf of our service men and women. 2. VA must never become a corporate for-profit enterprise.

The AVAPL Executive Committee (John McQuaid, Ron Gironda, Mary Beth Shea, Steve Cavicchia and I) along with our Advisory Board have worked steadily in building strong collaborative relations with Veterans Service Organizations as we strive to overcome well-funded efforts to privatize the VA. As you know, on January 21, 2016, John McQuaid, Russell Lemle, Edgardo Padin, and I, with the support of APA, the Association of VA Social Workers and the National Association of Social Workers, presented a review of empirical studies documenting the overwhelming effectiveness of VA behavioral health programs to the Commission on Care. As a result of the AVAPL presentation, the few unbiased members of the commission reported feeling buoyed in their efforts to accurately assess the current state of VA health care. As a result of the presentation to the Commission on Care, VSOs recognized AVAPL as an ally to be reckoned with in the fight to defeat special interests attempting to privatize the VA.

On March 23, 2016, Russell Lemle and his research team at the San Francisco VA next provided an in depth review of empirical studies on VA health care covering the past twenty years to AVAPL and then to the Commission on Care. Study after study indicates the overall superior care provided by VA when compared to other health care organizations on a wide variety of health care measures. That review helped to slow an

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attempt by the Koch brothers’ front organization, Concerned Veterans of America, to hijack the commission and begin a process of dismantling of the VA health care system and turning VA into a for-profit business.

On June 21, 2016, Russell Lemle and I represented AVAPL at an exceptionally informative and exhilarating conference sponsored by The Roosevelt Institute and Union of Veterans Council entitled, Keeping The Promise: What’s Next For The VA? The conference featured presentations by Dr. David Shulkin, Undersecretary for Health, a panel of experts moderated by Dr. Carolyn Clancy, VA Deputy Under Secretary for Health for Organizational Excellence, a panel of Veterans moderated by Jackie Maffucci, Research Director, Iraq and Afghanistan Veterans of America and a presentation by Dr. Kenneth Kizer, Distinguished Professor and Director, Institute for Population Health and Improvement, University of California Davis Health System. All presentations were outstanding but of special import for me were three facts presented by Terri Tanielian, Senior Research Analyst, Rand Corporation: 1. VA outperforms all other health care organizations on 45 of 47 outpatient care measures; 2. VA outperforms all other health care organizations on 26 of 37 inpatient care measures; 3. VA outperforms all other mental health care organizations by 30% on every indicator. It is important to know that Russell Lemle was successful in having two AVAPL documents (Comparison of VA to Community Healthcare: Summary of Research 2000-2016 and VA Medical Innovations and Discoveries placed in the folders provided to attendees and members of the press).

Within a month, Ron Gironda, and newly elected AVAPL Executive Committee members will take on the task of leading our organization. I am grateful for the opportunity you have provided me to be of service to Veterans, to the VA, and AVAPL during this past year and I look forward to continuing my service as Past President in the year to come.

—Thomas Kirchberg, PhD, President, AVAPL

(Continued from page 1)
Milestones in the 70-year History of the
VA Psychology Training Program

1946—The first VA psychology training class started in the fall with 215 clinical psychology graduate students from 22 universities. They were appointed part-time to work in a VA near their university, and supervision was primarily provided by their university faculty. The first appointment of counseling psychology graduate students began in 1953 with 55 more positions.

1968—Funding was provided for 771 psychology graduate students from 94 universities, with all universities now required to have APA accreditation before acceptance of their students into the VA psychology training program. VA psychologists now had been doing most of the supervision of VA students for the past several years.

1974—The psychology training program at the VA in Topeka became the first VA to be independently accredited by APA after a 1973 VA Central Office decision that mandated that all VA training programs must have independent accreditation for continued funding. Prior to that time, VA-funded psychology training programs were considered to have blanket accreditation by APA if their students came from APA-approved doctoral programs. By 1985, 84 VA internship training programs had received independent APA accreditation.

1991—The first VA funded psychology postdoctoral training programs were in substance abuse and were established at Dallas and Seattle as part of an interprofessional clinical team program. Prior to that, the training programs at Palo Alto, California and Knoxville, Iowa had received NIMH funding to do postdoctoral training in geriatric mental health in 1983 and 1984, respectively.

1999—The psychology training program at San Antonio became the first VA to have their postdoctoral training program accredited by APA and was only the third postdoctoral training program in the country to receive this accreditation.

2005—APA’s accreditation website noted that almost half of the accredited psychology postdoctoral training programs were housed in VA medical centers.

From 1946 through 2015, the VA provided over 30,000 funded psychology pre- and post-doctoral training positions for clinical and counseling psychology graduate students. Reducing that amount by an estimate of 1/3 receiving funding in the VA for both pre- and post-doc training, it is estimated that 28,000 unique individuals received some level of psychology training during that 70-year period. Thousands of other psychologists have received training without compensation.

— Rod Baker, Ph.D., Former VA Psychology Historian

*In the previous issue of the AVAPL newsletter, we neglected to give proper photo credit to Oberlin College Archives regarding the photo of Ruth Hubbard.
The shooting started just after 2 AM. I saw on the news at 8 AM that 20 were dead. By 11 AM, it was 50. At 3 PM, I was activated by our Emergency Management Team to go to the Family Reunification Center downtown. This is where the families of the missing were gathering to get news of their loved ones. I called the social worker on our EM team and she was on her way home from Pensacola. So I recruited 3 other AVAPL psychologists with disaster mental health training and we met at the Center. My hospital Director was already there, in shorts and a golf shirt. The atmosphere was extremely tense, as the families already knew their loved ones weren’t on the hospital rosters, but there is always hope—until there is not. All day and into the evening, the families met with the medical examiners and the mortuary team to give descriptions of their loved ones; that info was taken back to try to match it with someone in the morgue. When a match was found, the medical examiner gave the news to law enforcement, who then delivered the news to the families. Law enforcement requested a mental health person and a chaplain to be with them when the families were notified.

The notifications began Sunday night and went throughout the day on Monday. I was with 2 large families when they heard the news of their daughter and son being killed in this mass murder. The pain is difficult to describe, and was even more difficult to witness. There are no words that can help at that moment. The closest I was able to do was to be present with them, be compassionate, and give them all the time they needed to process what had happened. Fortunately, as I said, both were large, extended families, and they had each other to cry with and hold on to. There was no rushing this. Time was not a factor. We just waited, touching when it seemed appropriate, crying with them, rocking a baby when he awoke to the sound of his grandmother’s pain.

Eventually, someone would ask, “What do we do now?” and we would take them to the next step: meeting with the FBI and/or Attorney General’s office. We stayed with “our families” throughout their time at the Center, finally walking them to their cars (away from media) when they were ready.

When not with the families, we supported each other. We brought drinks to the cops who were outside in the heat, and asked about their involvement. Some had more to say than others. All were touched in some way by this event. We met our neighbors who were also there to help: chaplains and religious leaders of all faiths, the City of Orlando staff, Medical Examiners, city and county law enforcement, therapy dog handlers, public and private agencies, Red Cross, Vet Centers, the fire department, even the Governor. There was a closeness among strangers who were all there for one mission: to help our community get through this.

Being so close to the center of it, it’s been hard to see the extent of it. It feels like a personal event, not a national media show. When I think of what happened, I think of individual faces—families, caregivers, first

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The 19th annual VA Psychology Leadership Conference was held at the Westin Riverwalk Hotel in San Antonio, Texas from May 31 - June 3, 2016. This year’s theme was VA Psychology: Strengthening Partnerships, Building the Future. We had approximately 180 attendees, including 30 speakers, 66 first-time attendees, and 32 trainees!

The conference opened on a bittersweet note as we paid tribute to Dr. Kathy McNamara as she prepares for retirement. Despite a few weather-related challenges, Dr. McNamara’s friends and family, colleagues, and former and current supervisees were on hand to share her many accomplishments and attributes.

To start the main conference, we had a blockbuster morning line-up including Dr. Jennifer Lee, Deputy Under Secretary for Health for Policy and Services; Mr. Matthew Collier, Senior Advisor to the Secretary for Strategic Partnerships; and a panel discussion with Veteran Service Organization representatives Dr. Thomas Berger (Vietnam Veterans of America) and Dr. Jacqueline Maffucci (Iraq and Afghanistan Veterans of America). These three sessions highlighted current partnerships at the national level and ideas for strengthening ties to better advocate for Veteran mental health and VA psychology. The morning plenary sessions on Thursday were just as powerful, with an inspiring talk on integrated care from APA President Dr. Susan McDaniel and a rousing and provocative discussion on the current national policy environment by Mr. Stephen Trynosky. Among our interactive breakout sessions, the open discussions on Access to Treatment and Veterans’ Choice were standing room only! Another fantastic breakout, chaired by Ms. Kacie Kelly, included a panel of mental health providers all engaged in innovative partnerships. We also had amazing presentations on SAIL, peer support, C&P evaluations, EBP training, and VA psychology advocacy updates.

Our networking lunches provided ample opportunity for people to break bread over themes like early- and mid-career goals, training, advocacy, Title 38, and the glass ceiling. New this year was the well-received job exploration breakfast to provide a forum for sharing upcoming job openings and recruiting those seeking a job. The poster session was vibrant and alive with 20 posters over two sessions from all areas of scholarly inquiry. We were also fortunate to host our annual trainee dinner, which allowed senior leaders to meet our talented trainees and provided trainees a rare opportunity to enjoy the company of several high-ranking leaders.

The post-conference Behavioral Health Leadership Training Boot Camp workshop, featuring Dr. Lisa Kearney and Dr. David Carroll, had over 75 attendees and was a great interactive learning experience that provided a wonderful close to this year’s conference.

And finally, a hearty and well-deserved congratulations to Dr. Russell Lemle, our 2016 Patrick DeLeon Advocacy Award winner! Ever the champion for the VA and VA psychology, Dr. Lemle’s contributions to advocacy this past year were amazing! Congratulations, Dr. Lemle!

— Amee Patel, PhD, Conference Chair
What is the background for this initiative?

As part of the My VA Transformation (see link below), led by Secretary McDonald, VA established 12 Breakthrough Priorities for 2016. One of the 12 priorities focuses specifically on increasing access to health care and is further elaborated as the MyVA Access Initiative.


The initiative includes a focus on mental health by ensuring that any Veteran reaching out for care is provided prompt, personal attention by a provider. Although there have been policies in place to address this need, several challenges were noted in prior implementation of prompt initial screening for new patients and appropriate crisis responses. For example, schedulers might make an intake appointment but Mental Health was never notified to perform the initial screening evaluation as required in policy since 2007. The Veteran might then have a crisis situation occur or have an urgent need while waiting weeks for their appointment. This initiative assists in expediting access to the right mental health service and immediate urgent care, if needed. It also aims to increase Veterans’ satisfaction with care and likelihood of engagement.

What is most important for readers to know about the initiative?

This is not solely a mental health initiative. It is part of a system wide change process that needs to include every service and employee at our facilities to succeed by ensuring that any Veteran reaching out for care receives prompt, personal attention by a provider and feels personally cared for when first asking for help and are most vulnerable.

Could you comment on any anticipated “asks” that will be coming from VACO?

The first big “ask” is for sites to submit their SOPs that reflect the standards for prompt access to care. In order to be successful at implementing same day access, each facility will need to closely examine processes by thinking through how Veterans enter the system and how to ensure that they always get a personal touch by a provider. For example,

The first time a Veteran calls for an appointment, does the scheduler answering the phone not only know to make the appointment, but also to notify MH so that a LIP calls them back that day or no later than the next calendar day?

Doing this well means thinking through each scenario and ensuring that providers and staff throughout the system know how to make this happen seamlessly.

The next big step will be creating implementation plans to include all parts of the system in the process. There are examples of implementation plans on the Pulse Site (https://www.vapulse.net/groups/access-mental-health-services)

How will changes impact frontline providers?

Frontline providers may be called upon to open up appointment slots to assist with initial screening evaluations. In addition to being a part of a Veteran’s personalized care, one benefit is that you will be increasing the likelihood the Veteran gets to the exact appointment they need the first time.

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Could you tell us how this became such an important area of work for you?

I had the good fortune of developing a graduate school Independent Study, spending a day a week in the State legislature with the lobbyist for the Ohio Psychological Association (OPA). This offered a most valuable lesson – the power that one voice advocating for Psychology can have. After internship I continued my advocacy journey, serving on the OPA Legislative Committee and other roles requiring advocacy. Through successes, and long term struggles to have Psychology’s contributions recognized, my dedication to advocacy was reinforced. I remained involved in State level advocacy in Hawaii, and continued to be active at the national level, including on issues specific to veterans and for VA psychologists.

Though my advocacy activity may be most visible in the legislative arena, being a voice for Psychology, the essence of advocacy, existed across many venues. Opportunities to be Psychology’s voice at the local level sustained my commitment. Advocating that Psychology is present in primary care settings, with pain management programs, in women’s health clinics, or in other similar roles is as critical a type of advocacy as being in the legislature. Supporting staff in roles such as the Coordinator for Military Sexual Trauma or Evidence-Based Treatments, or in contributing to the Office of Mental Health Operations Best Practices, are invaluable avenues for advocacy. How advocacy became so important is tied directly to how deeply I believe in what we do as psychologists.

What have been some of the most rewarding aspects of teaching and training?

Rewards have been many, and began during my ten years as a faculty member at the WSU School of Professional Psychology - a classroom teacher, Director of Training for the Internship Program, and clinical supervisor. Rewards continued as the VA’s Director of Training and clinical supervisor. Some of the richest rewards came in seeing a supervisee exercise such competent judgment handling a difficult situation. The follow-up supervision, discussing how it is not always how much one knows, but what one does with what is known that is important, is very rewarding. Interns and Residents, eager to learn things about our profession not found in textbooks, bring more reward: their commitment to Psychology and the beginning of an identity as a psychologist. It is especially rewarding knowing that those who touched my life earlier in their careers are now in positions where their influence will make a difference as they take leadership roles in professional associations or in a VA or another employment setting.

What are some things you would like the future generations of VA psychologists to know?

Future generations should know that much is possible by believing in themselves. You can make things happen. Psychological practice is changing, and will certainly continue to change. With your education and training, your skills, and our profession’s ethics and standards, you have a great capacity to adapt to change and make it your own – Psychology’s own. You are not just a future generation, you are Psychology’s future. You, too, will be very proud to be a psychologist as you share your perspective with the next of our future generations.

What’s it like to work and live on a gorgeous island?

It is an incredible feeling to look around every morning and evening and tell myself that I live in this most beautiful place! I never lose the sense of awe and am ever mindful of how special it is that I am here. But, there is a beauty that goes far beyond the surroundings. It is the beauty of the people of Hawaii. There is a gentle spirit shared so readily if one who comes from a different place can be open to it. This really is a place of aloha – welcoming, accepting, sharing, caring….

It is this beauty that will be the foundation for my retirement. I will continue and slightly expand my existing neuropsychology practice - I enjoy the challenge and value providing this service for our local neurologists and the patients. I anticipate again being actively engaged in advocacy and the political process, without the restrictions as a federal employee. And, I definitely will be spending many more daylight hours outside, working in my yard or spending time in our beautiful mountains! Of course, all will be in balance!!!

Aloha.
The Minneapolis VA has had an outpatient Dialectical Behavior Therapy (DBT) program since 1995. The decision to start an intensive outpatient program was influenced by lack of resources at other VA hospitals (less than 10% of VA hospitals offer DBT) and new research indicating that delivering DBT and Prolonged Exposure (PE) therapy concurrently is less likely to result in self-harm or a suicide attempt than offering DBT alone (Harned et al, 2014). The program is a good fit for the Minneapolis VAHCS, which values training, research and dissemination of evidence-based treatment. In addition, Dr. Meyers used timing to her favor by lobbying for the new program in 2012, when there was an increase in funding for mental health. However, there are always barriers or hurdles to be overcome. In this case it was the assumption of risk: asking to bring some of the highest risk Veterans to an unsupervised lodging program in Minneapolis. Focusing on reduction of suicide attempts and the high national need helped overcome this barrier. The program receives referrals from across the country. They admit 8 Veterans on a split-cohort admission basis (i.e., 4 Veterans admitted every 6 weeks), with an equal number of male and female participants. They have 3 FTEE divided among 10 providers: 8 psychologists, 1 social worker, and 1 nurse. Participants will see a psychiatrist one time upon admission; medications are prescribed by the home VA. As the Program Coordinator, Dr. Meyers is mapped .3 administrative time.

Journeys is a 12-week program, M-F; they implement both PE and DBT with fidelity. Veterans participate in a DBT skills group 3 times/week and individual PE starts at week 3. Veterans participate in PE 2 times each week through approximately week 8, then focus on preparing to return home for 3-4 weeks. Veterans also participate in weekly community integration behavioral activation (“Enjoy Your Life”) and in vivo exposure (“Facing Your Life”) groups. An important feature of DBT is 24 hour telephone coaching to generalize DBT skills. Staff members share on-call responsibilities, which means that each staff member is on-call once every 10 weeks. Initially staff received special contribution awards based on hours worked (time spent responding to calls), which evolved to comp time. More recently, staff have been awarded on-call pay (10% of their hourly rate for every hour on-call).

The Journeys team has developed a supportive, collegial environment and a philosophically consistent team. Team members meet twice weekly for consultation and receive workload credit internally for time spent in consultation. Because the team is philosophically aligned, Veterans receive a consistent message and splitting is minimized. Staff utilize the concepts of empathic understanding and multiple truths in all areas of their work together. In addition the work is extremely rewarding: staff often see positive changes in Veterans who have been “written off” by others. Many Veterans continue to stay in contact with the team, thanking them for the program and letting them know how much it has saved and changed their lives.

Journeys collects data from all participants and currently has an article under review. Participants receive a battery of measures upon admission and after discharge. The PTSD Checklist and Depression Anxiety Stress Scale are given every 4th PE session. Large effect sizes have been found across the majority of measures given. One of their more interesting findings is that the dropout rate is 21.4 and the majority of drop-outs occur early in the program or at the end, not during trauma processing; prior to admission many of these Veterans had history of dropping out of PE or CPT.

If you are thinking about starting a similar program, Dr. Meyers recommends starting with an outpatient DBT program; this allows for the development of a solid DBT team that works well together. Doing so is also less resource intensive, because it can be developed using components from existing programs. Dr. Meyers and her staff are available for consultation. In addition, they can provide a three-day training upon request. Dr. Meyers can be reached at laura.meyers2@va.gov.

Website: [http://www.minneapolis.va.gov/services/Journeys.asp](http://www.minneapolis.va.gov/services/Journeys.asp)

— Laura Meyers, Ph.D.
CRATER THERAPY FOR VETERANS WITH MILD-TO-MODERATE COGNITIVE IMPAIRMENT

For patients with Acquired Brain Injury (ABI), the standard practice is cognitive remediation; these patients are seldom accepted into MHC for behavioral treatment due to memory difficulties. We have developed an alternative treatment model at the Palo Alto VA: treatment of the ABI with CRATER Therapy.

CRATER Therapy is one-on-one psychotherapy with embedded cognitive remediation focusing solely on strategies used in social settings. It teaches patients how to slow the flow of information in social interactions to increase engagement. After 6 months of weekly CRATER therapy, patients can engage in other forms of therapy from which they were previously excluded. We believe CRATER is more effective, because it addresses both psychological factors and cognitive retraining:

Patients want their memory, speed, attention, and ability to multi-task to return to previous levels. Cognitive deficits cause patients to feel overwhelmed in social situations; this results in a consistent catastrophic dysphoric affect that is frequently seen by others as a psychiatric difficulty. Most cognitive deficits appear in social situations; most cognitive remediation is not taught in the social context. Patients are expected to generalize strategies on their own. Group cognitive retraining is almost always ineffective.

CRATER therapy has six important components, encapsulated by the CRATER acronym:

- **C** Catastrophic reaction: tying the performance of a socially acceptable cognitive strategy to the particular symptom of cognitive overwhelm in the environment that evokes it.
- **R** Regularization of the sleep/wake cycle to provide physiological anchors for cognitive strategy performance.
- **A** Alliance between therapist, patient and significant other to:
- **T** Triangulate and
- **E** Externalize the blame for symptoms to something outside of the patient, the neurological insult.
- **R** Resilience and Reinvention by coping rather than by competing

The patient learns their catastrophic reaction (CR) resulting from cognitive overwhelm in social situations. There are six possible reactions, but individuals display only one consistently: Flight/avoidance, Anger, Laughing, Crying, Freezing, or Confusion.

In CRATER therapy, the patient uses their CR as the cue to perform a strategy that slows the interaction down to a manageable speed. The strategy must be socially acceptable and must be explicitly taught to patients, not “discovered” by them. Patients are encouraged to overlearn the strategy, so that it is readily available when under stress.

If available, a significant other is present in most sessions; to learn what the patient learns, and how long it takes them to over-learn. The partner is taught to give one thing to do at a time, learns to offer compliments realistically (5:1 ratio of positive comments to one correction), is taught that progress is based on the patient’s learning rate, and that closed-ended statements promote conversation.

We use a handheld application, PEAT™ software via smartphone, a voice-cued calendar and memory prosthetic. Software includes features that can be tied to physiological anchors. For example, an icon of a cupcake is pressed after every meal (PEAT Dessert). This shows today/tomorrow’s events, orienting the patient to what is coming up in the next 24 hours. The physiological anchor of eating/pressing the cupcake enhances orientation. The software also has an episodic memory cache which allows patients to record, scribble, type or take photos in the moment. At a set time of day, the software turns on and reviews all collected new information. The amount of time it takes to learn each feature is taught to the patient.

CRATER establishes resilience by promoting the concept that the patient knows how to survive neurological impairment, can struggle to reach skill competency a second time, can achieve a meaningful life when all is not perfect, and can cope with adversity and reduced life expectations. Keys to success are the ability to use remediation unassisted, alliance with therapists, and reducing slowed processing.

(Continued on page 12)
Russell Lemle was honored with the Pat DeLeon Advocacy Award during the 2016 AVAPL annual conference. Russell has been a tireless advocate for Veterans and for VA Health Care for the longest time. A list of his initiatives and achievements over the course of his VA service is lengthy. However, over the past year he has extended himself even more vigorously by working day-in and day-out to build and maintain collaborative relationships with VSOs, research groups, professional organizations, VACO, community and advocacy organizations with the goal of ensuring that Veterans will continue to receive the outstanding health care provided in the VA system. It has been a unique honor for me to work with Russell over this past year and I look forward to ongoing collaborative efforts with him. The battle to maintain our unique and prized mission of caring for Veterans will continue.

AVAPL, under the very able and diligent guidance of Mary Beth Shea, AVAPL Treasurer, has continued the work of moving VA Psychologists into full Title 38 status. While Mary Beth’s work on behalf of Title 38 status for VA Psychologists has resulted in widespread and strong support within VACO, VSOs, and APA, solidifying support within the congress is a work in progress. We owe a debt of gratitude to Mary Beth for her ongoing dedication to Title 38 for Psychologists.

I am grateful to Steve Cavicchia who stepped into AVAPL leadership and served as secretary following the departure of Monica Cortez-Garland. Steve provided in depth knowledge and experience of both AVAPL and VA that has strengthened our efforts to maintain effective and collaborative relations with VACO and VSOs.

Jeff Burke, besides providing wise counsel to the Executive Committee on multiple issues, has continued his outstanding management of our website. Jeff established our user friendly Advocacy page and has quickly vetted and mounted document after document over the past year. The AVAPL Advocacy page has become the one site where powerfully persuasive studies and articles supportive of VA health care can be easily accessed. The AVAPL Advocacy page is a source of pride for VA Psychologists. I personally have referred Veterans, VA employees, VSO leaders and members, and citizens to the page and the feedback to me on its usefulness is uniformly positive. The Advocacy page is the result of excellent collaboration among many AVAPL members. I am grateful for Jeff’s continued leadership and dedication to Veteran health care, VA, and AVAPL.

Amee Patel is due grateful recognition for her guidance of the planning which resulted in one of the most heralded annual conferences (VA Psychology: Strengthening Partnerships, Building the Future) in AVAPL history. She worked closely with Sam Wan who, having handed off the mantle of leadership last year, nevertheless continued to provide guidance in a gracious and thoughtful manner.

In all of our efforts, your executive committee has striven to maintain mutually respectful and informed working relationships with our Mental Health leaders in VACO especially Dave Carroll, Harold Kudler, Wendy Tenhula, Marsden McGuire and Stacey Pollack. I am grateful to our leaders who have made themselves readily accessible to frank and helpful conversations about AVAPL initiatives and concerns.

Finally, I need to let you know that through all these efforts the AVAPL leadership team has benefited from access to invaluable knowledge, support, and practical advice from Heather Obeirne-Kelly and Toni Zeiss. They are both strong advocates for Veterans and VA Psychology. I am personally grateful to Toni and Heather for their willingness to consult with me at even the most inopportune moments.

— Thomas Kirchberg, PhD, President, AVAPL
responders, volunteers—not the murderer. I don’t want to know his story. I don’t care. I want to know the stories of those who died, so they may live on with us.

But it is national. I have heard from VA colleagues from Alaska to Hawaii to Puerto Rico and nearly everywhere in between. The outpouring of emotion and support is astounding.

Our VA team stood down after 3 days. I redeployed as a Red Cross volunteer to the vigils, the GLBT Center, and the 49 crosses. Each experience has been profound.

Our home has changed. Right now, there are lots of hugs and tons of money. Everyone wants to help. But it’s a wound that won’t heal. Those 49 won’t come back. Our city will recover but we’re all changed forever.

What resources exist to assist with implementation of this initiative?

Weekly educational calls (Mondays at 2pm EST) provide detailed information about best practices and policy guidance. Smaller twice weekly Community of Practice calls (Tuesdays at 4pm EST, Thursdays at 9am EST) allow for open discussion and dialogue. The Pulse Site also includes many resources. “FOLLOW” the site for updates when a new resource is uploaded.

Further, partners from the Veterans Engineering Resource Center (VERC) are supporting the overall My VA Access initiative. VERC systems engineers can work with you to create implementation plans to support successful rollouts locally. There are also calls in our partner program offices like ACAP and Primary Care to educate schedulers and Primary Care staff who will be needed for successful implementation.

Finally, the PCMHI Same Day Dashboard provides a resource for weekly feedback on same day progress in each required clinic. The results of same day chart reviews will likely be available in June to help identify potential areas for improvement.

What can we anticipate from these efforts?

Veteran satisfaction and engagement with care will likely improve as these processes are solidified at your site. Other metrics will be added to support implementation, including measures of Veteran satisfaction with urgent care responses. Additionally, we will be looking at other methods to support implementation, such as templates for local utilization.
Vote Now in the AVAPL Elections!

It's time to elect new officers for AVAPL! This year, we are electing a new President-Elect and a new Treasurer. There are three candidates for each office.

The election will conclude at 1:00 AM Eastern time on Saturday, July 16, 2016, so be sure to cast your ballot before then. The newly elected President-elect and Treasurer will be announced at the AVAPL business meeting at the APA Convention in Denver.

If you have not received an email with your unique SurveyMonkey link to the election ballot, or if you have any questions, please contact John McQuaid, Past President, AVAPL.

Interested in submitting articles to the AVAPL Newsletter?

We have created an article submission portal. You can access it from your VA computer.

http://vaww.mysite.r02.portal.va.gov/personal/vha17_vhactxtsanj/AVAPL%20newsletter/default.aspx

- Click on “article submission”
- Keep submissions to 500-word limit and include a picture, image, or graph with each submission if possible.

If you have ideas about content, please contact Genevieve Davis at Genevieve.Davis@va.gov

Association of VA Psychologist Leaders  http://www.avapl.org/